



SCHOOL OF PUBLIC HEALTH
UNDERGRADUATE STUDY PROGRAM

**WOMEN'S AUTONOMY AND PARTNER INFLUENCE IN REPRODUCTIVE HEALTH
DECISION MAKING AMONG CLIENTS SEEKING FAMILY PLANNING AND SAFE
ABORTION SERVICES AT SAINT PAUL'S HOSPITAL MILLENNIUM MEDICAL
COLLEGE MICHU CLINIC**

BY: DR. KIDST AMARE (MEDICAL INTERN)

**A RESEARCH THESIS SUBMITTED TO THE SCHOOL OF PUBLIC HEALTH,
ST. PAUL'S HOSPITAL MILLENNIUM MEDICAL COLLEGE IN PARTIAL
FULFILMENT OF REQUIREMENTS FOR THE DEGREE DOCTOR OF
MEDICINE**

APRIL, 2026

ADDIS ABABA, ETHIOPIA



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Abbreviations

AOR	Adjusted Odds Ratio
DHS	Demographic and Health Survey
EDHS	Ethiopian Demographic and Health Survey
FP	Family Planning
LMICs	Low- and Middle-Income Countries
RHR	Reproductive Health and Rights
SAC	Safe Abortion Care
SPHMMC	St. Paul's Hospital Millennium Medical College
SPIDS	St. Paul Institute for Development Studies
SPSS	Statistical Package for the Social Sciences
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
WHO	World Health Organization

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Abstract

Background: Maternal health outcomes in Ethiopia are influenced by women's autonomy and the role of partners in reproductive health decision-making. Despite improved access to family planning and safe abortion services, disparities persist in decision-making power due to sociocultural, economic, and relational factors.

Objectives: To assess the level of autonomy among women seeking reproductive health services, the degree of partner influence, and identify factors associated with reproductive decision-making at Michu Clinic, St. Paul's Hospital Millennium Medical College.

Methods: A facility-based cross-sectional study was conducted among 176 women aged 15-49 years using systematic random sampling. Data were collected through structured interviewer-administered questionnaires and analyzed with SPSS version 26. Descriptive statistics summarized key variables, while bivariate and multivariable logistic regression identified predictors of autonomy and partner influence. Qualitative responses were analyzed thematically.

Results: From a total of 176 women who participated in the study, the majority (44.3%) were aged 15–24 years. Most respondents (92.0%) currently use family planning methods, with oral contraceptives (27.7%) and implants (26.5%) being the most common. Abortion experience was reported by 81.3% of participants. The mean autonomy score was 3.58, and 71.0% of women demonstrated high autonomy. The mean partner influence score was 3.6, with 67.1% reporting constructive partner influence. Multivariable logistic regression showed that urban residence (AOR = 8.12, $p = 0.01$) and tertiary education (AOR = 15.34, $p = 0.01$) were significant predictors of high autonomy. While urban residence (AOR = 8.56, $p = 0.01$) and history of induced abortion (AOR = 8.61, $p = 0.01$) were the primary predictors of constructive partner influence.

Conclusions: Women's autonomy in reproductive health decision-making remains limited in rural and less-educated women, and partner influence plays a decisive role. Interventions should prioritize women's empowerment through education, counseling, and economic support, while promoting constructive partner engagement to improve uptake of family planning and safe abortion.

1. Introduction

1.1 Background

Maternal health refers to the physical, mental, and social wellbeing of women during pregnancy, childbirth and the postnatal period [1]. Family planning (FP) and access to safe abortion care (SAC) are fundamental pillars of maternal health, significantly reducing maternal mortality and morbidity worldwide [1,2,3]. Family planning enables individuals to attain their desired number of children and spacing of pregnancies through the use of contraceptive methods and infertility treatment. Access to family planning supports informed choices about sexual and reproductive health advancing gender equality and plays a vital role in achieving broader development goals including education and economic opportunity [2].

Comprehensive abortion care includes the provision of accurate information; safe abortion procedures and post-abortion follow up. Worldwide, around 73 million induced abortions take place annually. Of these six out of 10 (61%) results of unintended pregnancies, and 3 out of 10 (29%) of all pregnancies end in induced abortion. Lack of access to safe, affordable, timely and respectful abortion care, as well as persistent stigma places women's physical and mental health at risk [3].

In many developing countries, maternal and child mortality remains a major health problem. The World Health Organization (WHO) suggested improving maternal health requires universal health coverage, equitable access to sexual and reproductive health services addressing all causes of maternal mortality, morbidities, and strengthening health systems to meet women's needs and priorities. Ensuring universal access to sexual and reproductive health services, particularly family planning, reduce maternal mortality by preventing unintended pregnancies and abortion related deaths. It also prevents risk associated with closely spaced pregnancies, early childbearing, and childbearing later in reproductive years, all of which increase maternal and infant mortality [4].

In Ethiopia contraceptive use increased from 8% in 2000 to 36% in 2016. Yet, over one-fifth of married women still unmet needs for family planning, indicating gaps in access to universal sexual and reproductive healthcare[5].

Women's reproductive health outcomes are not determined solely by the availability of services, but also by the dynamics of decision-making within households and intimate partnerships. Women's autonomy refers to their ability to independently make decisions regarding their health, fertility, and use of healthcare services, while reproductive health decision-making often occurs within the context of marital or partner relationships. In many settings, male partners play a significant role in influencing whether and when women seek care, use contraception, or continue pregnancies. Studies in Ethiopia have shown that women with greater decision-making power and autonomy are more likely to utilize maternal and reproductive health services. [4,5]

1.2 Statement of the problem

Women play a great role in family well-being, development of financial, political, social, and ecological atmosphere. Independent decision-making in family planning is defined as a woman's ability to freely choose to use or not to use contraceptives without external influence. Dimensions of women's empowerment including household decision making and general knowledge and awareness, are positively associated with contraceptive use in Ethiopia. Encouraging women's decision-making to contraceptives is an important determinant of fertility rate, maternal health outcome and health service utilization [6,7].

