



## **Religious Attitudes, Cultural Sensitivity, and Family Planning Individuals of Reproductive Age in Türkiye**

Türkiye’de Üreme Çaęındaki Bireylerde Dini Tutumlar,  
Kültürel Duyarlılık ve Aile Planlaması

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## RELIGIOUS ATTITUDES, CULTURAL SENSITIVITY, AND FAMILY PLANNING INDIVIDUALS OF REPRODUCTIVE AGE IN TÜRKİYE

### ABSTRACT

**Aim:** This study sought to examine the relationship between the reproductive and family planning (FP) attitudes of individuals of reproductive age in Türkiye and their religious attitudes and cultural sensitivity.

**Method:** A cross-sectional study was conducted among 485 individuals aged 18–49 years living in Türkiye. The sample size was calculated as 235 using power analysis. The study was completed with 485 participants recruited online. Instruments included the Descriptive Information Form, the Reproductive Health and Family Planning Attitude Scale (RHFPAS), the Ok-Religious Attitude Scale (ORAS-I), and the Intercultural Sensitivity Scale (ISS).

**Results:** The participants' mean RHFPAS, ORAS-I, and ISS scores were  $211.65 \pm 38.46$ ,  $28.03 \pm 7.89$ , and  $81.81 \pm 15.62$ , respectively. There was a statistically significant positive association between religious attitudes, cultural sensitivity, and reproductive and FP attitudes ( $p < 0.001$ ). Religious attitudes and cultural sensitivity together accounted for 45% of the variance in reproductive and FP attitudes.

**Conclusions and Suggestions:** Individuals of reproductive age in Türkiye demonstrated positive reproductive and FP attitudes, high religiosity, and moderate to high cultural sensitivity. Religious attitudes and cultural sensitivity significantly predicted reproductive and FP attitudes, accounting for nearly half of the explained variance. These findings highlight the importance of incorporating religious and cultural perspectives into FP counselling and education programs.

**Keywords:** Family Planning, Religious Attitudes, Cultural Sensitivity, Reproductive Health, Reproductive Age.



## TÜRKİYE'DE ÜREME ÇAĞINDAKİ BİREYLERDE DİNİ TUTUMLAR, KÜLTÜREL DUYARLILIK VE AİLE PLANLAMASI

### ÖZ

**Amaç:** Üreme ve aile planlaması konusunda toplumsal, dini ve kültürel unsurlar önemli rol oynamaktadır. Din ve kültüre duyarlı aile planlaması hizmetleri, yöntem kullanım düzeyini arttırabilir. Bu araştırmanın amacı, üreme çağındaki bireylerin üreme ve aile planlaması tutumları ile dini tutumları ve kültürel duyarlılıkları arasındaki ilişkiyi incelemektir.

**Yöntem:** Kesitsel ilişki arayan tipteki araştırmanın evrenini Türkiye’de yaşayan üreme çağındaki (18-49 yaş) bireyler oluşturmuştur. Örneklem güç analizi ile 235 olarak hesaplanmıştır. Araştırma 485 katılımcı ile tamamlanmıştır. Veriler Aralık 2023-Nisan 2024 tarihleri arasında “Tanıtıcı Bilgi Formu”, “Üreme ve Aile Planlaması Tutum Ölçeği (ÜAPTÖ)”, “Ok Dini Tutum Ölçeği (ODTÖ)” ve “Kültürel Duyarlılık Ölçeği (KDÖ)” ile online olarak toplanmıştır.

**Bulgular:** Katılımcıların ÜAPTÖ toplam puan ortalaması 211,65±38,46, ODTÖ toplam puan ortalaması 28,03±7,89 ve KDÖ toplam puan ortalaması 81,81±15,62’dir. Katılımcıların dini tutum, kültürel duyarlılık ile üreme ve aile planlaması tutumu arasında pozitif yönde bir ilişki vardı ( $p<0,001$ ). Katılımcıların üreme ve aile planlaması tutumlarına ilişkin toplam varyansın %45’ini dini tutumları ve kültürel duyarlılıkları açıklamaktaydı.

**Sonuç ve Öneriler:** Katılımcıların üreme ve aile planlaması tutumları olumlu, dindarlık seviyelerinin yüksek ve kültürel duyarlılıkları iyi düzeydeydi. Üreme ve aile planlaması ile dini tutumun ve kültürel duyarlılığın birbirlerini olumlu yönde etkilediği görülmüştür. Katılımcıların üreme ve aile planlaması tutumunun yaklaşık yarısını dini tutumları ve kültürel duyarlılıkları oluşturmuştur.

