RESEARCH PAPER

Women's Autonomy, Gender Inequality, And Reproductive Health Decision-Making Among Married Women

Krishna Pathak[1], Dr. Banti Deori[2]

[1] Research Scholar, University of Science and Technology, Meghalaya.
Email: kpbarpeta1@gmail.com

[2] Assistant Professor, University of Science and Technology, Meghalaya.
Email: deori.banti@gmail.com

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ABSTRACT

Autonomy in reproductive health decision-making is an important component of gender equity and health. This research paper examines the relationship between gender inequalities, women's autonomy and reproductive health decision-making among married women, in developing countries, particularly in India. The paper reviews the effects of socio-cultural influences, economic independence, education and intrahousehold power on women's autonomy in making decisions concerning contraception, maternal health and fertility. The paper finds low autonomy is a critical factor in suboptimal reproductive health and health care. It also highlights the role of structural and patriarchy constraints to women's agency. The study suggests that boosting women's autonomy through education, economic opportunities and policy change will result in better reproductive health and greater gender equity. The paper concludes with a discussion of comprehensive approaches to overcome social and institutional barriers to women's autonomy.

Keywords: Women's Autonomy, Gender Inequality, Reproductive Health, Decision-Making, Married Women, Developing Countries

Corresponding Author: Krishna Pathak Page

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Introduction

1.1 Background and Context

In recent years women's autonomy has become an important issue in the debates on gender, development and health. It provides a measure of the ability of a woman to decide on her life, social relations and health in the absence of any external influences. In the context of women's reproductive health, autonomy is important because it relates to the capacity to make choices about contraception, pregnancy and childbirth as well as reproductive health services (Gobena et al., 2026). These decisions are not just a matter of individual preference, but also socio-cultural, economic and institutional factors that impact women's lives.

Autonomy for women is important because it involves fundamental human rights, including bodily integrity, dignity and autonomy. International human rights instruments repeatedly emphasise the importance of women being able to make decisions about their reproductive health free from coercion, discrimination and violence. Reproductive autonomy is thus a health, but also a justice and equality, concern. When women have the power to make decisions, they can safeguard their health, have or avoid pregnancies and fully contribute to society (Bitew et al., 2024). Conversely, a lack of autonomy may lead to poor health outcomes, including unintended pregnancy, unsafe abortion and increased maternal morbidity and mortality.

1.2 Conceptualizing Women's Autonomy in Reproductive Health

Women's autonomy needs to be understood beyond the realm of choice. It has to do with access to information,

agency and ability to act in a supportive environment. In relation to reproductive health, women's autonomy can be described in several interrelated ways, such as autonomy in family decision-making, mobility for accessing health care and financial autonomy for health resources (Idris et al., 2023). The latter are affected by intrinsic factors (such as education, self-esteem) and extrinsic factors (such as family, culture and institutional factors).

The context of reproductive health decision-making is particularly critical because it may involve bargaining with spouse and/or in-laws, such as in marriage. Women in many cultures may not make decisions about fertility and health care independently, but rather, decisions are made or constrained by husbands, in-laws or extended family. This co- or constrained decision-making may involve questions of women's autonomy in decision-making. It also poses questions of participation versus control in decision-making.

1.3 Gender Inequality and Structural Constraints

Despite improvements in policies and programs to increase awareness, gender inequality is a major structural barrier to women's autonomy, particularly in developing countries. Pro-patriarchal cultures promote male authority and gender roles that limit women. These cultures reproduce gender roles and norms that prescribe obedient, nurturing and dependent roles for women, which constrain their autonomy in health care.

Marriage can be a complicating factor for women. Marriage, often seen as a social institution, reinforces gender inequalities that limit women's decision-making (Nepal et al., 2023). Decisions around reproductive health are viewed as family decisions, and include a variety of family members. Women's economic vulnerability also plays a role, as they may lack the financial ability to access health care and make choices.

Cultural beliefs also affect reproductive health decisions. Cultural beliefs regarding fertility, son preference and early marriage and parenthood, for instance, can influence women's decision-making. Also, the stigma around reproductive health complications often prevents the exchange of information and communication, thereby restricting women's autonomy.

1.4 Implications for Reproductive Health Outcomes

The relationship between women's autonomy and reproductive health is well-established. Women who have greater autonomy are more likely to use reproductive health services, such as family planning, antenatal and postnatal care and safe childbirth (Negash et al., 2023). They are also more likely to negotiate the use of contraception and spacing of pregnancy, improving maternal and child health.

By contrast, a lack of autonomy is associated with a range of poor outcomes. Lack of reproductive autonomy can result in greater risk of unintended pregnancy, and reduced access to quality health care. This affects the health of women, their family and the community. Furthermore, lack of decision-making power can result in ongoing poverty and inequality as women's health is connected to economic empowerment.