However, many Ethiopian women experience limited autonomy due to rooted economic, political, and sociocultural factors. These limitations often place women at risk of gender-based violence, unwanted pregnancies, sexually transmitted infections, and mental health issues. They may lack power to make decisions about sex, marriage, and access to healthcare [8].

Male dominance in reproductive decision-making is common in Ethiopia, particularly in rural communities where over 80% of women live. In these areas, women are often considered as subordinate to their husbands, severely restricting their ability to exercise reproductive health rights [9]. This study aims to investigate the lived experiences of women seeking family planning and safe abortion care at Michu Clinic, focusing on perceived autonomy and partner influence. Awareness targeted interventions and

counseling strategies that empower women, and promote constructive engagement with partners.

1.3 Significance of the study

Within the operational context of Michu Clinic at St. Paul's Hospital Millennium Medical College, understanding the dynamics of women's autonomy and partner influence in reproductive health decision making is essential. Although the clinic provides essential services, the degree to which women can independently access and use these services, free from partner pressure or control, not well documented. Anecdotal evidence indicates some women face considerable challenges in seeking care without their partner's explicit consent or awareness. Such challenges may lead to delayed treatment, poor adherence to prescribed methods, or reliance on unsafe alternatives.

Furthermore, partner influence including financial leverage, emotional persuasion, or outright prohibition needs further exploration. These dynamics can directly affect women's reproductive health outcomes and service utilization. This study designed to address these critical knowledge gaps by examining women's autonomy, partner influence, and usage patterns of reproductive health services at Michu Clinic. Findings will support targeted interventions and counseling strategies ultimately empowering women, encourage supportive partner involvement, and ultimately improve access to and uptake of FP and SAC across Ethiopia.

2. Literature Review

Globally, women's autonomy in reproductive health is widely recognized as a critical determinant of maternal and child health outcomes. A 2022 meta-analysis by the Guttmacher Institute demonstrated that autonomy is associated with reduced maternal mortality and increased uptake of contraception and antenatal care in low- and middle-income countries (LMICs). A multicountry analysis of Demographic and Health Survey (DHS) data across 28 LMICs found that only 42.5% of women had full decision-making power regarding their reproductive health. Education, urban residence, and media exposure were significant predictors of autonomy, while gender norms and low socioeconomic status were barriers [10].

In sub-Saharan Africa, studies reveal similarly low autonomy. A 2023 cross-sectional study of nine African countries reported that only 35% of women could decide independently about contraceptive use. Cultural expectations often normalize male dominance, and in many cases, joint decision-making is perceived as autonomy even when male partners dominate those decisions [10]. Qualitative research in Kenya and Nigeria further emphasized that autonomy is contextually defined; in communities where women are expected to consult their husbands, even minor decision-making may be perceived as empowerment [11].

In Ethiopia, women's autonomy in reproductive health decision-making remains constrained by sociocultural norms, regional disparities, and partner influence. Multiple studies done from analysis of EDHS data show that only 22–28% of women made independent decisions regarding healthcare or contraceptive use, with autonomy significantly higher among urban, educated, and employed women.[12, 13] These findings are consistent with patterns observed in other low- and middle-income countries (LMICs), where women's autonomy is strongly associated with education, economic status, and access to information [10].

However, the level of independent decision-making reported in Ethiopia is generally lower than the averages reported in multicountry LMIC studies, where approximately 35–42% of women demonstrate full reproductive decision-making power [10]. This suggests that

Ethiopian women may experience stronger sociocultural constraints on reproductive decision-making compared with women in some other LMIC settings.

Autonomy varies regionally within Ethiopia, with higher levels reported in regions such as, with Addis Ababa, Tigray, and Somali showing higher levels compared to Dire Dawa and Afar [13,14]. Factors such as media exposure, participation in women's groups, and choosing one's marriage partner are positively associated with autonomy [15,16].

An important conceptual distinction exists between independent decision-making and joint decision-making. While joint decision-making with partners is often interpreted as empowerment in Ethiopian contexts, true autonomy requires that women retain the ability to make final decisions and access services independently [11,15]. In many cases, shared decision-making may still reflect male-dominated power structures, even when women perceive the process as cooperative [11].

Women who had chosen their marriage partner were more likely to demonstrate reproductive autonomy, suggesting a link between early life choices and future health decision-making capacity [17]. A study also revealed that women in communities that opposed wife beating were significantly more likely to access maternal healthcare services, underscoring how collective norms can influence reproductive autonomy [5,18].

A 2021 WHO multi-country study found that partner opposition was a major reason for discontinuing contraceptive use among women in LMICs [19]. Studies in sub-Saharan Africa indicate that many married women still lack full reproductive decision-making power due to sociocultural expectations and partner influence [20]. Yet, programs in Rwanda, Uganda, and Malawi that included male-targeted counseling and education saw increased shared decision-making, reduced opposition to contraception, and improved maternal outcomes [21].

Nearly 39% of women in Ethiopia discontinued contraceptive use within one year due to partner disapproval or pressure [22]. Male partner education and open communication were the key factors for reduced discontinuation and promoted contraceptive uptake [23].

Community attitudes and peer influences also shape male partner [24]. The 2016 EDHS found that 16.6% of non-use of contraceptives was due to husband dominance, and 42% reported that their husbands solely made the decision [7]. Another retrospective study reported that 10.44% of non-use was exclusively husband-decided. Higher education, religion, desire for more children, and lack of health worker outreach contributed to male dominance [12]. However, positive male involvement, equitable communication, and supportive community norms are associated with enhanced female autonomy. These findings underscore the need for gender-transformative interventions that empower women and engage partners in fostering equitable reproductive health.

Conceptual Framework

The conceptual framework for this study is adapted from socio-ecological and gender-power theories. It posits that women's autonomy in reproductive decision-making is influenced by individual (education, knowledge), interpersonal (partner support or control), institutional (health service quality), and societal (cultural norms) factors.

