REVIEW ARTICLE

REVISTA ENFERMAGEM ATUAL IN DERME

REPRODUCTIVE AUTONOMY AMONG WOMEN: AN INTEGRATIVE LITERATURE REVIEW

AUTONOMÍA REPRODUCTIVA ENTRE LAS MUJERES: UNA REVISIÓN INTEGRATIVA DE LA LITERATURA

AUTONOMIA REPRODUTIVA ENTRE MULHERES: UMA REVISÃO INTEGRATIVA DA LITERATURA

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ABSTRACT

Aim: to analyze the scientific evidence about the woman's ability to decide freely on reproductive issues through the subscales of the Reproductive Autonomy Scale and their association with sociodemographic characteristics. **Method:** integrative literature review on the analysis of reproductive autonomy among women. For the selection of articles, the Health Science Descriptors (DeCS) and Medical Subject Headings (MeSH) were consulted, and the following descriptors were identified and used: Reproductive Autonomy Scale, Decision-Making, Women, Decision-making, Women, and combined using the Boolean AND operator. **Results:** the bibliographic search took place in December/2021 in Pubmed, SCOPUS, Scielo, Lilacs and BVS portal, initially found 238 titles with the exclusion of 93 duplicates, and after screening, seven articles were included. After performing the analyses of these studies, the categories "Reproductive autonomy: gender and power" and "Sociodemographic characteristics of women and reproductive autonomy" were pointed out. **Final considerations:** it is important to know the sociodemographic context and the dynamics of reproductive autonomy in which women are inserted. Thus, faced with a real scenario of social weaknesses that women experience, including those in unfavorable conditions, such as racial issues, actions that strengthen the promotion of reproductive rights in primary health care are necessary.
Keywords: Reproductive Health; Personal Autonomy; Women; Gender.

RESUMEN

Objetivo: analizar las evidencias científicas sobre la capacidad de las mujeres para decidir libremente sobre cuestiones reproductivas a través de las subescalas de la Escala de Autonomía Reproductiva y su asociación con características sociodemográficas. **Método:** revisión integrativa de la literatura sobre el análisis de la autonomía reproductiva de las mujeres. Para seleccionar los artículos se realizó una consulta a los Descriptores de Ciencias de la Salud (DeCS) y a los Encabezamientos de Temas Médicos (MeSH), y se identificaron y utilizaron los siguientes descriptores: Escala de Autonomía Reproductiva, Toma de Decisiones, Mujeres, Toma de Decisiones, Mujeres, y combinados usando el operador booleano AND. **Resultados:** la búsqueda bibliográfica se realizó en diciembre/2021 en Pubmed, SCOPUS, Scielo, Lilacs y el portal de la BVS, encontró inicialmente 238 títulos con la exclusión de 93 duplicados, y después de la selección, se incluyeron siete artículos. Luego de realizar el análisis de estos estudios, se identificaron las categorías “Autonomía reproductiva: género y poder” y “Características sociodemográficas de las mujeres y autonomía reproductiva”. **Consideraciones finales:** es importante conocer el contexto sociodemográfico y la dinámica de autonomía reproductiva en la que se insertan las mujeres. Así, ante un escenario real de fragilidades sociales que viven las mujeres, incluidas aquellas en condiciones desfavorables, como las cuestiones raciales, son necesarias acciones que fortalezcan la promoción de los derechos reproductivos en la atención primaria de salud.
Palabras clave: Salud Reproductiva; Autonomía Personal Mujeres; Género