**Anahtar Kelimeler:** Aile Planlaması, Dini Tutum, Kültürel Duyarlılık, Üreme Sağlığı, Üreme Yaşı.



## INTRODUCTION

Individuals have the right to decide whether or not to use family planning (FP) methods and to make informed choices regarding their fertility. FP encompasses practices that assist couples in having children at a time they consider appropriate and desirable, as well as determining the number of children and the spacing of births in line with personal preferences and financial circumstances (Gavas & İnal, 2019). As one of the key components of reproductive health, FP enhances both fetal and maternal well-being, reduces unintended pregnancies, enables individuals to have as many children as they wish and are able to care for, promotes a safe and satisfying sexual life, and helps prevent complications during pregnancy, childbirth, and the postpartum period. In this way, FP contributes not only to the health of women and children but also to the overall well-being of society (Şolt & Bulut, 2023; Sundararajan et al., 2019). Expanding access to FP services and meeting unmet FP needs are also crucial for achieving universal reproductive health coverage, as emphasised in the 2030 Agenda for Sustainable Development (Kantorová, Wheldon, Ueffing, & Dasgupta, 2020). Despite this, FP utilisation rates remain below the desired level both globally and in Türkiye (Nazik et al, 2021; Sundararajan et al., 2019). Worldwide, only 64% of women aged 15–49 who are married or co-

habiting use any contraceptive method, while the rate drops to around 40% in less developed countries (Hossain, Khan, Ababneh, & Shaw, 2018). In Türkiye, unmet FP needs are reported at 12% (Türkiye Demographic and Health Survey, 2018).

FP utilisation and attitudes are shaped by social, cultural, religious, environmental, and familial factors (Gavas & İnal, 2019; Götmark & Andersson, 2020; Hossain et al., 2018; Sundararajan et al., 2019). Beliefs and misinformation are particularly influential in method uptake. Culturally and religiously informed counselling has therefore been recommended to foster more favourable views of FP (Gavas & İnal, 2019; İbar Aydın & Çıtak Bilgin, 2020; Pinter et al., 2016). Recent global assessments suggest that progress is uneven and unmet need remains substantial, underscoring the importance of sustained investment in FP (Kantorová et al., 2020).

Religion is a multifaceted phenomenon that shapes individuals' attitudes and behaviours and is deeply embedded in culture (Ok, 2016). It influences ethics, ideology, and decision-making across societies. Beliefs about FP differ across major religions, and recognising these differences is important for cultural competence (Pinter et al., 2016). Some studies report no religious influence on FP use (Bakibinga et al., 2016; Karaoğlan & Duman, 2017), while others find the opposite (Dynes et al., 2018; Sundararajan et al., 2019). Historical debates, such as those at the 1994 UN Population Conference in Cairo, illustrate how religious opposition—particularly to abortion and women's autonomy—can shape demographic trends (Götmark & Andersson, 2020). Doctrinal positions also vary: the Roman Catholic Church prohibits FP, while many Protestant denominations permit it; Judaism forbids certain methods considered “wasting seed”; Islam commonly supports birth spacing for maternal and child well-being (Quran 2:286); and Hinduism generally permits all forms of birth control, including permanent methods (Pinter et al., 2016). Collectively, these examples highlight the strong influence of religious beliefs on FP attitudes and practices.

Culture is a dynamic force that shapes societies' ways of life, values, and practices. Intercultural sensitivity—the ability to respect and respond to cultural differences—entails awareness, openness, and the absence of prejudice. Women's access to and utilisation of FP services are strongly linked to cultural beliefs (Vizheh et al., 2024). For instance, in some Middle Eastern Muslim contexts, sexual relations are viewed primarily as a means of childbearing, and FP is perceived as contradicting divine will. In parts of Indian culture, FP is sometimes regarded as sinful because it is seen as rejecting a gift from God (Liu et al., 2024).