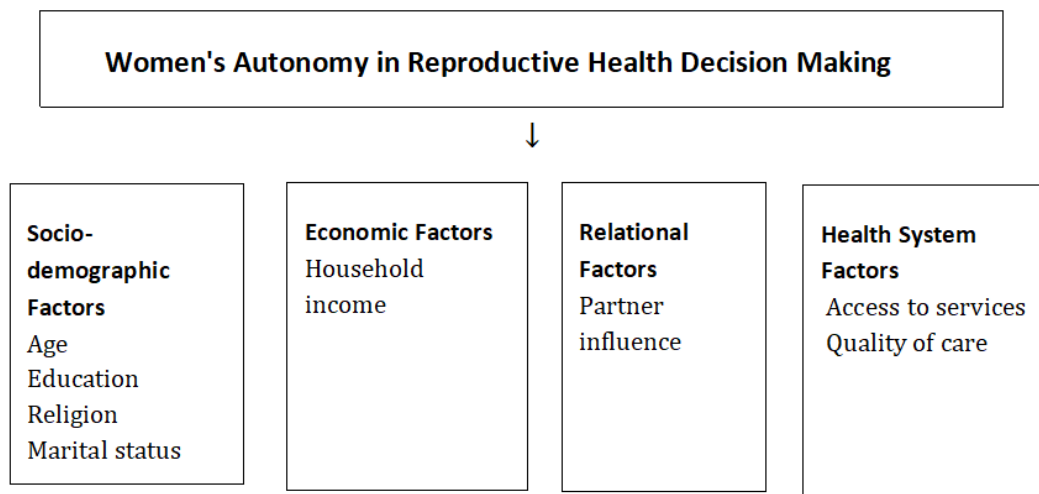


Figure 1 Conceptual Framework

3. Objectives

3.1 General Objective

To assess the level of women's autonomy and partners influence in reproductive health decision-making among women seeking family planning and safe abortion care at St. Paul's Hospital Millennium Medical College Michu Clinic.

3.2 Specific Objectives

- To assess the factors affecting autonomous reproductive health decision-making among women seeking family planning and safe abortion care at Michu Clinic.
- To assess the factors affecting partner influence in women's reproductive health decision-making among those seeking family planning and safe abortion care at Michu Clinic.
- To examine the association between women's autonomy, partner influence, and the utilization of family planning and safe abortion care services at Michu Clinic

4. Methods

4.1. Study setting

This study was carried out at St. Paul's Hospital Millennium Medical College (SPHMMC) Michu Clinic, located in Gullele sub-city, Addis Ababa. The clinic provides family planning, safe abortion care, gender-based violence management, cervical cancer screening, and postnatal services [25]. It caters a socioeconomically diverse patient population from Addis Ababa and surrounding areas. This setting was selected for its provision of both family planning and safe abortion services and its accessibility for primary data collection.

4.2. Study design

An institution-based cross-sectional study was employed to assess the level of women's autonomy and partner influence in reproductive health decision-making at Michu clinic.

4.3. Study Period

The entirety of this study spans a duration of approximately 1 year, commencing from February, 2025 and concluding in March, 2026.

4.4. Population

4.4.1. Source Population

The source population encompassed all women of reproductive age (15 to 49 years), who are actively seeking family planning and safe abortion care services at Michu Clinic.

4.4.2. Study Population

The study population comprises all eligible women of reproductive age who visit Michu Clinic for family planning or safe abortion care services during the data collection period, and provide informed consent to participate in the study.

4.5. Data collection method

Structured interviewer-administered questionnaires were used to gather primary data. These questionnaires were crafted to elicit comprehensive information on socio-demographic characteristics, women's perceptions of autonomy, nature and extent of

partner influence, lived experiences using family planning and safe abortion services, and enabling risk factors hindering autonomous decision-making.

4.6.Data collection tools

A structured questionnaire was developed, incorporating both closed- and open-ended questions. For quantitative data, validated scales were used where applicable. Women's autonomy was measured using a modified version of the DHS autonomy index, which includes decision-making on healthcare, contraceptive use, and mobility. Partner influence was assessed using a Likert-scale based instrument adapted from previous studies on reproductive decision-making.

4.7. Eligibility criteria

4.7.1. Inclusion Criteria

- Women aged 15–49 actively seeking FP or SAC services at Michu Clinic.
- Mentally competent individuals and able to provide informed consent.
- Willingness to participate and to complete the questionnaire.

4.7.2. Exclusion Criteria

- Women who are critically ill or experiencing severe pain
Those who decline to give informed consent.

4.8 Sample size determination and sampling method

The sample size was determined using the single population proportion formula

$$n = \frac{\{Z^2 \cdot p \cdot (1 - p)\}}{\{d^2\}} = \frac{\{(1.96)^2 \cdot (0.5) \cdot (1 - 0.5)\}}{\{(0.05)^2\}} = 384$$

where:

n = required sample size

Z = Z-score corresponding to the desired confidence level (e.g., 1.96 for 95%)

p = estimated proportion of the population 50% (due to lack of precise data in this specific setting)

d = margin of error (5%)

- Considering a 10% non-response rate: $n = 384 + 10\% = 422$

Since the total number of women visiting the clinic during the study period is estimated to be around 300 (i.e. < 10,000), finite population correction was used to calculate the adjusted sample size.

$$n_f = \frac{\{n\}}{\left\{1 + \frac{\{n-1\}}{\{N\}}\right\}} = \frac{\{422\}}{\left\{1 + \frac{\{422-1\}}{\{300\}}\right\}} = 176$$

n_f is the final adjusted sample size, n is the initiate sample size estimated above and N is total population size

Although the adjusted sample size of 176 reflects the clinic's actual patient volume, it may limit broader generalizability. Nonetheless, systematic sampling and mixed-method analysis enhance internal validity and provide meaningful insights within this context.

A systematic random sampling technique was employed.

The sampling interval (k) was calculated by the formula : $K = \frac{N}{n} = 1.7 \approx 2$

where:

N = total population size (i.e., total number of women visiting the clinic during the study period) =300

n = desired sample size=176

Thus, every other patient presenting during the study period was approached until the sample size was reached.