RESUMO

Objetivo: analisar as evidências científicas acerca da capacidade da mulher de decidir livremente sobre questões reprodutivas através das subescalas da Escala de Autonomia Reprodutiva e sua associação com as características sociodemográficas. **Método:** revisão de literatura integrativa em torno da análise da autonomia reprodutiva entre mulheres. Para a seleção dos artigos foi efetuada uma consulta aos Descritores em Ciência da Saúde (DeCS) e Medical Subject Headings (MeSH), sendo identificados e utilizados os descritores: Reproductive Autonomy Scale, Decision-Making, Women, Tomada de decisões, Mulheres, e combinados através do operador booleano AND. **Resultados**: a busca bibliográfica ocorreu em dezembro/2021 nas bases Pubmed, SCOPUS, Scielo, Lilacs e portal BVS, inicialmente encontrou 238 títulos com exclusão de 93 duplicatas, e após a triagem, sete artigos foram incluídos. Após realização das análises desses estudos foram apontadas as categorias “Autonomia reprodutiva: gênero e poder” e “Características sociodemográficas das mulheres e autonomia reprodutiva”. **Considerações finais:** é importante conhecer o contexto sociodemográfico e a dinâmica de autonomia reprodutiva no qual as mulheres estão inseridas. Assim, diante de um cenário real de fragilidades sociais que a mulher vivencia, inclusive as que estão em condições desfavoráveis, a exemplo das questões raciais, faz-se necessário ações que fortaleçam a promoção dos direitos reprodutivos na atenção primária de saúde.
Palavras-chave: Autonomia Pessoal; Saúde Reprodutiva; Mulheres; Gênero.

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INTRODUCTION

Reproductive autonomy is the right to freely make choices about contraception, pregnancy and childbirth. Including the most opportune time to get pregnant, interrupt or continue the pregnancy, which would reduce the number of unintended pregnancies and their unsafe interruptions[1]. Increasingly, reproductive autonomy makes it possible to plan women's future decisions, allowing them to enjoy a life as an integral social being, who, among other interests, can choose their reproductive future.

However, the reproductive right is often disrespected, being justified by cultural norms, interrelated to gender, tradition, religion, social condition, age, education, by gender inequalities, by social and historical norms, which grant men the power to control women's decisions about sexual, reproductive and motherhood behavior[2].

In particular, autonomy over reproductive life may involve the interaction of influences on the woman, relationship, community and society. At the individual level, the reproductive autonomy model focuses on individual characteristics such as knowledge, attitude, beliefs, skills, age, and behavior. The second factor is a relationship level that considers the importance of relationships with family, intimate partners and peers and the role of the woman's immediate social circle in her decisions. At the community level, the model explores the influence of settings on social relationships that take place, for example, in schools and workplaces. Finally, factors at the social level, which are concentrated in society and which inhibit or encourage autonomy for certain behaviors, including the influence of social norms, public policies and systems of religious and cultural beliefs[3].

Thus, reproductive autonomy represents a complex issue, involving multivariable circumstances, making knowledge and analysis necessary not only on the subject, but also regarding sociodemographic characteristics, among which age can be mentioned. In a study of women in Africa, it was observed that older women, around 35 to 49 years old, were more likely to make decisions about sexual engagement for the type of choices involving issues related to sexual intercourse and the use of drugs. condoms when compared to women aged 15 to 24 years[4].

The analysis of reproductive autonomy in women is not an easy task, due to the fact that it involves several factors and the scarcity of valid instruments for its assessment[5]. For this, an instrument was developed, characterized as the first validated tool in order to assess a woman's ability to achieve her reproductive intentions and a greater understanding of reproductive autonomy, the Reproductive Autonomy Scale. This was prepared and validated in 2014 by professors/researchers from the Department of Obstetrics, Gynecology and Reproduction at the University of California, consisting of 14 items arranged in three subscales: Decision making; Absence of coercion and Communication, and was validated for the Portuguese language in 2019[5].

