Autonomy in the reproductive health of quilombolas women and associated factors

Autonomia na saúde reprodutiva de mulheres quilombolas e fatores associados

Autonomía en la salud reproductiva de mujeres cimarronas y factores relacionados

Elionara Teixeira Boa Sorte Fernandes[I]
ORCID: 0000-0001-8302-6887

Sílvia Lúcia Ferreira[II]
ORCID: 0000-0003-1260-1623

Cláudia Suely Barreto Ferreira[III]
ORCID: 0000-0002-9801-9169

Eliene Almeida Santos[III]
ORCID: 0000-0002-7561-8775

[I] *Universidade do Estado da Bahia. Guanambi, Bahia, Brazil.*
[II] *Universidade Federal da Bahia. Salvador, Bahia, Brazil.*
[III] *Universidade do Estado da Bahia. Senhor do Bonfim, Bahia, Brazil.*

Corresponding author:
Elionara Teixeira Boa Sorte Fernandes
E-mail: naratbsorte@gmail.com

ABSTRACT

Objective: Identify the level of reproductive autonomy of *quilombola* women and associate it with sociodemographic characteristics and aspects of sexual and reproductive health. **Methods:** Cross-sectional census study carried out in *quilombola* communities in a municipality in Bahia. Data was collected through questionnaires from the National Health Survey and the Reproductive Autonomy Scale, applied to *quilombola* women who agreed to participate. Descriptive statistics procedures were used and associations were made between reproductive autonomy scores and sociodemographic and reproductive characteristics. **Results:** The average total score for reproductive autonomy was 2.06. An association was found between the "decision-making" score and marital status. The score for "total reproductive autonomy" was associated with the use of contraceptive method. **Conclusion:** The reality of the study participants converges with the literature regarding the interference of sociodemographic and reproductive factors in the reproductive autonomy of black women.

Descriptors: Reproductive Health; Personal Autonomy; African Continental Ancestry Group; Socioeconomic Factors; Women.

RESUMO

Objetivo: Identificar o nível de autonomia reprodutiva de mulheres quilombolas e associá-lo com características sociodemográficas e aspectos da saúde sexual e reprodutiva. **Métodos:** Estudo censitário transversal realizado em comunidades quilombolas de um município baiano. Os dados foram coletados por meio dos questionários da Pesquisa Nacional de Saúde e da Escala de Autonomia Reprodutiva, aplicados às mulheres quilombolas que aceitaram participar. Utilizaram-se procedimentos da estatística descritiva e realizaram-se associações entre os escores de autonomia reprodutiva e as características sociodemográficas e reprodutivas. **Resultados:** O escore médio total de autonomia reprodutiva foi 2,06. Verificou-se associação entre o escore de "tomada de decisão" e estado conjugal. O escore de "autonomia reprodutiva total" foi associado à utilização de método contraceptivo. **Conclusão:** A realidade das participantes do estudo converge com a literatura quanto à interferência de fatores sociodemográficos e reprodutivos na autonomia reprodutiva de mulheres negras.

Descritores: Saúde Reprodutiva; Autonomia Pessoal; Grupo com Ancestrais do Continente Africano; Fatores Socioeconômicos; Mulheres.

RESUMEN

Objetivo: Identificar el nivel de autonomía reproductiva de mujeres cimarronas y relacionarlo a las características sociodemográficas y aspectos de la salud sexual y reproductiva. **Métodos:** Estudio censorio transversal realizado en comunidades cimarronas de un municipio baiano. Los datos han sido recogidos por medio de los cuestionarios de la Investigación Nacional de Salud y de la Escala de Autonomía Reproductiva, aplicados a las mujeres cimarronas que aceptaron participar. Se utilizaron procedimientos de la estadística descriptiva y se realizaron relaciones entre las calificaciones de autonomía reproductiva y las características sociodemográficas y reproductivas. **Resultados:** La calificación media total de autonomía reproductiva ha sido 2,06. Se verificó relación entre la calificación de "toma de decisión" y estado conyugal. La calificación de "autonomía reproductiva total" ha sido relacionada a la utilización de método contraceptivo. **Conclusión:** La realidad de las participantes del estudio converge con la literatura cuanto a la interferencia de factores sociodemográficos y reproductivos en la autonomía reproductiva de mujeres negras.