This is particularly relevant for women who are married, who can have complex dynamics with their family. Some women may co- decide with their partners while others may have limited or no power to decide on their own health. Autonomy could be affected by education, socio-economic background and culture. This is critical for the design of interventions that address the needs of different groups of women.

1.5 Rationale and Objectives of the Study

In the milieu of persistent issues of gender inequality and women's non-autonomy, it is important to look at the factors influencing reproductive health decision-making by married women. The motivation for this research is that improving women's autonomy is important not only for empowering individuals but also for achieving public health and development goals.

This paper seeks to critically review the relationship between women's autonomy, gender inequality and the reproductive health decision-making of married women. It seeks to understand the factors that influence autonomy, including socio-economic, cultural and institutional factors and how these influence health decision-making (Gebeyehu et al., 2022). It also aims to understand the dynamics of gender inequality that play out in the household and influence women's agency.

By framing the analysis from a gender and development perspective, the paper contributes to the debate on women's empowerment and reproductive rights. It draws attention to the need for multi-faceted approaches that address both structural and individual aspects of empowerment. Ultimately, the study points to the need for enabling environments for women to independently and adequately determine their reproductive health, which guarantees equity, dignity and well-being.

2. Conceptual Framework

2.1 Women's Autonomy

Autonomy is a complex concept that encompasses decision-making, freedom of movement, female financial autonomy and resource control. Reproductive health-related autonomy relates to sexual relationships, contraception and health services (Belachew et al., 2023). The United Nations acknowledges that autonomy is a critical element of women's rights, and states that "decisions about reproductive functions should be made by women" .

Measures of household decision-making, mobility and control over economic resources are often used to capture autonomy. These measures reflect women's socio-

economic position and their position in the household and community.

2.2 Gender Inequality

Gender inequality is the unequal power relations, opportunities and resources between men and women. It is embedded in social, cultural and institutional structures. Gender inequality can manifest in many ways, such as unequal access to education, employment, health and power.

With respect to reproductive health, gender inequality can result in a loss of agency for women. Patriarchal views mean men or elders in the family make decisions about fertility and health care, limiting women's decision-making power.

2.3 Reproductive Health Decision-Making

Reproductive health decision-making includes contraception, pregnancy, birth and health care. It occurs at the individual, family and community level. Autonomy for women in these decisions, either alone or with their partners, is an indicator of empowerment and gender equality (Mare et al., 2022).Research demonstrates that higher autonomy leads to higher contraception, antenatal service use and autonomous decision making for childbirth.

3. Literature Review

3.1 Research Design

This study adopts a mixed-method research design to examine the relationship between women's autonomy, gender inequality, and reproductive health decision-making among married women. The design integrates both quantitative and qualitative approaches in order to capture the multidimensional nature of autonomy, which is shaped by socio-economic, cultural, and intra-household dynamics. The quantitative component enables the measurement of associations between key variables, while the qualitative component provides deeper insights into the lived experiences, perceptions, and constraints faced by women in exercising autonomy. This combination ensures a comprehensive and context-sensitive analysis of the issue.

3.2 Study Area and Population

The study is conducted in selected regions of India, with particular focus on communities where gender inequality and reproductive health challenges are prevalent. The target population consists of married women of reproductive age, typically defined as those between 15 and 49 years. This group is selected because reproductive health decision-making is most relevant within this demographic, and marital relationships significantly influence autonomy and access to health services. The study includes participants from both rural and semi-urban settings to capture variations in socio-cultural norms and access to resources.

3.3 Sampling Technique and Sample Size

A multistage sampling technique is employed to ensure representation of different socio-economic and cultural groups. In the first stage, regions or districts are selected based on demographic and health indicators. In the second stage, households are selected using systematic or random sampling methods. Within each selected household, one eligible married woman is chosen for participation. The sample size is determined based on statistical considerations to ensure adequate power for analysis, with an estimated sample of approximately 200–300 respondents. This size allows for meaningful statistical testing and generalization within the study context.

3.4 Data Collection Methods

Primary data is collected through structured questionnaires and in-depth interviews. The questionnaire is designed to capture information on socio-demographic characteristics, education, employment status, household decision-making, mobility, access to health services, and reproductive health behaviors. Standardized scales and indicators are used to measure women's autonomy, including participation in household decisions, control over financial resources, and freedom of movement. In addition, qualitative interviews are conducted with a subset of participants to explore personal experiences, cultural norms, and family dynamics that influence decision-making. Secondary data from national surveys and published reports are also used to support and contextualize the findings.