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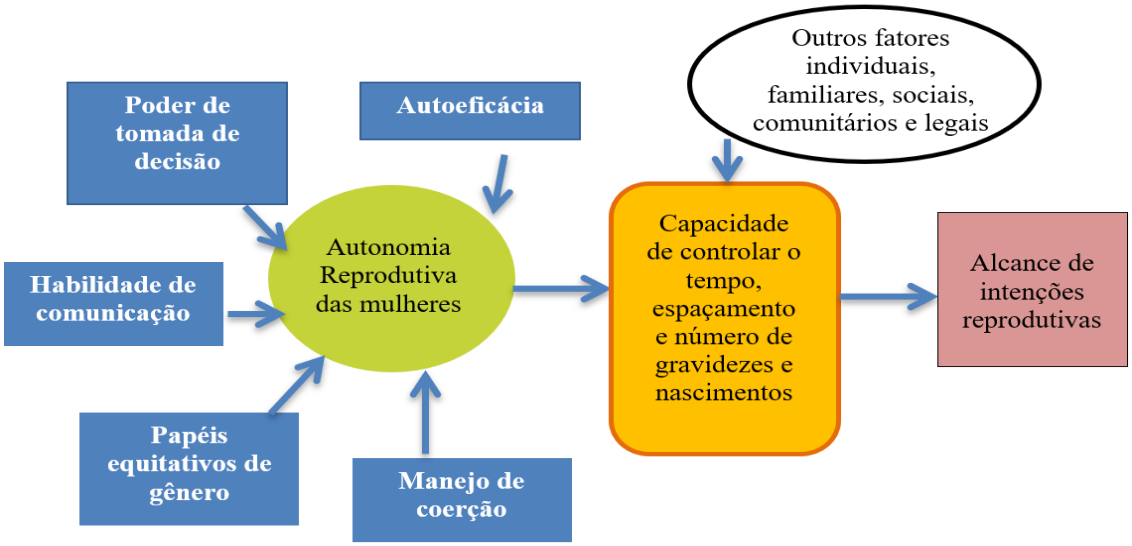
For the elaboration of the scale, the researchers were based on Connell's Theory of Gender and Power, due to this theory it is structured in the three main dimensions of gender of the social experience: sexual division of work, sexual division of power and the emotional attachments that individuals have with each other, fostering inequalities between men and women, making the process of autonomy difficult[1].

Figure 1 − Conceptual framework used for the development of the Reproductive Autonomy Scale.



Source: Translated from Upadhyay *et al.*[1], 2014.

Detailing the image, we have the five concepts, according to Upadhyay *et al.*[1]: 1) Self-efficacy: someone's ability to decide and control issues such as contraceptive use, pregnancy and childbirth; 2) Decision-making power: over who has the main say, whether alone or with a partner; 3) Communication skills: ability to feel comfortable talking with the partner about such matters; 4) Equitable gender roles: perception that men and women have equal responsibilities, needs, sexual and reproductive desires; 5) Management of coercion: ability to avoid or respond appropriately to a person who wants to impose decisions contrary to those desired by the woman in relation to contraception, pregnancy and maternity.

Worldwide, it is assumed that 222 million women are unable to exercise their reproductive autonomy, a situation that is increasingly evident in specific populations, especially those with low socioeconomic status and living in rural communities, making it a major health problem. public in most countries, due to the unmet need for contraception and unwanted pregnancies, which have an impact on abortion[6] and the increased risk of sexually transmitted infections[7]. In this sense, reproductive planning and health education about their rights and power and gender relations are important actions so that women can be guided and thus promote their reproductive autonomy. Thus, we intend to answer the question: What does the scientific evidence say about women's ability to freely decide on reproductive issues through the

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subscales of the Reproductive Autonomy Scale and its association with sociodemographic characteristics?

In this way, it is believed that this study will contribute to the knowledge of health professionals involved with the care and attention to women's health, as well as, it aims to analyze the scientific evidence about women's ability to freely decide on issues reproductive characteristics through the subscales of the Reproductive Autonomy Scale and its association with sociodemographic characteristics.

METHOD

This is an integrative literature review, which has the advantage of the possibility of searching, evaluating and synthesizing the scientific knowledge already produced on the investigated topic, in addition to allowing the inclusion of studies with different research designs to understand the phenomenon studied. The six steps taken to prepare this integrative review were: definition of the research question, establishment of inclusion and exclusion criteria by searching the literature, definition of information to be extracted from studies, evaluation of included studies, interpretation of results and synthesis of data[8].