4.9.Study variables

Dependent Variables

There are two dependent variables in this study: Level of women's autonomy in reproductive decision-making and the degree of partner influence

- **Level of women's autonomy in reproductive decision-making**

Women's autonomy was assessed using a set of structured questionnaire items that evaluate the respondent's ability to make independent decisions regarding reproductive health, including family planning and abortion care. It was measured using a composite autonomy score derived from five Likert-scale items assessing independent reproductive health decision-making. These items evaluated the respondent's ability to:

- Make decisions about reproductive health independently
- Use contraception without external pressure
- Decide the number and spacing of children
- Seek reproductive health services independently
- Visit a health facility without requiring permission

Each item was scored on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). The overall autonomy score was calculated by taking the mean value of the five items for each participant. Higher scores indicated greater autonomy.

The sample mean autonomy score was used as the cut-off point for classification. Women with autonomy score above the mean were considered have high autonomy, while those with autonomy score below the mean were considered as having low autonomy, consistent with previous studies using DHS-based composite autonomy indices [13].

Joint decision-making was not classified as full autonomy unless the respondent reported that she retained the final decision-making power and could access services independently. Joint decision-making was considered under constructive partner influence, rather than under women's autonomy, to distinguish supportive involvement from independent decision-making.

- **Degree of partner influence**

Partner influence was measured by evaluating the nature and extent of the partner's involvement in reproductive health decisions by using five Likert-scale items. Each item was scored from 1 (strongly disagree) to 5 (strongly agree). A composite partner influence score was calculated by taking the mean of the item scores.

Participants were classified based on the mean partner influence score: above the mean constructive partner influence and below the mean restrictive partner influence.

Independent Variables

- Socio-demographic variables (age, education, marital status, income, occupation, residence)
- Reproductive history (parity, contraceptive use, prior abortions)
- Health system factors (access, waiting time, provider counseling)
- Sociocultural factors (gender norms, household power dynamics)

4.10. Operational definitions

Women Autonomy: The ability of a woman to independently make decisions regarding family planning or abortion care without coercion. [4]

High Autonomy: Women with composite autonomy score above the sample mean, indicating relatively greater decision-making power compared to other participants on autonomy-related questionnaire items. [13]

Low Autonomy Women who score below the mean on autonomy-related questionnaire items, suggesting limited or no independent decision-making power.[12]

Partner Influence: Any form of partner involvement or control in the reproductive decision-making process. [11]

Constructive Partner Influence: Partner supports woman's choices or participates jointly.[23]

Restrictive Partner Influence: Partner dominates or controls reproductive decisions , often leading to delayed care, non-use of contraception, or discontinuation of services.[26]

4.11. Data Analysis

Data was entered into EpiData and exported to SPSS version 26 for analysis. Descriptive statistics (frequencies, means, proportions) were to summarize variables. Bivariate logistic regression analysis identified variables associated with autonomy. Variables with $p < 0.25$ in bivariate analysis were included in multivariable logistic regression to control for confounders. Adjusted odds ratios (AOR) with 95% confidence intervals were reported. A p -value < 0.05 was considered statistically significant.

Qualitative data from open-ended questions was analyzed using thematic content analysis. Responses were transcribed, coded manually, and categorized into themes reflecting autonomy, partner influence, and barriers to decision-making. Findings were triangulated with quantitative results to enrich interpretation and contextual understanding.

The internal consistency of the autonomy measurement scale was assessed using Cronbach's alpha coefficient. The autonomy scale demonstrated excellent reliability with a Cronbach's alpha value of 0.95.

4.12. Ethical considerations

Approval was requested from the medical school's ethical and research committee, and permission was obtained from Michu clinic of SPHMMC and the Department of Obstetrics and Gynecology.

Written informed consent was obtained from all participants. Confidentiality and anonymity were strictly maintained by removing personal identifiers. Participation was voluntary, and participants may withdraw at any time without consequence. The data was securely stored and used solely for research purposes.

4.13. Plan for dissemination of results

The findings from this study was presented and submitted to SPHMMC, School of Public Health, School of medicine, Department of Obstetrics and Gynecology as one of the partial fulfillments of medical certificates. For broader dissemination, the manuscript will be submitted to one of the peer-reviewed journals for publication.

5. Results

5.1. Socio-demographic Characteristics

In this study nearly half of the respondents (44.3%) were between 15–24 years and the majority were either single (48.9%) or married (42.0%). Educational attainment varied with 14.2% had no formal education while upto 39.2% had secondary education. Urban residents comprised 70.5% of the sample and regarding occupation the majority of respondents were unemployed (including students) (36.9%). Monthly income was generally low, with 64.2% reporting less than 5000 Birr.

Table 1: Socio-demographic Characteristics of Respondents (n=176)

Characteristic	Category	Frequency (n)	Percentage (%)
Age Group (Years)	15–24	78	44.3
	25–34	76	43.2
	35–44	22	12.5
Marital Status	Single	86	48.9
	Married	74	42.0
	Divorced	13	7.4
	Widowed	3	1.7
Education Level	No Formal Education	25	14.2
	Primary	26	14.8
	Secondary Education	69	39.2
	Teritiary Education	56	31.8
Place of Residence	Urban	124	70.5
	Rural	52	29.5
Occupation	Unemployed (incl. Students)	65	36.9
	Sales/Service Worker	27	15.3
	Housewife	24	13.6
	Other/Unspecified	28	15.9

	Business Owner	21	11.9
	Civil Servant	11	6.3
Monthly Income (Birr)	<5000	113	64.2
	5000–15000	53	30.1
	>15000	10	5.7

5.2. Reproductive Health History

A high prevalence of family planning use was observed, with 92.0% of respondents reporting current contraceptive use. The most common methods were oral contraceptives (27.7%) while barrier and natural methods accounted for less than 6% of use. Abortion experience was reported by 81.3% of the women. Among these, induced abortion was most common (69.9%), while 14.0% reported spontaneous abortion.