Descriptores: Salud Reproductiva; Autonomía Personal; Equipo con Ancestrales del Continente Africano; Factores Socioeconómicos; Mujeres.

INTRODUCTION

Brazilian social conformation, marked by patriarchy, has compromised and still compromises the autonomy of women in different aspects of their lives. When it comes to reproductive decisions, living conditions and certain social impositions determine their conduct and lead many women to experience reproductive planning in an unreflective and/or imperative way. Furthermore, social, cultural, economic, educational factors, as well as difficulties in accessing health services, deprive many women, specifically the less favored, such as black *quilombola* women, of their sexual and reproductive rights.

According to an estimate, of all pregnancies that occur in the world in one year, 38% are not planned[1]. The high prevalence of unplanned pregnancies is a reality in both poor and developed countries, accounting for almost half of pregnancies in the United States and 44.3% in Malawi, an African country[2-3]. In Brazil, this percentage reaches 48%, and inequalities in class, race and gender result in a lack of opportunities and mark the lives of those women who report unplanned pregnancies[4-5].

As a complex phenomenon, pregnancy, in addition to the objective issues for its planning, involves a socially and culturally constructed symbolic system that naturalizes motherhood and places it as the first realization of women. Alternatively, access to information and the means of regulating fertility enable more reflective choices on the part of women[6].

In Brazil, the Family Health Strategy (FHS) has become a reference for women's sexual and reproductive health demands. Within its priorities, reproductive planning is inserted, in order to enable women's reproductive autonomy. This objective is not always achieved, as the strategies for accessing information and contraceptive methods disregard the reception and the link with the health service, which compromises autonomy for free reproductive choices[7].

Linked to this, women with unfavorable social conditions are more likely to experience unplanned pregnancies than women with better social and financial conditions[8]. Education, occupation and income are related and determine access to goods and opportunities, favoring success in health actions, such as reproductive planning[9].

Racial inequalities are also revealed in the use of preventive services, both in access and in the limitation of care, because, when compared to white women, black women have a higher percentage for bad access[10]. In this way, racial and gender violence linked to institutional racism, which determine the assistance provided to black women, block the achievement of health equity and violate human rights[11].

In the case of *quilombola* women, the geographic conditions of the communities where they live, almost always located in rural areas, represent another difficulty in accessing health services and, together with the historical segregation of these communities, contribute to maximize the recurring damages to this portion of the population[12]. This difficulty of access in line with low education and worse living conditions limit knowledge about contraceptive methods and their availability, which interferes with reproductive autonomy.

Thus, an answer to the question is sought: What is the level of reproductive autonomy of *quilombola* women and what sociodemographic factors and aspects of sexual and reproductive health are related?

OBJECTIVE

Identify the level of reproductive autonomy of *quilombola* women and associate it with sociodemographic characteristics and aspects of sexual and reproductive health.

METHODS

Ethical aspects

The research started after the submission of the thesis project to the Research Ethics Committee and its approval. The entire methodological path followed the ethical standards for research with human beings of Resolution No. 466/2012 of the National Health Council[13].

Study design, period and location

This is a cross-sectional census study conducted with data from the doctoral thesis research entitled "Reproductive autonomy of *quilombola* women". This research was carried out in *quilombola* communities in a municipality in the *Sertão Produtivo*, a identity territory of Bahia, from July 2018 to March 2019. Equator's STROBE instrument was used to guide the methodology.

The municipality in question, Palmas de Monte Alto, Bahia, was chosen because it has the largest number of *quilombola* communities certified by the *Palmares* Foundation within the territory of Bahia's identity, as updated by the certified communities published on the Foundation's website on February 18, 2019[14].