The research question that guided the study was: What does the scientific evidence say about women's ability to freely decide on reproductive issues through the subscales of the Reproductive Autonomy Scale and its association with sociodemographic characteristics? From the leading question, in order to help define the terms, the acronym PVO (Population, Variable of interest and Outcome/outcome) was used, shown in Table 1.

Table 1 - Acronym PVO to obtain the descriptors and keywords. Recife, Pernambuco, Brazil, 2021.

Acronym	DeSC	MeSH
Population	Women	*Women*
Variables	Gender, Power, Factors Socioeconomic	*Power, Gender, Socioeconomic Factor*
Outcome	Reproductive Autonomy	*Reproductive Autonomy*

Source: Authors' elaboration, 2021.

The literature survey was carried out in December 2021 through a simple search with a time filter in Pubmed, SCOPUS, Scielo, Embase, Cochrane, Web of Science and the VHL portal. To formulate the search strategy, a query was made to the Health Science Descriptors (DeCS) and the Medical Subject Headings (MeSH), using the following search strategy: (Socioeconomic Factors OR Power OR Gender OR Personal Autonomy OR Women OR Decision Making OR Reproductive Health OR Reproductive Autonomy OR Sexuality OR Sexual Health OR Reproductive Health OR Reproductive Rights

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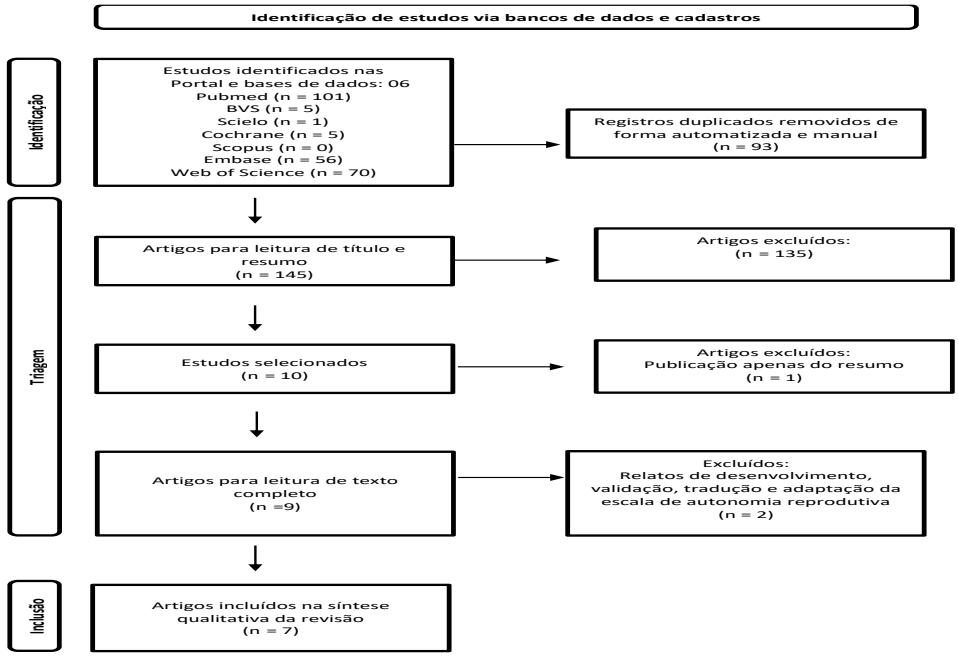
OR Sexual and Reproductive Health) AND (Reproductive Autonomy Scale).

The inclusion criteria were: articles that met the object of study, available in full, without language filter, published from January 2014 to December 2021, which addressed the relationship between the sociodemographic characteristics of women and the subscales of the Scale of Reproductive Autonomy. The time frame is justified by searching for articles published from 2014 onwards, because that was the year in which the Reproductive Autonomy Scale[1] was published. Exclusion criteria were scale validation articles, literature reviews, reports, theses, dissertations or monographs.