Table 2: Reproductive Health History of Respondents

Characteristic	Category	Frequency (n)	Percentage (%)
Current FP Use	Yes	162	92.0
	No	14	8.0
FP Method Used (n=155)	Oral Contraceptives	43	27.7
	Implants	41	26.5
	Combination Methods	34	21.9
	Injectables	27	17.4
	Barrier Methods	9	5.8
	Natural Methods	1	0.6
Abortion Experience	Yes	143	81.3
	No	33	18.8
Type of Abortion (n=143)	Induced	100	69.9
	Unsafe	23	16.1
	Spontaneous	20	14.0

5.3. Health System & Community Factors

Most respondents lived within 5–10 km of a health facility (59.1%), and nearly half reported reaching the clinic within 30–60 minutes (48.3%). Public transport was the dominant mode of travel (73.9%), while 22.2% reached the clinic on foot. Waiting times were moderate, with 68.2% waiting for 30–60 minutes before receiving services. Encouragingly, 85.8% of providers explained available options, and 55.7% of respondents were satisfied with the services.

Community support was evenly split, 49.4% reported supportive attitude and 50.6% reported none. Stigma remained a concern, with 33% of respondents reported experienced stigma related to reproductive health decisions.

Table 3: Health System and Community Factors (N=176)

Variable	Category	Frequency (n)	Percentage (%)
Distance to Facility	<5 km	38	21.6
	5–10 km	104	59.1
	>10 km	34	19.3
Time to Reach Facility	<30 min	45	25.6
	30–60 min	85	48.3
	>60 min	46	26.1
Transport Mode	Walking	39	22.2
	Public Transport	130	73.9
	Private Transport	6	3.4
Wait Time	<30 min	39	22.2
	30–60 min	120	68.2
	>60 min	17	9.7
Provider Explained Options	Yes	151	85.8
	No	25	14.2
Service Satisfaction	Satisfied	98	55.7

	Neutral	61	34.7
	Dissatisfied	17	9.7
Community Support	Yes	87	49.4
	No	89	50.6
Faced Stigma	Yes	58	33.0
	No	116	65.9

5.4. Assessment of Women's Autonomy and Partner Influence

The overall mean autonomy score was 3.58 on a 5-point scale, suggesting a moderate to high level of perceived autonomy. When categorized based on the mean score, 71.0% (n=125) of the participants reported a high level of autonomy in decision-making, while 29.0% (n=51) reported low autonomy. The women's autonomy scale demonstrated excellent internal consistency with a Cronbach's alpha of 0.95.

The mean partner influence score was 3.6 on a 5-point scale, 67.1% (n=108) of the participants reported constructive partner influence, while 32.9% (n=53) reported restrictive partner influence. It is important to note that 15 participants (8.5%) were excluded from this analysis due to missing data on partner influence.

Table 4: Autonomy level and partner influence level

Variable	Category	Frequency (n)	Percent	95% Confidence Interval (CI)	P-value
Autonomy Level	Low Autonomy	51	29.0	22.3% – 35.7%	< 0.001
	High Autonomy	125	71.0	64.3% – 77.7%	
Partner Influence Level	Restrictive	53	32.9	25.7% – 40.1%	< 0.001
	Constructive	108	67.1	59.9% – 74.3%	

5.4. Factors Associated with Women's Autonomy (Bivariate & Multivariate Analysis)

In the bivariate analysis, variables including age, educational level, place of residence, monthly income, history of abortion, distance to the health facility, and community support were found to be candidates for the multivariable model (p-value < 0.25). After adjusting

for covariates in the bivariate model only education, place of residence, type of abortion and community support remained statistically significant predictor of high autonomy.

Women with tertiary education were 15.3 times more likely to demonstrate high autonomy compared to those with no formal or only primary education (AOR = 15.34, 95% CI: 1.92–122.4, $p = 0.01$). Similarly, women residing in urban areas were 8.1 times more likely to have high autonomy than those from rural areas (AOR = 8.12, 95% CI: 1.74–37.89, $p = 0.01$).

The type of previous abortion was also associated with women autonomy levels. Compared to women with a history of unsafe abortion, those who had experienced a spontaneous abortion had significantly lower odds of being in the high autonomy group (AOR = 0.01, 95% CI: 0.00–0.17, $p = 0.001$). This counter-intuitive finding may suggest a complex relationship where women experiencing spontaneous abortions in this study may face distinct vulnerabilities or limitations to their overall reproductive health autonomy compared to those who have underwent unsafe abortion, who may have exercised high autonomy within unsafe conditions.

Interestingly, community support was also found to be inversely associated with high autonomy (AOR = 0.07; 95% CI: 0.01–0.53, $p = 0.01$). This counter-intuitive finding suggests that women who report community support may, in fact, have lower odds of demonstrating high individual autonomy in reproductive health decisions.

Table 5: Factors Associated with Women's Autonomy

		COR (95% CI)	P value	AOR (95% CI)	P value
Age Group	15–24 (ref.)	1.00			
	25–44	0.75 (0.38 – 1.45)	0.39		
Education	No Formal /Primary Education(ref.)	1.00			
	Secondary Education	5.15 (2.34 – 11.34)	p < 0.001	2.45(0.48 – 12.42)	0.28
	Tertiary Education	45.47 (9.93 – 208.17)	p < 0.001	15.34(1.92 – 122.4)	0.01
Marital status	Married (ref.)	1.00			
	Not married	0.24 (0.12–0.47)	p < 0.001		
Place of residence	Rural (ref.)	1.00			
	Urban	34.24 (14.01–83.73)	p < 0.001	8.12(1.74 – 37.89)	0.01
Occupation	Employed	1.598(0.83 -3.09)	0.163		
	Unemployed/Housewife (ref.)	1.00			
Income	<5000birr	0.16(0.06 – 0.40)	p<0.001		
	>5000birr(ref.)	1.00			
FP Method	Short Acting (ref.)	1			
	Long Acting	2.46 (0.88 – 6.85)	0.09		
History of Abortion	Yes	4.00 (1.82–8.80)	0.001		
	No (ref.)	1.00	—		
Type of Abortion	Induced	8.70 (3.17–23.88)	p < 0.001	0.15(0.02 – 1.05)	0.06
	Spontaneous	2.41 (0.70–8.30)	0.16	0.01(0.00 – 0.17)	0.001
	Unsafe (ref.)	1.00	—		
Distance to facility	<5 km	21.45 (6.27–73.38)	p < 0.001		