Religious and cultural attitudes, shaped by environmental influences and individual reasoning, reflect personal values and perspectives. Identifying the family planning (FP), religious attitudes, and cultural sensitivities of individuals of repro-

ductive age can increase the use of preferred FP methods consistent with their religious and cultural values. Increasing the use of FP methods can contribute to maternal, fetal, and community health, prevent unwanted pregnancies, maximize compliance with the FP method used, increase male participation in FP method use, and enhance individuals' biopsychosocial quality of life. This can be beneficial for healthcare professionals providing FP counseling services that align with clients' religious and cultural values. It can also pave the way for innovative ideas in FP methods to develop new FP methods aligned with individuals' religious and cultural values. It is recommended that studies be conducted examining religious attitudes and cultural factors, as they may be related to reproduction and FP attitudes in the literature (Götmark & Andersson, 2020; Sundararajan et al., 2019). Moreover, studies involving single individuals and men are still limited (D'Souza et al., 2022; Kantorová et al., 2020). To date, no national study in Türkiye has simultaneously explored FP attitudes alongside religious attitudes and intercultural sensitivity, and international evidence on this topic also remains scarce. Accordingly, this study sought to investigate the relationship between reproductive and FP attitudes, religious attitudes, and cultural sensitivity among individuals of reproductive age in Türkiye.

### Research Questions

- What are the total mean scores of the Reproductive Health and Family Planning Attitude Scale (RHFPAS), the Ok-Religious Attitude Scale (ORAS-I), and the Intercultural Sensitivity Scale (ISS) among individuals of reproductive age?
- Do the mean RHFPAS, ORAS-I, and ISS scores differ according to the personal characteristics of reproductive-age individuals?
- Is there a relationship among the mean RHFPAS, ORAS-I, and ISS scores of individuals of reproductive age?
- Do the ORAS-I and ISS mean scores predict the RHFPAS among individuals of reproductive age?

## METHOD

**Research Design:** This cross-sectional study was conducted using the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) checklist.

**Sample/Study Group:** The study population consisted of individuals of reproductive age (18–49 years) living in Türkiye. A power analysis was performed using

G\*POWER 3.1.9.7 to determine the sample size. Based on the mean total score of The Ok-Religious Attitude Scale ( $4.43 \pm 0.94$ ) reported by Turgay (2018), a power of 95% and  $\alpha=0.05$  were assumed for the calculation, yielding a sample size of 235. Accounting for potential data loss, the study aimed to include 259 participants, with an additional 10% increase in each group. Ultimately, 485 participants who met the inclusion criteria were enrolled in this study. The inclusion criteria were as follows: (1) between 18 and 49 years of age (participants of any gender), (2) being literate, (3) not being pregnant, (4) not being menopausal or andropausal, (5) not having any physical or mental disability, (6) using an Android smartphone, (7) having internet access, and (8) volunteering to participate. A post hoc power analysis showed that the study had a post hoc power of 99%.

**Data Collection Tools:** Data were collected through the “Descriptive Information Form,” the “Reproductive Health and Family Planning Attitude Scale (RHF-PAS),” “The Ok-Religious Attitude Scale (ORAS-I),” and the “Intercultural Sensitivity Scale (ISS).”

*Descriptive Information Form:* Developed by the researchers based on the literature, this 18-item form gathered the demographic information (such as age, marital status, educational level, employment status, monthly income level) of the participants (Şolt & Bulut, 2023; Dynes et al., 2018; Kökcü, 2010; Sundararajan et al., 2019).

*Reproductive Health and Family Planning Attitude Scale (RHF-PAS):* Reproductive Health and Family Planning Attitude Scale (RHF-PAS): It was developed by Kökcü et al. (2010) to determine individuals’ reproductive and family planning attitudes.

*The Ok-Religious Attitude Scale (Islam) (ORAS-I):* It was developed by Ok (2011) to determine the religious attitudes of individuals

*The Intercultural Sensitivity Scale (ISS):* The Intercultural Sensitivity Scale (ISS): It was adapted into Turkish by Bulduk et al. (2011) to determine the cultural sensitivity of individuals.

**Data Collection Process:** Data were collected via online survey software (Google Forms) using the snowball sampling method between December 2023 and April 2024. In order to reach more participants from the Turkish sample, the snowball sampling method was preferred in this study. In snowball sampling, contact is first made with one member of the target population, who then refers the researcher to another member. This process continues, expanding the sample in the manner of a “snowball.” Initially, the researchers reached the participants through their own social circles and then extended the call for participation through tho-

se individuals. The survey link was shared on WhatsApp, Twitter, Instagram, and Facebook at the beginning of each week. The first page of the online questionnaire provided participants with information about the purpose of the study and obtained written informed consent. On average, the participants completed the self-reported questionnaire in approximately 15 minutes.