The articles were selected from the reference base exported from Mendeley and, after the exclusion of duplicates by automation and manually, the research selection process was carried out independently by two reviewers in two stages. Initially, eligible studies were selected by evaluating the titles and abstracts of publications retrieved during the search. In the second step, the full text was evaluated to confirm eligibility. Disagreements were resolved by consensus among the authors. In the absence of consensus, a third reviewer would be consulted, but it was not necessary. The flowchart for selecting reports is shown in Figure 1 according to Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA).

Figure 1 - Flowchart for selecting articles in the databases.



Source: Prepared by the authors, 2021.

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The extraction of data from the publications included was also performed independently of the researchers and the information was compared. To extract the variables necessary to achieve the proposed objective, we used our own data collection form, prepared by the authors, with the following variables: authors and article title, objectives and results.

The evaluation of the quality of the studies was performed according to the level of evidence, such as: Level I - systematic reviews or meta-analysis; Level II - randomized controlled trials; Level III - controlled studies without randomization; Level IV - case-control study or cohort study; Level V - systematic review of qualitative or descriptive research; Level VI - qualitative or descriptive research; Level VII - opinion or consensus[9].

This was followed by the recommendation for organizing the qualitative synthesis of data into categories and descriptive presentation. And, as they are copyright, they were respected by preserving the content exposed by the authors and by referencing the information extracted from the articles available in the public domain.

RESULTS

The seven selected articles were published in the following years: two in 2019, three in 2020 and two in 2021, produced in countries such as the United States, Brazil, Africa and Vietnam. Regarding the type of study and level of evidence, all publications were descriptive research (n=7) with level VI of evidence, there was no mixed study. The other characteristics of the reports are described in Table 2.

Table 2 - Studies included in the integrative review. Recife, Pernambuco, Brazil, 2021.

Authors/ Title	Objetive	Results
Greenwal, Keele, Huttlinger[10] Contraception among women on probation and parole on the United	Examine contraceptive methods used by women on probation to understand whether certain individual and interpersonal factors were associated with the chosen method.	Of the 82 women considered for the study, 52 participated. Reproductive autonomy was associated with the use of effective contraceptives. Unprotected sex during the three months prior to the survey was 32% less likely among women with higher scores on the “Communication” subscale and 26% less likely with higher scores on the “Absence of coercion” subscale.

States–Mexico border.		
Dias *et al.*[11] Influence of sociodemographic and reproductive characteristics on reproductive autonomy among women.	To analyze the influence of sociodemographic and reproductive characteristics on reproductive autonomy among rural women through the subscales of the Reproductive Autonomy Scale.	Of the 346 rural workers registered in the Chapéu de Palha Mulher Program in Pernambuco, those who were married/with a partner had greater reproductive autonomy in the "Absence of coercion" subscale, when compared to single women or those without a partner. On the other hand, women with a higher educational level (≥ high school) showed greater autonomy in the "Communication" subscale than women with little schooling (elementary school or lower). As for the "Decision Making" subscale, there were no differences, according to the sociodemographic variables evaluated.
Fernandes *et al.*[12] Autonomy in the reproductive health of quilombola women and associated factors.	Identify the level of reproductive autonomy of quilombola women and associate it with sociodemographic characteristics and aspects of sexual and reproductive health through the subscales of the Reproductive Autonomy Scale.	There were 153 quilombola women participants. The total mean score of 2.06 for global reproductive autonomy demonstrated an average level of reproductive autonomy among the women in the study. There was an association between the "decision making" score and marital status. The score of "total reproductive autonomy" was associated with the use of a contraceptive method.
Loll *et al.*[13] Reproductive autonomy and pregnancy	To examine who had the most say in the outcome of the Ghanaian girls' last pregnancy and	The reproductive autonomy of 380 previously pregnant women in urban Ghana was measured using the modified communication and decision-making subscales that ranged from 3 (low