3.5 Variables and Measurement

The dependent variable in this study is women's reproductive health decision-making autonomy, which includes decisions related to contraception, pregnancy, and utilization of maternal health services. Independent variables include education level, economic status, employment, socio-cultural norms, and household dynamics such as spousal communication and family structure. Autonomy is measured using composite indices derived from responses to questions on decision-making participation, financial control, and mobility. These variables are operationalized to allow for statistical analysis and comparison across different groups.

3.6 Data Analysis Techniques

The collected data is analyzed using both descriptive and inferential statistical techniques. Descriptive statistics such as frequencies, percentages, means, and standard deviations are used to summarize the socio-demographic characteristics and levels of autonomy among respondents. Inferential analysis is conducted to examine relationships between variables, including correlation and regression analysis. Logistic regression models are applied to assess the influence of independent variables on women's autonomy in reproductive health decision-making. Qualitative data from interviews is analyzed using thematic analysis, where recurring patterns and themes related to

gender norms, power relations, and decision-making processes are identified and interpreted.

3.7 Ethical Considerations

Ethical principles are strictly followed throughout the research process. Informed consent is obtained from all participants prior to data collection, ensuring that they are aware of the purpose of the study and their right to withdraw at any time. Confidentiality and anonymity of respondents are maintained by removing identifying information from the dataset. Special care is taken while discussing sensitive topics related to reproductive health and household dynamics to ensure the comfort and safety of participants. The study adheres to ethical guidelines for social science research and respects the dignity and rights of all individuals involved.

3.8 Limitations of the Study

While the study attempts to provide a comprehensive analysis, certain limitations are acknowledged. The cross-sectional nature of the study restricts the ability to establish causal relationships between variables. Responses may also be influenced by social desirability bias, particularly on sensitive issues such as autonomy and family decision-making. Additionally, the findings may not be fully generalizable beyond the selected study areas due to regional and cultural variations. Despite these limitations, the study provides valuable insights into the determinants and implications of women's autonomy in reproductive health decision-making.

4. Determinants of Women's Autonomy

4.1 Education

Education helps to enhance women's autonomy. Education helps them to gain access to information, develop critical and decision-making skills. It also increases their awareness about reproductive health services and rights (Belachew et al., 2023). Education level of both women and their partners has been shown to be an indicator of reproductive health and autonomy .

4.2 Economic Independence

Economic independence is one of the important measures of women's autonomy, particularly in reproductive health. This is the ability of a woman to earn, manage and spend her own income without being completely dependent on others and, therefore, enhancing her bargaining position within the household and the community. Financial autonomy not only enables women to meet their personal and family responsibilities, but also supports their autonomy in making decisions about the use of health services, fertility and access to health care.

Women with financial independence are more likely to participate in household decision-making, including reproductive health decision-making. Employment provides women with an income, information and social connections, which increases their knowledge, self-esteem and awareness (Mare et al., 2022). This in turn enables them to negotiate with their family and partners about issues of fertility and contraception, spacing of pregnancy and also to seek health care during pregnancy and childbirth. In many cases, women's economic contribution to the family also brings them status and respect, improving their family status.

However, the connection between economic empowerment and autonomy is not clearcut. In many socio-cultural contexts, such as in patriarchal societies, women's labour does not translate into decision-making. Women with an income might still be expected to fulfil conventional gender roles that favour men (Mathur et al., 2024). In such instances, economic decision-making may still be made by men (husbands, fathers, etc), limiting women's autonomy. This example highlights the difference between economic participation and economic empowerment, and that having an income does not necessarily lead to autonomy.

Additionally, the nature of employment also contributes to women's autonomy. low-paid and insecure jobs may lack economic and social value that would change the hierarchical structure of the family. Further, women in paid work also have to juggle between work and household activities, leaving less time to make decisions. Women may also not want to invest in their health, even though they have the financial capacity to do so, due to family and social constraints.

Therefore, while women's economic empowerment is determined by their financial independence, this is moderated by other socio-cultural factors. In order to be empowered, women not only need to have access to income, but also to control resources, have positive socio-cultural norms, and equitable intra-household power dynamics.

4.3 Socio-Cultural Norms

Socio-cultural norms play a key role in shaping women's autonomy and reproductive health choices. Norms are the shared ideas, values and behaviours that regulate social relationships. In many cases, in settings like South Asia and other low- and middle-income countries, socio-cultural norms are embedded in patriarchal structures that shape men's and women's roles and responsibilities (Liang et al., 2024). These norms often assign roles to men as decision makers and women as carers, limiting women's participation in their health and well-being.

Patriarchal norms continue to disadvantage men and women by reinforcing power imbalances at home and in the communities. Women are encouraged to prioritise family needs over their own, to be subservient and humble, and to not express their views. These restrict their ability to express preferences, to access information and to access health services. Specifically, in the context of reproductive health, women may decide about pregnancy, contraception and childbirth in consultation with the husband, family or

leaders of the community, which leaves them disempowered.