**Data Analysis:** Data were analyzed using IBM SPSS Statistics for Windows, version 26.0 (Statistical Package Corp., Armonk, NY, USA). Descriptive statistics were used, such as frequencies, percentages, means, and standard deviations. Normality was assessed using the Kolmogorov-Smirnov test. For comparisons, t-tests and ANOVA were used for normally distributed data, and Bonferroni tests were applied for post hoc analyses. Pearson's correlation analysis was used to examine the relationships among the scales, and linear regression was employed to identify the factors influencing the RHFPAS scores. Scale reliability was measured using Cronbach's alpha ( $\alpha$ ). Statistical significance was set at  $p < 0.05$ .

### Validity and Reliability:

*Reproductive Health and Family Planning Attitude Scale (RHFPAS):* RHFPAS is a five-point Likert-type scale consisting of 52 items and three subdimensions (unintended pregnancies, sexually transmitted infections, infertility, and assisted reproductive treatments). It contained 21 positive and 37 negative items. The lowest and highest possible scores were 1 and 5, respectively. There was no cut-off point; higher scores indicated more positive attitudes toward reproductive health and FP. Cronbach's alpha for the scale was 0.88 (Kökçü, 2010). In this study, Cronbach's alpha was 0.95.

*The Ok-Religious Attitude Scale (Islam) (ORAS-I):* ORAS-I is a five-point Likert-type scale with eight items and four subdimensions (behavioral, emotional, cognitive, and relational). Items 5 and 6 were reverse-coded. The minimum possible score was 8, and the maximum score was 40; higher scores indicated greater religiosity. The Cronbach's alpha for the scale was 0.91 (Ok, 2011). In this study, Cronbach's alpha was 0.89.

*The Intercultural Sensitivity Scale (ISS):* The ISS is a five-point Likert-type scale with 24 items and five subdimensions (interaction engagement, respect for cultural differences, interaction confidence, interaction enjoyment, and interaction attentiveness). Items 2, 4, 7, 9, 12, 15, 18, 20, and 22 are reverse-coded. The minimum possible score was 24, and the maximum score was 120. The Cronbach's alpha for the ISS was 0.72 (Bulduk et al., 2011). In this study, Cronbach's alpha was 0.89.

**Ethics Committee Approval** Ethical approval was obtained from the Bartın University Social and Human Sciences Ethics Committee of the university to whi-

ch the researchers were affiliated (Protocol No: 2023-SBB-0825, Date: December 11, 2023). On the first page of the online data collection form, participants were given a written explanation of the research's purpose and its potential contributions to the literature. They were then asked to provide written confirmation of their voluntary participation if they wished to participate. The research was conducted in accordance with the Declaration of Helsinki.

## RESULTS

Table 1 shows the differences in the mean RHFPAS, ORAS-I, and ISS scores according to the participants' demographic characteristics. The mean age of the participants was  $22.31 \pm 3.95$  years, and the mean duration of marriage was  $2.81 \pm 5.83$  years. A significant relationship was found between educational level, employment status, monthly income-expense perception, FP method use, opinions on who should use FP methods, opinions on who should decide on FP methods, type of religious belief, and the RHFPAS ( $p < 0.005$ ). A significant relationship was also found between employment status, geographical region of residence, perception of reflecting on one's cultural characteristics, FP method use, opinions on who should use FP methods, opinions on who should decide on FP methods, type of religious belief, and ORAS-I ( $p < 0.005$ ). Additionally, there was a significant relationship between employment status, geographical region of residence, perception of reflecting one's cultural characteristics, opinions on who should use FP methods, opinions on who should decide on FP methods, type of religious belief, and ISS ( $p < 0.005$ ) (Table 1).

**Table 1.** Differences in RHFPAS, ORAS-I, and ISS Mean Scores by Participants' Demographic Characteristics (n=485)

Variables	$\bar{X} \pm SD$			
Age (min: 19, max: 49)	22.31±3.95			
Number of pregnancies (min: 0, max: 9)	0.09±0.57			
Number of children (min: 0, max: 4)	0.07±0.36			
Number of miscarriages (min: 0, max: 2)	0.01±0.12			
Duration of marriage (min: 0, max: 28) (years)	2.81±5.83			
Variables	N (%)	RHFPAS	ORAS-I	ISS
<b>Gender</b>				
Female	320 (65.9)	3.98±0.85	27.53±7.85	80.65±13.25
Male	165 (34.1)	3.20±0.90	25.62±7.87	72.90±14.17
t / p		0.183 / 0.605	0.355 / 0.95	0.474 / 0.957