Palmas de Monte Alto is located 840 kilometers from the capital of Bahia[4] and has 17 certified quilombola communities, located in the rural area of the municipality, some of which are part of the same community association and are therefore represented by the same association president.

Population or sample; inclusion and exclusion criteria

All *quilombola* women who met the adopted inclusion criteria participated in the study: living in the *quilombola* community, being of reproductive age, with the exception of minors (18 to 49 years old), and accepting to participate in the research by signing the Free and Clarified Consent Form. The exclusion criteria were: not completing the answers to fill out the data collection instruments and not having cognitive conditions to answer the questions. In this way, 153 *quilombola* women participated, and four refusals were recorded.

Study protocol

Data collection was performed using two instruments: the adapted National Health Survey (PNS) questionnaire[15] and the Reproductive Autonomy Scale, applied to *quilombola* women who agreed to participate in the study.

The PNS questionnaire consists of a block of information about the home and another about the individual. In the individual questionnaire, the questions are distributed in ten blocks of information, however only blocks A (sociodemographic characteristics and social support) and F (women's health) were used.

The variables in block A include: age, marital status, education level, occupation, monthly income, color/race, religion. The variables in block F are: age at menarche, preventive examination, sexual activity, participation in a family planning group, use of contraception, pregnancy.

The Reproductive Autonomy Scale is characterized as a validated, multidimensional measure of a woman's ability to achieve her reproductive intentions. It has 14 items organized into three subscales (Decision making; Absence of coercion and Communication)[16]. The scale's total reproductive autonomy score ranges from 1.00 to 4.00, with higher scores indicating higher levels of reproductive autonomy.

The scale is applicable to women in any type of relationship (married, single, living or not living with partners), in a variety of gender equity contexts worldwide, and is able to capture the influence of individuals beyond the sexual partner , like parents, in-laws, friends, etc.[16]. This scale was translated into Portuguese and culturally adapted[17].

The interviews were conducted at the women's residence during visits to the communities. First, communities were asked to attend by contacting the presidents of *quilombola* associations to present the research and schedule the best day and time for visits. After receiving the authorizations by signing the terms of consent and approval by the Research Ethics Committee, the other visits to the communities took place. During these visits, all women who met the inclusion criteria were approached in their homes.

Analysis of results and statistics

Descriptive statistics procedures were used to express the results as means, standard deviations and minimum and maximum values. The normality of the data was tested using the Shapiro-Wilk and Kolmogorov-Smirnov tests, whereas homoscedasticity was verified using the Levene test. Associations between reproductive autonomy scores and sociodemographic and reproductive characteristics were tested using the Mann-Whitney, Kruskal-Wallis and Spearman correlation tests. The level of significance adopted in the study was 5% ($\alpha = 0.05$),

and all analyzes were performed using IBM SPSS Statistics for Windows (IBM SPSS, 21.0, 2012, Armonk, NY: IBM Corp.).

RESULTS

Study participants had an average age of 32.3 years. Most of the population was made up of married women or living with a partner (71.9%), who declared themselves to be black color/race (64.7%), Catholic (88.2%) and who had the occupation of farm worker or housewife (79.7%). About half of the population (49.7%) had low education (≤ elementary), and the individual monthly income ranged from 0 to 1,908 reais, with the average being 329.2 reais.

Regarding sexual and reproductive characteristics, 12.8 years was the average age of the first menstruation; 51.6% of women took the preventive exam two years ago or less; 87.6% had sex in the past 12 months; 86.9% did not participate in a family planning group in the last 12 months; 49.7% do not use any method to prevent pregnancy, and 44.6% of these claimed that they did not use the method because they had been sterilized; 83.7% of them have already become pregnant.