decision-making among young Ghanaian women.	whether this is correlated with their level of reproductive autonomy.	autonomy) to 12 (high autonomy). Reproductive autonomy was associated with an adjusted relative hazard ratio of 0.79 (95% CI: 0.66-0.93; p = 0.006) of the partner with the most voice compared to the woman.
Pindar *et al.*[14] The Role of Reproductive Autonomy in Adolescent Contraceptive Choice And Acceptance of Long-Acting Reversible. Contraception.	To examine the association between reproductive autonomy and adolescent receptivity to long-acting reversible contraceptive methods (LARC).	Eighty-nine participants with a mean age of 16 years. At study enrollment 56.2% were using Depo-Provera, 15.7% oral contraceptives, 3.4% implants and 24.7% no method. Only 13.5% of participants liked the idea of using LARC. The mean score on the decision-making subscale was 9 (range 4-12). In the bivariate analysis, age was associated with the decision-making subscale score, but was not retained as a confounder in the multivariate analysis. The odds of liking LARC decreased by 30% with each unit increase in the autonomy decision-making subscale score (OR 0.70, 95% CI 0.52 to 0.94, p=0.02).
Loll *et al.*[15] Factors associated with reproductive autonomy in Ghana.	To understand the sociodemographic, reproductive history and social context variables associated with two subscales of reproductive autonomy validated among 516 Ghanaian youth aged 15 to 24 years.	The final models demonstrated that factors associated with the communication scale included education (p=0.008), ethnic group (p=0.039) and social support for sexual and reproductive health (B=0.12, p=0.003). Factors associated with the decision-making scale included ethnicity (p = 0.002), religion (p = 0.003), religious attendance (p = 0.043) and previous pregnancy (p = 0.008).
Nguyen *et*	Assess reproductive	Based on the evaluation of 500 sexually

al.[16] Reproductive autonomy and contraceptive use among women in Hanoi, Vietnam.	autonomy through the subscales of the Reproductive Autonomy Scale.	active women who did not wish to become pregnant and who were treated at the obstetrics-gynecology department of a large public hospital in Hanoi, Vietnam, between November 2017 and September 2018. Of these women, 17% (n = 85) married or with a partner had unprotected sex in the last month. These women showed greater reproductive autonomy for the "Decision Making" subscale for the use of contraceptive methods. The "Communication" subscale showed greater power of communication between the woman and her partner. And for the "Absence of coercion" subscale, women were not coerced into not using contraceptive methods.

Source: Prepared by the authors, 2021.

The analysis of the mapped reports was based on answering the guiding question of this review. The studies analyzed the association of the subscales of reproductive autonomy with the use of effective contraceptives, having a voice in decision-making in the last pregnancy and aspects of sexual and reproductive health in women belonging to different population groups and some also brought the relationship with sociodemographic characteristics, in addition to, it was possible to investigate issues related to gender and power. Thus, to better organize and discuss the research results, two categories were created: "Reproductive autonomy: gender and power" and "Sociodemographic characteristics of women and reproductive autonomy".

DISCUSSION

Reproductive autonomy: gender and Power

Reproductive autonomy is strongly linked to gender issues and patriarchal culture, with regard to men's non-acceptance of this type of women's autonomy[17]. The patriarchal view of gender roles is socially constructed and reinforced within various cultural contexts, and can contribute to reducing women's freedom to make their own decisions, including reproductive ones[18].

In societies that follow the patriarchal model, the man remains the main influence at the

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time of the reproductive decision. As an example, a study in Africa found that 84% of male partners disapprove of the use of contraceptives and that women immediately stop using the family planning method, making the power dynamics between the couple evident[19].

In addition to the power of the partner to influence the reproductive decision, according to research by Greenwal, Keele, Huttlinger[10], interpersonal influences impacted decision-making around the use of permanent contraceptive methods, evidencing the importance of relationships with family members and friends. Additionally, the reproductive autonomy of these women was associated with the use of effective contraceptives. The results showed that women with the highest reproductive autonomy were 1.3 times more likely to use effective contraception compared with those with the lowest levels of autonomy.