<b>Marital status*</b>				
Married	37 (7.6)	4.07±0.74	28.06±7.85	81.96±15.52
Single	448 (92.4)	4.04±0.70	27.70±8.45	79.97±16.87
t / p		0.253 / 0.801	0.265 / 0.791	0.744 / 0.457
<b>Education level*</b>				
High school and below	55 (11.3)	3.87±0.83	28.23±8.47	81.07±16.55
High school and above	430 (88.7)	4.09±0.73	28.00±7.82	81.90±15.51
t / p		-2.110 / <b>0.035</b>	0.203 / 0.839	-.371 / 0.710
<b>Working status*</b>				
No	376 (77.5)	4.11±0.74	28.43±7.85	82.63±15.36
Yes	109 (22.5)	3.91±0.72	26.63±7.89	78.95±16.24
t / p		2.521 / <b>0.012</b>	2.110 / <b>0.035</b>	2.176 / <b>0.030</b>
<b>Education level of spouse (n=37)*</b>				
High school and below	14 (37.8)	3.94±0.73	28.42±9.92	77.00±20.01
Above high school	23 (62.2)	4.10±0.70	27.26±7.63	81.78±14.83
t / p		-0.651 / 0.519	0.402 / 0.690	-.833 / 0.411
<b>Spouse's employment status (n=37)*</b>				
Yes	32 (86.5)	3.75±0.93	24.40±11.69	70.00±24.99
No	5 (13.5)	4.08±0.67	28.21±7.96	81.53±15.21
t / p		-.983 / 0.332	-.937 / 0.355	-1.442 / 0.158
<b>Monthly income/expense perception**</b>				
Income less than expenses (1)	188 (38.8)	4.06±0.77	27.12±8.08	81.48±16.85
Income equal to expenses (2)	52 (10.7)	3.81±0.77	27.73±7.20	78.92±14.94
Income more than expenses (3)	245 (50.5)	4.12±0.70	28.79±7.83	82.66±14.73
F / p		3.844 / <b>0.022</b> 2>3	2.448 / 0.088	1.299 / 0.274
<b>Region of residence**</b>				
Black Sea Region (1)	178 (36.7)	4.11±0.74	29.02±7.70	84.10±15.56
Marmara Region (2)	88 (18.1)	4.16±0.72	27.31±8.09	82.40±15.47
Aegean and Mediterranean Region (3)	66 (13.6)	3.94±0.78	25.39±7.96	78.19±15.94
Central Anatolia Region (4)	83 (17.1)	4.03±0.73	27.67±7.18	79.45±14.39
Eastern and Southeastern Anatolia Region (5)	70 (14.4)	3.96±0.73	29.03±8.33	81.42±16.43
F / p		1.169 / 0.324	3.297 / <b>0.011</b> 1>3, 5>3	2.379 / <b>0.050</b>

<b>Thinking that you have the characteristics of your culture*</b>				
Yes	434 (89.5)	4.09±0.74	28.70±7.86	82.33±15.67
No	51 (10.5)	3.90±0.77	22.31±5.55	77.37±14.63
t / p		1.728 / 0.085	7.393 / <b>0.000</b>	2.152 / <b>0.032</b>
<b>Family planning method use**</b>				
No sexual life (1)	327 (67.4)	4.15±0.72	28.97±7.84	82.83±15.48
Yes (2)	138 (28.5)	3.90±0.75	26.23±7.72	80.08±15.75
No (3)	20 (4.1)	3.75±0.71	25.10±7.18	76.90±15.87
F / p		7.471 / <b>0.001</b> 1>2	7.484 / <b>0.001</b> 1>2	2.551 / 0.079
<b>Who should use family planning?***</b>				
Women (1)	33 (6.8)	3.62±0.74	24.90±8.41	75.24±14.75
Men (2)	42 (8.7)	3.44±0.71	23.07±6.79	73.19±12.93
Both (3)	410 (84.5)	4.17±0.70	28.79±7.72	83.22±15.55
F / p		27.379 / <b>0.000</b> 3>1>2	13.436 / <b>0.000</b> 3>1>2	11.455 / <b>0.000</b> 3>1>2
<b>Who should decide on family planning method?***</b>				
Woman (1)	41 (8.5)	3.83±0.79	25.07±8.07	15.76±2.46
Man (2)	37 (7.6)	3.17±0.41	24.18±6.90	9.51±1.56
Both (3)	407 (83.9)	4.17±0.70	28.68±7.80	15.64±0.77
F / p		37.560 / <b>0.000</b> 3>1>2	8.921 / <b>0.000</b> 3>1>2	11.873 / <b>0.000</b> 3>2
<b>Type of religious belief*</b>				
Islam	433 (89.3)	3.82±0.80	29.09±7.57	82.51±14.45
Other religions	52 (10.7)	4.10±0.73	19.17±3.99	15.92±2.20
t / p		-2.555 / <b>0.011</b>	-14.962 / <b>0.000</b>	-2.869 / <b>0.004</b>