Table 1 – Descriptive analysis of reproductive autonomy scores, according to each domain of the Reproductive Autonomy Scale, Palmas de Monte Alto, Bahia, Brazil, 2019

Factor (subscale)	Mean	Standard deviation	Minimum - maximum
Decision-making	2.40	0.35	1.25 - 3.00
Absence of coercion	1.90	0.47	1.00 - 3.00
Communication	1.95	0.49	1.00 - 3.20
Total	2.06	0.30	1.36 - 2.64

Table 2 – Association between reproductive autonomy scores and sociodemographic characteristics of study participants, Palmas de Monte Alto, Bahia, Brazil, 2019

Variable	Decision-making	Absence of coercion	Communication	Total
Age (Spearman correlation)	- 0.07 (p = 0.420)	0.14 (p = 0.084)	- 0.01 (p = 0.922)	0.04 (p = 0.608)
Marital status				
Single/without partner	2.55 ± 0.35	1.86 ± 0.45	2.00 ± 0.51	2.11 ± 0.29
Married/with partner	2.34 ± 0.33	1.91 ± 0.48	1.93 ± 0.48	2.04 ± 0.30
*p value	< 0.001	0.417	0.255	0.262
Education level				
< Elementary school	2.37 ± 0.43	1.92 ± 0.57	1.90 ± 0.41	2.04 ± 0.30
Elementary school	2.44 ± 0.28	1.95 ± 0.47	2.00 ± 0.54	2.11 ± 0.28
Middle school	2.32 ± 0.35	1.87 ± 0.44	1.99 ± 0.49	2.04 ± 0.30
≥ High school	2.44 ± 0.35	1.84 ± 0.43	1.88 ± 0.48	2.03 ± 0.31
†p value	0.348	0.818	0.523	0.480
Color/race				
Black	2.39 ± 0.36	1.89 ± 0.48	1.94 ± 0.49	2.05 ± 0.31
Non-black	2.41 ± 0.33	1.91 ± 0.46	1.96 ± 0.49	2.07 ± 0.28
*p value	0.828	0.329	0.873	0.464
Religion (%)				
Others	2.35 ± 0.45	1.90 ± 0.39	1.96 ± 0.49	2.05 ± 0.34
Catholic	2.41 ± 0.33	1.90 ± 0.48	1.94 ± 0.49	2.06 ± 0.29
*p value	0.852	0.645	0.633	0.693
Occupation				
Farm worker/housewife	2.38 ± 0.35	1.89 ± 0.48	1.93 ± 0.50	2.04 ± 0.30
Others	2.50 ± 0.32	1.91 ± 0.43	2.01 ± 0.45	2.12 ± 0.29
*p value	0.067	0.991	0.382	0.393
Monthly income (Spearman correlation)	0.11 (p = 0.183)	- 0.06 (p = 0.432)	- 0.04 (p = 0.603)	- 0.03 (p = 0.701)

*Note: Values are expressed as mean ± standard deviation; * Mann-Whitney Test; †Kruskal-Wallis test.*

Table 3 – Association between reproductive autonomy scores and reproductive characteristics of study participants, Palmas de Monte Alto, Bahia, Brazil, 2019

Variable	Decision-making	Absence of coercion	Communication	Total
Age at first menstruation (Spearman correlation)	0.03 (p = 0.697)	0.00 (p = 0.961)	- 0.06 (p = 0.506)	0.02 (p = 0.076)
Last preventive exam				
Never had /> 2 years	2.38 ± 0.36	1.91 ± 0.41	2.04 ± 0.48	2.09 ± 0.26
≤ 2 years	2.42 ± 0.33	1.88 ± 0.52	1.86 ± 0.49	2.03 ± 0.33
*p value	0.593	0.727	0.024	0.381
Sexual intercourse in the last 12 months				
No	2.45 ± 0.34	1.84 ± 0.47	2.19 ± 0.43	2.14 ± 0.30
Yes	2.39 ± 0.35	1.90 ± 0.47	1.91 ± 0.49	2.05 ± 0.30
*p value	0.480	0.501	0.008	0.147
Family planning group participation in the last 12 months				
No	2.40 ± 0.35	1.90 ± 0.46	1.96 ± 0.48	2.07 ± 0.29
Yes	2.39 ± 0.31	1.85 ± 0.54	1.85 ± 0.57	2.00 ± 0.34
*p value	0.607	0.762	0.288	0.792
Use of method to prevent pregnancy				
No	2.38 ± 0.39	1.94 ± 0.45	2.11 ± 0.43	2.13 ± 0.27
Yes	2.42 ± 0.30	1.85 ± 0.49	1.79 ± 0.49	1.99 ± 0.31
*p value	0.879	0.220	< 0.001	0.008
Already got pregnant				
No	2.44 ± 0.32	1.90 ± 0.39	2.11 ± 0.40	2.13 ± 0.24
Yes	2.39 ± 0.35	1.90 ± 0.49	1.91 ± 0.50	2.04 ± 0.31
*p value	0.542	0.834	0.044	0.180