On the other hand, a research carried out with 52 women on parole in the United States showed that unprotected sex is less likely in the relationships of women with higher scores on the subscale of "Communication" and "Absence of coercion" in relation to the partner[10]. And, research has identified that young Ghanaian women with higher levels of the "decision-making" subscale experienced a lower likelihood of their partners having more decision-making power over their pregnancy[13].

In Brazil, the studies by Dias *et al.*[11] and Fernandes *et al.*[4,12] involving peasant and quilombola women workers, respectively, showed that the social and historical construction of Brazilian society still has patriarchy rooted, including in rural communities, which ends up compromising the autonomy of women in several aspects of their lives, including reproductive rights. When it comes to reproductive decisions, the living conditions of these women and certain social impositions determine their behavior on reproductive planning in an imperative or dominated way.

In general, these points reinforce the importance of considering the aforementioned issues in rural areas, since traditionally this is built by cultural and social norms that favor male exclusivity in decision-making, portraying the gender issue marked by patriarchal ideology, inequality of gender and power[20], which results in women without autonomy to make their own decisions, including reproductive ones[18].

For a better understanding, the concept of "power" in the relationship is expressed through the domain of decision-making, with the greatest power being held by a member of the couple, maintaining control over their own actions and that of their partner[21], in this case, the woman has her decision-making annulled, including in the sexual or reproductive domain[22]. This concept is a historical construction and has remnants of patriarchy[23].

Another worrying factor regarding reproductive autonomy is the relationship between contraception and abortion. A research carried out in Hanoi (Vietnam), despite having pointed out that women showed autonomy over the use of contraceptives, there is a contradiction, because, although there is a high reported use of

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these contraceptives, the abortion rate in this country is among the highest in the world. world. From this perspective, it is estimated that 44% of pregnancies worldwide were unwanted in 2000 - 2014. For women and their families, the consequences of an unwanted pregnancy are often long-lasting and severe; unwanted pregnancy can lead to health problems among children, loss of educational opportunities and increased levels of pregnancy-related morbidity and mortality[16].

Reproductive autonomy and the sociodemographic characteristics of women

It is known the complexity and difficulty of assessing reproductive autonomy among women. For a woman to achieve her reproductive intention, it depends on several factors, including the type of relationship with her partner and the sociodemographic and cultural context in which she is inserted. Each of these points will determine your level of freedom to exercise your reproductive autonomy[1,24].

However, the scientific literature points out the difficulties among rural and black women to fully exercise their reproductive rights, since the barriers established by structural racism still remain[5,11]. Regarding this situation, the study by Fernandes *et al.*[5] revealed that quilombola communities are marked by patriarchy, impacting reproductive decisions, in addition to the influence of social determinants on the health of this population, with a mean age of 32.3 years, mostly made up of married women or living with a partner (71.9%), self-declared black color/race (64.7%), Catholic (88.2%), whose occupation was a farmer or housewife (79.7%). About half of the population (49.7%) had low schooling (≤ elementary) and individual monthly income ranged from 0 to 1,908 reais, with the average being 329.2 reais.

Regarding the economic issue and reproductive autonomy among economically disadvantaged women, in South Africa a review of the literature shows that women with low socioeconomic status have more difficulties in exercising their reproductive autonomy[1], have limited participation in decision-making. reproductive decision and, consequently, may not reach their reproductive goals[15].

In addition to economic status, low education can negatively impact reproductive autonomy. A study with peasant workers[11] pointed out that rural Brazil has more than 14 million women, 24.8% with a low level of education and, of these, 52.3% are illiterate or have only 3 years of schooling, low economic conditions, in addition to presenting cultural diversity and links between the inequalities that mark them, since they are women (gender) and rural workers (class), this condition may cause difficulties for women to exercise their reproductive autonomy.