\*Independent sample t testi. \*\*Anova test

RHFPAS: Reproductive Health and Family Planning Attitude Scale; ORAS-I: Ok-Religious Attitude Scale; ISS: Inter-cultural Sensitivity Scale; SD: Standard deviation

Table 2 presents the participants' mean RHFPAS, ORAS-I, and ISS scores. The mean total RHFPAS score was  $211.65 \pm 38.46$ , the mean total ORAS-I score was  $28.03 \pm 7.89$ , and the mean total ISS score was  $81.81 \pm 15.62$ .

**Table 2.** Participants' mean RHFPAS, ORAS-I, and ISS scores (N=485)

Scales	Points received		Scale min-max
	$\bar{X}\pm SD$	min-max	
<b>RHFPAS total score</b>	4.07±0.74	2-5	1-5
<b>ORAS-I total score</b>	28.03±7.89	8-40	8-40
<b>ISS total score</b>	81.81±15.62	32-120	24-120

RHFPAS: Reproductive Health and Family Planning Attitude Scale; ORAS-I: Ok-Religious Attitude Scale; ISS: Inter-cultural Sensitivity Scale; SD: Standard deviation.

Table 3 shows the relationships between the participants' RHFPAS, ORAS-I, and ISS scores. There was a statistically significant positive relationship between RHFPAS and ORAS-I ( $r=0.475$ ,  $p<0.01$ ), RHFPAS and ISS ( $r=0.667$ ,  $p<0.01$ ), and ORAS-I and ISS ( $r=0.579$ ,  $p<0.01$ ).

**Table 3.** Correlations among RHFPAS, ORAS-I, and ISS mean scores

Scales	RHFPAS	ORAS-I	ISS
<b>RHFPAS</b>	-	0.475** / <b>0.000</b>	0.667** / <b>0.000</b>
<b>ORAS-I</b>	-	-	0.579** / <b>0.000</b>
<b>ISS</b>	-	-	-

$r$ =Spearman correlation coefficient. \*\*Correlation is significant at 0.01 level.

RHFPAS: Reproductive Health and Family Planning Attitude Scale; ORAS-I: Ok-Religious Attitude Scale; ISS: Inter-cultural Sensitivity Scale; SD: Standard deviation.

The results showed that the ORAS-I and ISS total scores were significant predictors of participants' reproductive and FP attitudes ( $R^2=0.457$ ,  $p<0.005$ ). Religious attitudes and cultural sensitivity explained 45% of the variance in participants' reproductive and FP attitudes, indicating a positive relationship between religious attitudes, cultural sensitivity, and reproductive and FP attitudes (Table 4).

**Table 4.** Simple regression for predicting reproductive and family planning attitude based on ORAS-I and ISS mean scores (n=485)

Variable	$\beta$	Standart Error	Beta	t	p	F	Model (p)	R <sup>2</sup>	Durbin Watson
Constant	1.413	0.134		10.523	0.000				
ORAS-I total score	0.013	0.004	0.134	3.259	0.001	202.995	<b>0.000</b>	0.457	1.790
ISS total score	0.028	0.002	0.590	14.326	0.000				