	5–10 km	13.65 (5.38–34.61)	p < 0.001		
	>10 km (ref.)	1.00	—		
Time to reach facility	<30 min	3.82 (1.41–10.36)	0.01		
	30–60 min	1.69 (0.80–3.58)	0.17		
	>60 min (ref.)	1.00	—		
Mode of transport	Walking	N/A (Complete Separation)	1		
	Public transport	1.20 (0.80–1.80)	0.48		
	Private transport (ref.)	1.00	—		
Waiting time	<30 min	1.23 (0.37–4.10)	0.74		
	30–60 min	1.44 (0.49–4.20)	0.51		
	>60 min	1.00	—		
Provider explanation	Yes	N/A (Insufficient Variation)	—		
	No (ref.)	1.00	—		
Stigma	Yes	0.24 (0.12–0.48)	p < 0.001		
	No (ref.)	1.00	—		
Disclosure of decisions	Yes	34.03 (10.91–106.17)	p < 0.001	12.18(0.98 – 151.3)	0.05
	No (ref.)	1.00	—		
Community support	Yes	7.75 (3.46–17.34)	p < 0.001	0.07(0.01 – 0.53)	0.01
	No (ref.)	1.00	—		

*Variables that were not contributing significantly to the model's predictive power were removed automatically by the Backward LR method once the other factors were accounted for.

*Complete separation occurred for 'Mode of transport: Walking', indicating that all observations in this category were associated with a single outcome category, preventing stable odds ratio estimation. This suggests a strong, but unquantifiable, association within the current model structure. Insufficient variation in the 'Provider explanation' variable (due to highly skewed distribution) led to an unstable estimate, thus not reported in the multivariate model

5.5. Factors Associated with Constructive Partner Influence

The multivariable logistic regression model identified place of residence and the type of contraceptive method as significant predictors of constructive partner influence.

Women living in urban areas had significantly higher odds of experiencing constructive partner involvement compared to their rural counterparts (AOR = 8.56; 95% CI: 1.89–38.78, $p = 0.01$). Additionally, women with a history of induced abortion were significantly more likely to report constructive partner influence compared to those with a history of unsafe abortion (AOR = 8.61; 95% CI: 1.62–45.79, $p = 0.01$).

Table 6: Factors Associated with Constructive Partner Influence

variables	Categories	COR (95% CI)	P value	AOR (95% CI)	P value
Age group	15–24 (ref.)	1.00	—	—	—
	25–44	0.41(0.2 – 0.83)	0.01		
Education	No formal/Primary Education (ref.)	1.00			
	Secondary Education	3.911 1.727 – 8.859	0.001	0.40(0.08 – 1.97)	0.26
	Tertiary Education	18.49(6.14– 55.7)	p < 0.001	5.15(0.66 – 40.19)	0.12
Marital status	Married (ref)	1.00			
	Not Married	5.06(2.49 – 10.26)	p<0.001	5.142(1 – 26.48)	0.05
Residence	Urban	21.39(8.80 – 51.99)	p<0.001	8.56(1.89 – 38.78)	0.01
	Rural (ref.)	1.00	—	—	—
Income	<5000Birr	0.37(0.17 – 0.77)	0.01		
	>5000 Birr(ref.)	1.00			
Occupation	Employed	1.40(0.72 – 2.71)	0.32		
	Unemployed/Housewife (ref.)				
FP use	Yes	N/A (Complete Separation)	0.99		—
	No	1.00	—	—	—
FP method	Short Acting (ref.)	1.00			
	Long Acting	2.29(0.92– 5.7)	0.08		
History of abortion	Yes	2.88 (1.06–7.83)	0.03		
	No	1.00	—		
Type of abortion	Induced	15.87 (5.3–47.5)	p < 0.001	8.61(1.62 – 45.79)	0.01
	Spontaneous	2.55 (0.7–9.0)	0.16	1.17(0.15 – 9.49)	0.88
	Unsafe (ref.)	1.00	—		

Distance to facility	<5 km	7.94 (2.6–24.1)	p < 0.001		
	5–10 km	9.25 (3.6–23.7)	p < 0.001		
	>10 km (ref.)	1.00	—		
Time to reach facility	<30 min	0.96 (0.39–2.4)	0.93		
	30–60 min	1.33 (0.6–3.6)	0.49		
	>60 min (ref.)	1.00	—		
Mode of transport	Walking	0.71 (0.12–4.2)	0.72		
	Public transport	1.17 (0.2–6.7)	0.86		
	Private transport (ref.)	1.00	—		
Waiting time	<30min	0.79 (0.23–2.7)	0.71		
	30–60 min	1.72 (0.57–5.2)	0.34		
	>60 min (ref.)	1.00	—		
Provider explanation	Yes	3.27 (1.3–8.2)	0.02		
	No (ref.)	1.00	—		
Satisfaction	Satisfied	1.69 (0.48–6.0)	0.41		
	Neutral	1.90 (0.5–7.0)	0.34		
	Dissatisfied (ref.)	1.00	—		
Disclosure of decisions	Yes	13.37 (4.2–42.5)	p < 0.001		
	No (ref.)	1.00	—		
Community support	Yes	4.48 (2.2–9.1)	p < 0.001		
	No (ref.)	1.00	—		
Stigma	Yes	0.24 (0.12–0.48)	p < 0.001		
	No (ref.)	1.00	—		

*Variables that were not contributing significantly to the model's predictive power were removed automatically by the Backward LR method once the other factors were accounted for.

*COR for FP Use could not be calculated due to zero cell count (all participants using FP reported constructive partner influence/Complete Separation)

5.6. Qualitative Findings (Thematic Summary)

The qualitative data provided preliminary insights into the lived experiences of the participants. Qualitative responses were analyzed alongside quantitative findings to provide contextual interpretation and to triangulate these narratives with the statistical results, allowing for a more nuanced understanding of how structural barriers intersect with individual decision-making power. The primary themes identified first include **financial and structural barriers**. Participants highlighted economic constraints and transport costs as significant obstacles to accessing reproductive health services. This aligns with the quantitative finding that lower income was associated with lower autonomy. *Women reported:* “I wish I had financial support.” “Transportation is too expensive for me to access health care services.” These responses highlight a critical gap between **perceived autonomy** (the right to decide) and **practical agency** (the means to act). Even when women reported high decision-making power, their ability to utilize services was frequently restricted by a lack of independent financial resources and the high cost of public transport.