It is worth noting that, in many situations, rural work is marked by social determinants and certain sociodemographic characteristics that may lead to social exclusion, devaluation and precariousness in the activities carried out, as it is mostly composed of young, black workers with

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low education level[16]. Furthermore, these young women suffer other types of exclusion from the mechanism of intersectionality, whose intersection of various social categories such as race/ethnicity, gender, class, sexuality, age, can enhance their marginalization.

In general, the study by Dias *et al.*[11] suggests that the total reproductive autonomy of rural women is influenced by sociodemographic variables, marital status (married or with a partner), level of education and color/race (white). However, the scientific literature is emphatic in stating that black women, with low education and single have limitations when making reproductive decisions that may be related to power dynamics, gender inequalities and interpretations of masculinity[25].

In this situation, it can be inferred that the uncertainty in which the woman finds herself during a casual relationship provides the man with greater coercive control over her[1]. This is characterized by a phenomenon of gender inequality and social and cultural norms that determine that men, in order to demonstrate their masculinity, are obliged to project an image of power over women[13].

Still, it can be inferred that the barriers imposed for women to exercise their reproductive autonomy and sociodemographic characteristics also involve populations from other countries, for example, the study by Loll *et al.*[13], pointed out the difficulty of younger women pregnant women in Ghana (Africa) to decide whether to terminate or continue a pregnancy. It suggests that men have decision-making power over women, with gender and power inequality prevailing. However, in 2020, another study carried out by Loll *et al.*[13] showed that social support can increase the empowerment of young women by helping to increase communication skills with their partners on sexual and reproductive health issues, being a major construct the domain of reproductive autonomy.

Another study with young women aged between 14 and 21 years[14] identified that those with greater reproductive autonomy, measured by the decision-making subscale, were less likely to use long-acting reversible contraceptive methods - LARC. This may reflect the lack of knowledge about this contraceptive method, highlighting the need to increase literacy in sexual and reproductive health in this population, that is, the motivation and skills for women to obtain, understand, evaluate and apply information related to sexual and reproductive health. reproductive health, as well as implementing public health policies that support the trajectory of adolescents and young people, with a focus on providing LARC in the Unified Health System, as these are highly effective[26] and can help to combat health inequities.

Especially for adolescents, little is discussed about their reproductive autonomy, as there is still a simplified view of sexual and reproductive health at this stage of life, only related to risk factors of sexual experience and the prevention of diseases and unwanted pregnancy, however, it should also address issues such as the body, self-care, family relationships and religious beliefs[27].

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Based on the above, there is a need for more studies to be carried out to understand the reproductive decision process of these women, for a deeper understanding of their reproductive choices and the dynamics of power in a relationship, and beyond this understanding, to understand why such high rates involving abortion.

FINAL CONSIDERATIONS

In view of the analyzed articles, it can be said that sexual and reproductive rights and sexual and reproductive health are closely linked to reproductive autonomy, which reinforces attention not only because it deals with the well-being of women and because reproduction occurs in their bodies. , but also because there are factors, in addition to beliefs and social constructions, that devalue the options of choice, hindering the full right to exercise such autonomy.

Assessing the reproductive autonomy of women and its relationship with sociodemographic characteristics became important due to the opportunity to use a multidimensional instrument, the Reproductive Autonomy Scale, in three subscales “Decision Making”, “Absence of coercion” and “Communication” , which makes it possible, through the understanding of the concept of each subscale, that women deserve greater attention and actions that can provide greater opportunities and knowledge to exercise their reproductive autonomy.

In addition, this review highlights a significant gap in the scientific literature on reproductive autonomy addressing the issue of gender and power, however, it reinforces what is found in studies that claim that for women to achieve their reproductive autonomy there is a dependence on several factors, as an example of the sociodemographic context in which it is inserted.

It becomes important recommendations for assistance, health programs and education, in the sense of increasing women's reproductive autonomy, among them, health education involving topics on reproductive rights and communication of women with their partner. It is important to consider the participation of men and/or couples, promoting actions to reduce reproductive coercion.

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