ORAS-I: Ok-Religious Attitude Scale; ISS: Intercultural Sensitivity Scale

## DISCUSSION

This study examined the relationship between the religious attitudes and cultural sensitivities of individuals of reproductive age and their reproductive and FP attitudes. In countries such as Türkiye, which has a young population largely of reproductive age, FP is of great importance (Tanrıverdi & Demirezen, 2021). In this study, there was a significant relationship between participants' educational level, employment status, monthly income perception, FP method use, opinions on who should use FP methods, opinions on who should decide on FP methods, type of religious belief, and RHFPAS. This finding aligns with the literature, which indicates that individuals' demographic characteristics influence their reproductive and FP attitudes (Aydoğdu & Akça, 2018; Gözükara et al., 2015; Ortaç & Koruk, 2024; Öztaş et al., 2015; Semachew et al., 2018). Gözükara et al. (2015) revealed that an increase in couples' educational level and making FP decisions jointly positively contributed to FP attitudes. In a study examining the attitudes of postpartum women toward family planning in Şanlıurfa, Türkiye, Ortaç and Koruk (2024) found that family planning was associated with the couple's level of education and the spouse's employment status. Contrary to existing findings, this study found no relationship between women's employment status and their perceived monthly income (Ortaç & Koruk, 2024). In a study of reproductive-age women in Ethiopia, educational level and monthly income perception were associated with FP method use (Semachew et al., 2018). In a systematic review of 29 articles exploring the factors influencing FP choice and use worldwide, women's educational level, monthly income level, family structure, religion, and cultural practices were positively associated with FP attitudes (D'Souza et al., 2022). In contrast, Dynes et al. (2018) found that women who regularly attend religious services are less likely to receive information about FP from healthcare facilities. Overall, these findings suggest that AP attitudes are influenced by demographic, sociocultural, and religious factors.

FP is recognized by all religions as a fundamental human right because it is viewed as a means of establishing a strong family, protecting maternal and child health, reducing abuse, and preventing unintended pregnancy (World Health Organization, 2025). Therefore, reproductive health and AP use are related to religious and social practices. (Stacey, 2019). In the current study, a significant relationship was observed between participants' employment status, region of residence, perception of cultural characteristics, FP method use, opinions on who should use FP methods, opinions on who should decide on FP methods, type of religious belief, and ORAS-I. Although men often consider FP a shared responsibility in many developing countries, they typically prefer using the actual FP method (Tanrıverdi & Demirezen, 2021). A study in Tanzania found that those who used the FP method and decided on its use were crucial considerations, as was the religious acceptability of the FP method (Sundararajan et al., 2019). A study examining the relationship between religious beliefs and childbirth decision-making in Nigeria indicated that religious and cultural factors are significant in decisions about having children (Oyediran et al., 2020). In a study conducted to evaluate the effectiveness of FP training given by religious leaders among Muslim communities in Tanzania, participants were satisfied with the training given by religious leaders and requested that it be repeated (Cordeiro ve ark., 2025). The FP method is also correlated with religious beliefs (Smith & Johnson, 2019). In this regard, it may be beneficial to structure FP trainings in accordance with the individuals' current religion and in cooperation with multidisciplinary teams.

Cultural factors, religious beliefs, and values influence individuals' use of FP services (Tanrıverdi & Demirezen, 2021). In this study, there was a significant relationship between participants' employment status, region of residence, perception of cultural characteristics, opinions on who should use FP methods, opinions on who should decide on FP methods, type of religious belief, and ISS scores. Consistent with our findings, Güner and Aydın (2021) found that region of residence and cultural context affect FP method use. The region of residence, beliefs about who should use FP, and who should decide on FP use are closely related to culture (Smith & Johnson, 2019). Depending on their religion's teachings and doctrines, individuals of different faiths may exhibit various perspectives on FP methods (Ok, 2016). Some religions encourage the use of FP, whereas others may impose restrictions or outright reject it (Pinter et al., 2016; Sundararajan et al., 2019). Therefore, religious beliefs and cultural factors should be jointly evaluated with regard to FP usage (Smith & Johnson, 2019; Sundararajan et al., 2019). Despite progress in FP worldwide, it remains a contemporary issue in both developed and developing countries (Bakibinga et al., 2016). Existing research suggests the provision of culturally informed FP services grounded in cultural values and norms (Götmark & Andersson, 2020; Mjaaland, 2018).

In the present study, individuals' knowledge of reproductive and FP methods, religious attitudes, and cultural sensitivities were at high or good levels. These results are consistent with those reported in the literature. For example, İkbâl Aydın and Çıtak Bilgin (2020) reported that participants' FP attitudes were above the average. Similarly, Eraslan and Aymankuy (2023) reported that individuals exhibit high levels of cultural sensitivity (Eraslan & Aymankuy, 2023). Contrary to these findings, Gözükara et al. (2015) showed that women's attitudes toward FP were not at the desired level. Differences in the sample groups and their sociocultural characteristics may explain this discrepancy.