Another theme identified was a **need for comprehensive support**. The data suggests a need for support beyond clinical services, particularly in addressing the financial and logistical challenges faced by women. Women reported “I need people to support me and government to work on the people's awareness.”. Participants emphasized that autonomy is not solely an individual trait but is reinforced by supportive health systems and community awareness. The call for 'government to work on people's awareness' suggests that reducing social stigma is perceived as a prerequisite for exercising true reproductive freedom, explaining why community support appeared as a complex variable in the multivariable model.

6. Discussion

This study assessed the level of women's autonomy and the nature of partner influence among clients seeking reproductive health services at Michu Clinic. While a majority of participants were classified as having high autonomy and constructive partner involvement, multivariable analysis identified only place of residence and higher education as consistent predictors of autonomy. These findings highlight the persistent structural and educational disparities between urban and rural women in accessing and exercising reproductive health decision-making power.

The study found that 71.0% of participants reported high autonomy in reproductive decision-making. This is substantially higher than the national figures reported in the 2016 Ethiopian Demographic and Health Survey (EDHS), which indicated that many women still lack sole decision-making power over their own healthcare [7, 13]. This discrepancy may be explained by the facility-based and predominantly urban nature of the study population. Women who actively seek reproductive health services at a tertiary-level urban clinic may already possess greater awareness, mobility, and confidence in navigating health systems compared to women in community-based or rural samples.

However, it is important to interpret these findings cautiously. Autonomy was measured using a composite self-reported scale, which reflects perceived decision-making power rather than objectively verified independence. An important conceptual consideration in interpreting these findings is the sociocultural meaning of autonomy within the Ethiopian context. In contrast to individualistic frameworks where autonomy is often defined as independent decision-making, reproductive decisions in Ethiopia are frequently embedded within marital relationships, social expectations, and shared responsibilities. Marriage is widely regarded as a socially and morally binding institution, and decisions such as childbearing are often understood as collective rather than purely individual choices.

As a result, women may perceive joint decision-making with their partners as appropriate and even desirable, rather than as a limitation of autonomy. In some cases, decisions that appear "non-autonomous" from an individualistic perspective may be socially legitimate and culturally consistent within the local context. Therefore, the concept of complete

independent autonomy may not fully reflect the lived realities of women in this setting. Instead, autonomy may be better understood as relational and negotiated, shaped by both individual preferences and social norms. Therefore, high reported autonomy does not necessarily imply complete independence from relational or contextual influences.

6.1 Predictors of Autonomy

Place of residence and educational attainment were statistically significant independent predictors of autonomy after adjustment for potential confounders. Urban women were significantly more likely to demonstrate higher autonomy compared to rural women. Furthermore, women with tertiary education were over 15 times more likely to have high autonomy than those with no formal or only primary education. This finding aligns with previous Ethiopian studies demonstrating that urban residence and higher education are strongly associated with increased contraceptive use, health service utilization, and decision-making power [4,8,13]. Urban settings and higher education may provide women with better educational opportunities, income-generating activities, transportation access, and exposure to gender-equity messaging through media and community programs.

In contrast, rural communities often maintain more traditional gender norms in which reproductive decisions are influenced by husbands, elder family members, or community expectations.

Interestingly, community support was found to be inversely associated with high autonomy. This counter-intuitive finding suggests that women who report community support may, in fact, have lower odds of demonstrating high individual autonomy in reproductive health decisions. This could be interpreted in several ways: it might indicate that women who perceive a need for community support are those who face greater challenges to their autonomy, or that community support structures, while beneficial in some aspects, may also reinforce traditional norms that limit individual decision-making power. Alternatively, it could reflect that women with lower individual agency are more reliant on community networks for navigating reproductive health services. This complex

relationship warrants further qualitative investigation to understand the specific dynamics of community support and its influence on women's autonomy in this context.

Women who had history of a spontaneous abortion also had lower odds of being in the high autonomy group compared to women with a history of unsafe abortion. This counter-intuitive finding may suggest a complex relationship where women experiencing spontaneous abortions in this study may face distinct vulnerabilities or limitations to their overall reproductive health autonomy compared to those who have undergone unsafe abortions. Additionally in the context of this study, women who underwent unsafe abortion may have exercised high autonomy within unsafe conditions, by independently seeking terminations despite legal, financial or social barriers. Further qualitative research is warranted to explore the nuanced social and health contexts contributing to this observed association.

Given the rural–urban disparity observed in this study, strengthening women’s autonomy requires context-specific interventions. In Ethiopia’s primary health care system, integrating empowerment-focused counseling within routine family planning services may enhance women’s independent decision-making. Health extension workers can incorporate couple-based counseling sessions, particularly in rural communities, to promote constructive male engagement while safeguarding women’s autonomy. Community dialogue platforms involving religious and local leaders may also help address restrictive gender norms and reduce stigma surrounding reproductive health services.

6.2 Partner Influence

A majority of women (67.1%) reported constructive partner influence, while approximately one-third experienced restrictive influence. The distinction between constructive and restrictive influence is critical. In many Ethiopian settings, joint decision-making is culturally normative and may be viewed as positive partnership. However, joint participation does not necessarily equate to autonomy if women lack final authority or independent access to services [11].

The finding that nearly one-third of women experienced restrictive partner influence indicates that male dominance in reproductive matters remains a significant barrier for a

substantial minority of women. This aligns with prior studies showing that partner opposition contributes to contraceptive discontinuation and delayed healthcare utilization in Ethiopia and other LMICs [12,19].

6.3 Predictors of Constructive Partner Influence

Women residing in urban areas were significantly more likely to experience constructive partner involvement compared to their rural counterparts. This suggests that urban environments, often characterized by greater exposure to diverse information, educational opportunities, and potentially more progressive gender norms, may foster more supportive partner dynamics in reproductive health decision-making. Previous studies in Ethiopia have similarly highlighted that urban residence is associated with increased women's empowerment and better reproductive health outcomes, which can facilitate more open communication and shared decision-making within partnerships [12] [17].