Note: Values are expressed as mean ± standard deviation; * Mann-Whitney test.

The means, standard deviations and minimum and maximum scores of the reproductive autonomy scores are shown in Table 1. The mean scores varied between the subscales from 1.90 to 2.40; the average total score of reproductive autonomy was 2.06.

Associations between reproductive autonomy scores (subscales and total) and the sample's sociodemographic characteristics were tested, as shown in Table 2. An association was found between the "decision-making" score and marital status. The analyzes indicated that single women or without a partner had greater autonomy in the construct "decision making", compared to married women or with a partner. There was no association between the scores of "absence of coercion", "communication" and "total reproductive autonomy" with the sociodemographic characteristics assessed.

Associations between the reproductive autonomy scores and the reproductive characteristics of the sample were also investigated (Table 3). There was an association between the "communication" score and preventive exam, sexual intercourse in the last year, use of contraception and pregnancy. According to the analyzes, women who have not had a preventive examination in the past two years, have not had sexual intercourse in the past 12 months, have not used a method to prevent pregnancy and have never become pregnant have demonstrated greater autonomy in the "communication" construct, compared to their pairs. The score for "total reproductive autonomy" was also associated with the use of contraceptive methods. The data showed that women who did not use a method to prevent pregnancy had greater overall reproductive autonomy, compared to women who used contraception. The scores of "decision making" and "absence of coercion" were not associated with the reproductive characteristics evaluated.

DISCUSSION

The total average score of 2.06 of global reproductive autonomy demonstrated an average level of reproductive autonomy of the women in the study, considering the minimum score of 1.00 and maximum of 4.00.

In the first subscale (Decision making), the scores vary from 1 to 3, and the women in the study had an average score of 2.40, a result close to the highest score (3) and the value of the study carried out by the authors of the reproductive autonomy with American women (2.46)[16]. This demonstrates a good performance of the study participants regarding decision making.

The variation of the subscales "absence of coercion" and "communication" ranges from 1 to 4, and women had an average of 1.90 and 1.95, respectively, indicating greater autonomy in the communication subscale than in the absence of coercion. In the American study, the score for the absence of coercion was 3.57 and that for communication was 3.53[16], which demonstrates greater autonomy of the Americans in these aspects when compared to the participants of the present study. The socioeconomic profile can determine differences found, as the women in the study are older, mostly married and have low education, compared to the women in the original study.

Socioeconomic conditions are decisive in women's reproductive autonomy, especially in view of the living conditions in which they are inserted and the lack of opportunities that often lead them to follow a common flow of marriage and family constitution, specifically those with less education and less power purchasing. As a result, disadvantaged populations also experience higher levels of unwanted pregnancies[18].

In the study carried out with the American women for the construction of the scale of reproductive autonomy, the youngest women had greater autonomy in the constructs "lack of coercion" and "communication" than women with low education (elementary school); and black women had less autonomy in the absence of coercion and communication[16].

The influence of sociodemographic characteristics on women's access to preventive health examinations determines black women's exposure to unqualified access to health services. This can also be seen among *quilombolas*, who have difficulties in accessing preventive exams included in the list of care provided to the woman's care program[10].

A study aimed at identifying the barriers perceived by women in Nicaragua to access reproductive health care showed that

violence against women, sexism, criticism from others and the lack of communication and education limit their ability to make their own reproductive health decisions. It also showed that they had a general lack of knowledge about reproductive rights[19].