Culturally sensitive services need to be provided to increase accessibility and awareness about FP (Flores et al., 2025). In this study, the ORAS-I and ISS mean scores were significant predictors of participants' reproductive and FP attitudes. Religious attitudes and cultural sensitivity accounted for 45% of the total variance in RH-FPAS scores. A positive correlation was observed between the RHFPAS and ORAS-I scores. Similarly, Baker and Collins (2020) found a positive relationship between religious and reproductive/FP attitudes. Our results also indicated a positive correlation between RHFPAS and ISS scores. In parallel, Kiyat and Süt (2023) underscored the importance of cultural sensitivity in providing reproductive health and FP services. Culturally sensitive approaches can enhance the effectiveness and accessibility of FP services, boost individuals' trust in these services, and foster positive health outcomes (Kiyat & Süt, 2023). Smith and Johnson (2019), who examined the differences in FP practices and decision-making processes between Islamic and Christian communities, emphasized that religious beliefs significantly influence FP and should be considered in conjunction with cultural factors. The present study also had a positive and statistically significant relationship between ORAS-I and ISS. Similarly, a study conducted in Nigeria revealed that religious and cultural patterns played an important role (32%) in decisions about having children (Ojo and Afolabi, 2025). Similarly, Nguyen et al. (2020) examined FP decision-making processes in Asian and African communities with diverse cultural and religious backgrounds and highlighted that culture and religion are crucial factors influencing FP decisions. In parallel with developing technology, it is recommended that culturally sensitive response features be added to even AP-related chatbots (Deva et al., 2025). Therefore, the importance of considering cultural and religious factors in AP service delivery is clear.

## CONCLUSIONS AND RECOMMENDATIONS

In this study involving individuals of reproductive age living in Türkiye, the participants reported positive reproductive and FP attitudes, a high level of religiosity, and moderate to high cultural sensitivity. Reproductive and FP attitudes were positively influenced by both religious attitudes and cultural sensitivity, which were also positively correlated with each other. Religious attitudes and cultural sensitivity accounted for nearly half of the variance in reproductive and FP attitudes.

Accordingly, nurses providing reproductive and FP education should consider individuals' religious and cultural characteristics. As religious and cultural attitudes can foster greater health awareness, they should be integrated into educational programs. It is equally important to assess whether individuals engage in religious or cultural practices that could be detrimental to their health. Religious leaders can play a motivational role in encouraging the adoption of healthy behaviors. Further studies are recommended to explore additional factors affecting reproductive and FP attitudes. Additionally, it would be beneficial to conduct comparative research across different cultures and religions.

## LIMITATIONS

This research provides important and current evidence from Turkey regarding individuals' attitudes toward reproduction and family planning, religious attitudes, and cultural sensitivity. In this respect, it is an original study and is believed to contribute significantly to the literature. However, the study has several limitations. The research is cross-sectional in design. Cross-sectional studies represent the characteristics of a sample within a specific period. A cross-sectional design was chosen in this study to reveal the relationship between reproductive and family planning attitudes, religious attitudes, and cultural sensitivity among individuals of reproductive age. Furthermore, participants from all reproductive ages were included in the study. However, the majority of participants were younger. Therefore, future studies could benefit from research specific to groups in the middle and late reproductive ages. The fact that the study only presents evidence from Turkey limits its generalizability. First, the study relies on self-reporting. Self-reported studies can be subject to social desirability bias. Data were collected online to avoid this bias, but participants may have exhibited social desirability bias, particularly in questions related to religious and cultural values. The portion of the data not explained by regression analysis in this study may be due to various differences among participants, such as gender equality, family roles, access to healthcare, etc. Furthermore, the lack of sufficient and up-to-date research examining the relationship between AP, religion, and culture in the literature may have caused limitations in the discussion.

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## Conflict of Interest

The authors declare no conflict of interest.

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## Author Contribution

Design of the Study: ECE(%50), DB(%25), EÇ(%25)

Data Acquisition: DB(%40), EÇ(%40), ECE(%10)

Data Analysis: ECE(%60), DB(%20), EÇ(%20)

Writing of the Manuscript: ECE(%60), DB(%20), EÇ(%20)

Manuscript Submission and Revision: ECE(%80), DB(%10), EÇ(%10)

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