Furthermore, a history of induced abortion was significantly associated with higher odds of constructive partner influence. This finding is particularly noteworthy and could indicate several dynamics. It might suggest that the sensitive nature of induced abortion necessitates or leads to more open and supportive communication between partners, fostering a more constructive influence. Alternatively, it could imply that women in already constructive partnerships are more likely to access safe induced abortion services, or that the experience itself strengthens the couple's communication and mutual decision-making regarding reproductive health. This aligns with the importance of partner communication and male involvement in reproductive health decisions and the broader efforts to engage men in gender equality and sexual and reproductive health as emphasized by previous studies [17,21,23]. Further qualitative research could explore the nuanced reasons behind this association.

6.4 Barriers and Qualitative Insights

Despite high reported autonomy, 33.0% of women faced community stigma, and qualitative responses highlighted "financial constraints" as a major hurdle. These findings underscore an important distinction between decision-making power and practical agency. This indicates that while a woman may have perceived right to decide (autonomy), she may

lack the *means* to act (agency) such as economic resources, mobility, or social protection necessary to act on that decision. In Ethiopia's sociocultural context, economic dependency, community stigma surrounding abortion, and entrenched gender norms continue to shape reproductive choices. These structural and normative factors may disproportionately affect rural women and those with limited income.

The presence of restrictive influence in nearly one-third of the sample (32.9%) further suggests that male dominance in reproductive matters remains a significant barrier for a substantial portion of women.

7. Strength and Limitations

7.1 Strengths

- The autonomy scale demonstrated high internal consistency (Cronbach's $\alpha = 0.95$), indicating reliable internal measurement within this study population.
- **Mixed-Methods Approach:** The integration of qualitative thematic fragments provided a more nuanced understanding of the financial and social barriers that quantitative data alone might miss.

7.2 Limitations

- **Sample Size and Precision:** The final sample of 176, while statistically valid, resulted in wide confidence intervals in the multivariable model. This limits the precision of the specific odds ratios, although the direction and significance of the associations remain clear.
- **Mean cut-offs for autonomy and partner influence levels:** The use of a sample-based mean cut-off may limit comparability with national surveys but was appropriate for relative classification within this facility-based sample
- **Facility-Based Bias:** As the study was conducted among women already seeking services, it may not represent the experiences of the most marginalized women who are unable to reach a health facility due to a total lack of autonomy.

- **Self-Reporting Bias:** The sensitive nature of reproductive health and partner dynamics may have led some participants to provide socially desirable answers regarding their level of independence.
- **Sociocultural context:** The study conceptualized autonomy primarily in terms of individual decision-making, which may not fully capture the relational and culturally embedded nature of reproductive decision-making in the Ethiopian context.

8. Conclusion

The majority of women seeking services at Michu Clinic possess high levels of autonomy, which in turn fosters constructive partner involvement. However, rural and less-educated women remain at a significant disadvantage. The study underscores that women's empowerment is the cornerstone of healthy reproductive decision-making.

9. Recommendations

For Policy Makers

- Strengthen rural health extension programs to include autonomy-focused reproductive health education.
- Integrate structured male-engagement counseling modules into national family planning guidelines and services.

For Michu Clinic

- Introduce couple-based counseling options while ensuring confidential services for women who prefer independent consultation.
- Develop targeted counseling support for rural clients and women with low education.

For Future Research: Conduct longitudinal studies with larger sample sizes to better understand the causal pathways between autonomy, partner influence, and long-term health outcomes.

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11. Annexes

Section 1: Socio-Demographic Information

1. Age in complete years: _____
2. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
3. Educational Level: ☐ No formal education ☐ Primary ☐ Secondary ☐ Tertiary
4. Occupation: _____
5. Monthly Income in Birr: _____
6. Place of Residence: ☐ Urban ☐ Rural

Section 2: Reproductive Health History

7. Have you ever used family planning methods? ☐ Yes ☐ No
8. If yes, which method(s)? _____
9. Have you ever had an abortion? ☐ Yes ☐ No
10. If yes, was it: ☐ Spontaneous ☐ Induced ☐ Unsafe
11. Number of children: _____

Section 3: Autonomy in Reproductive Health Decision-Making

(Likert Scale: Strongly Disagree – Disagree – Neutral – Agree – Strongly Agree)

12. I make decisions about my reproductive health independently.
13. I feel confident making reproductive health decisions without external pressure.
14. I can decide on my own whether to use contraception.
15. I have control over when and how many children I want to have.
16. I can visit a health facility without needing permission.

Section 4: Partner Influence

(Likert Scale: Strongly Disagree – Disagree – Neutral – Agree – Strongly Agree)

17. My partner supports my decision to use contraception.

18. My partner discourages me from seeking abortion care.
19. I need my partner's approval before accessing reproductive health services.
20. My partner and I make joint decisions about family planning.
21. My partner has prevented me from using certain reproductive health services.

Section 5: Health Facility Access and Services

22. Distance to Health Facility: ☐ <5 km ☐ 5–10 km ☐ >10 km
23. Time taken to reach facility: ☐ <30 minutes ☐ 30–60 minutes ☐ >60 minutes
24. Preferred mode of transport: ☐ Walking ☐ Public Transport ☐ Private Transport
25. How long did you wait to receive services today?
- ☐ Less than 30 minutes ☐ 30–60 minutes ☐ More than 1 hour
26. Did the provider explain your options clearly?
- ☐ Yes ☐ No
27. Are you satisfied with the services provided? ☐ Satisfied ☐ Neutral ☐ Dissatisfied

Section 6: Psychosocial Aspects

28. Have you disclosed your reproductive health decisions to anyone? ☐ Yes ☐ No
29. If yes, to whom? ☐ Family ☐ Friends ☐ Health Provider ☐ Others: _____
30. Have you faced stigma or discrimination regarding family planning or abortion?
- ☐ Yes ☐ No
31. Do you feel supported by your community in reproductive health decisions?
- ☐ Yes ☐ No

Section 7: Open-Ended Questions

32. What challenges have you faced in making reproductive health decisions independently?
33. What kind of support do you wish you had when making these decisions?
34. How do you perceive your partner's role in your reproductive health choices?