Additionally, in a randomized clinical trial, the simple discussion about reproductive coercion among family planning clients, asking if they experience this fact and offering advice on ways to minimize the risk of partner interference with contraception, resulted in a 60% probability the greater number of these women ending up with unsafe or unhealthy relationships in a period of three to six months, compared to the control group[20].

The data indicated an association of reproductive autonomy with the marital situation in the construct "decision making". Single or unmarried women had greater autonomy in this construct, whereas, in the American study, being married was associated with having a higher level of autonomy in the communication subscale and a lower level of autonomy in the decision-making subscale[16].

Family relationships marked by patriarchy reveal the submission of women to their husbands in different aspects of their life together, which most often shows the lack of autonomy in reproductive decisions. A woman's ability to achieve her reproductive intentions is influenced by the relationship she has with her sexual partner and the culture and context in which she lives[16].

A study carried out in the capital of Bahia pointed to financial dependence as a determining factor in women's autonomy and freedom of choice, since the occurrence of unplanned pregnancies was more prevalent among housewives, therefore among those with financial dependence on their partners or on relatives[7].

The failure to perform the preventive exam in the last two years, the absence of sexual intercourse in the last 12 months, the non-use of contraceptives and the fact of never having been pregnant, variables that in the analysis demonstrated greater autonomy in the "communication" construct, are characteristics common to women who do not have a partner.

Thus, the marital situation presented itself as a determining sociodemographic factor in the reproductive autonomy of *quilombolas*, as well as sexual and reproductive characteristics related to marital status. The belief in the fidelity of the partner and/or the imposition of the husband leads many women to not access preventive and sexual and reproductive health services.

There was also an association between the use of contraceptives and global reproductive autonomy: women who did not use contraceptive methods had greater autonomy compared to those who used them.

Most women who said they did not use contraceptives justified this practice because they had undergone tube ligation. Thus, it appears that the choice for a definitive method (tube ligation) demonstrates greater autonomy by the woman of her body.

However, it is worth mentioning that many black women were taken to mass ligatures, convinced by an inclusion discourse, access to service and health improvements, when in fact the action was motivated by the policy of whitening and by curtailing the reproductive autonomy of black women[21].

Thus, in the face of a real fragile scenario of health care, education, access to information, accentuated by racial issues, and the distancing of communities vulnerable to integral and equitable health, the eminent need for actions that strengthen health promotion[22].

Study limitations

One identified limitation was related to the fact that the reduced amount of research focused on the subject in question makes it impossible to discuss specifically with *quilombolas*. Thus, it is necessary that new studies expand knowledge in this area, especially in the investigation of other aspects related to the reproductive autonomy of black/*quilombola* women.

Contributions to the Area

The contributions of this study are directed to health professionals, especially to Nursing, which has a strong connection with vulnerable populations, such as the remaining quilombos; they also serve other areas and public policies, as support to plan and execute strategic actions with a view to achieving female autonomy and breaking inequalities, which women, especially black women, experience.

CONCLUSION

Based on the results presented, it is possible to conclude that: life in a stable union (married/with a partner) had a negative impact on the reproductive autonomy related to the "communication" of *quilombola* women; reproductive autonomy related to the "absence of coercion" was not influenced by sociodemographic and reproductive factors; the performance of preventive examination, sexual activity, use of a method to prevent pregnancy and gestational experience were factors associated with greater reproductive autonomy in the "communication" construct; *quilombola* women using contraception had less total reproductive autonomy.

The reality of the study participants converges with the literature regarding the interference of sociodemographic and reproductive factors in the reproductive autonomy of black women. The predominance of low education, low income and a certain dependence on the partner makes it difficult for women to control their bodies, an essential condition for reproductive autonomy.

Public policies aimed at women must promote better social, educational, income and work conditions, comprehensive and equitable access to health services, free from discrimination of gender, race and class. Furthermore, the planning and execution of health actions that favor female autonomy are essential in professional practice.

ACKNOWLEDGMENT

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