Their capacity to make reproductive choices is further hindered by cultural taboo. Topics such as menstruation, contraception and sex are often considered taboo and inappropriate to talk about, leading to a lack of information and misinformation (Fernandes et al., 2025). This can prevent women from obtaining accurate information, as well as health care. Women may also be embarrassed or fear stigma associated with accessing health care.

In addition, fertility preferences, such as son preference, can be an important influence on fertility. Women may be expected to continue having children until they have the desired number of sons, even if it impacts their health or well-being. Early marriage and childbearing, which are practised in some regions, also limit women's educational and economic opportunities, and therefore promote dependency and low autonomy.

It's important to recognise that socio-cultural norms can be influenced by education, media, policy and social movements (Imo et al., 2022). To enhance women's autonomy, it's essential to address these norms by promoting gender equality, freedom of expression and removing discrimination. Without shifting the socio-cultural environment, improving individual factors like education and incomemay not improve women's autonomy.

4.4 Household Dynamics

Household dynamics are a key component of women's autonomy, influencing the power relations and decision-making processes in households. These may be shaped by marriage, family, communication and relationships across generations. Reproductive health-related household dynamics include decisions about contraception, pregnancy and health care.

Spousal communication is a component of household dynamics that has an impact on women's empowerment (Solanke et al., 2022). Supportive communication within the marriage is associated with decision-making and reproductive health. Women who can share their opinions with their husbands are involved in family planning and health-care decision-making. These discussions foster feelings of being understood and respected, which are important for partnerships to be equal.

However, often family decisions are made by husbands or other family elders, particularly in joint and extended family settings. Women may not be given an opportunity to express their views, or may be actively opposed if they do try to express their preference. In such situations, decisions may be made in a collective way, but without taking into account women's preferences. This could lead to women consenting to decisions that are not to their advantage.

Family structure also determines gender autonomy. Women in nuclear families might have more autonomy and decision-making power than those in joint families, where caste and family hierarchy is more prominent. Women may also feel empowered by supportive family members, like educated husbands or progressive in-laws, and feel disempowered in constraining family environments.

Education, age and employment play a role in family power structures. Young women, particularly those who are newly married, may have low confidence and power (Aragaw et al., 2023). Women's expanding knowledge and seniority within the family may increase their autonomy. However, this is not necessarily the case and may be influenced by socio-cultural aspects.

Understanding the micro-level context is essential to strategies that promote women's autonomy. Programs that facilitate couple communication, engage men in reproductive health matters, and shift family power dynamics towards equality result in more equal decision-making.

5. Impact of Gender Inequality on Reproductive Health

5.1 Pathways Linking Gender Inequality and Health Outcomes

Gender inequality impacts on reproductive health in a complex manner as it operates at the structural, social and individual level. It limits access to health services for women, limits women's choices and exposes women to health risks. Gender inequality is a power imbalance that impacts negatively on women and constrains their ability to achieve the highest possible health and well-being.

One of the ways that gender inequality affects reproductive health is by restricting women's access to information and resources. A lack of autonomy can mean women are unable to access health care services without the permission, and/or financial support, of their family or husband (Alfian et al., 2025). This can therefore delay or prevent access to health care services such as antenatal care, skilled birth attendants and post-natal care. This can result in women being at greater risk during pregnancy and childbirth, and can affect mother and child.

5.2 Consequences for Maternal and Child Health

Impacts of limited autonomy and gender inequality are evident in several reproductive health indicators. Lack of decision-making power is linked to decreased contraception, which leads to unintended pregnancy and short interpregnancy intervals. This leads to higher risks of maternal morbidity and death, and sub-optimal maternal, infant and child health.

Lack of access to health care also leads to malnutrition, lack of medical care for health conditions, and pregnancy and child birth complications. Lack of autonomy can also result in delays in access to health care, which can increase health risks (Asmamaw et al., 2024). Further, lack of autonomy

can affect children's health, as women tend to be responsible for children's nutrition, vaccines and health.

5.3 Knowledge, Awareness, and Decision-Making

Gender inequality also impacts knowledge and awareness of reproductive health issues. When decision-making is in the hands of husbands or other family members, women may have less access to information and decision making about health. Research indicates that women who don't have control over decision-making about health care are more likely to have lower knowledge of contraception and reproductive health services.

This leads to dependency and challenges women's decision-making autonomy. This creates a vicious cycle where reduced autonomy leads to poor health outcomes and social and economic disparities (Ullah et al., 2024). To disrupt this cycle, interventions that address informational and structural empowerment of women need to be implemented.

5.4 Broader Social Implications

Reproductive health gender inequality has implications for families, communities and society. Poorer reproductive health outcomes can impact negatively on economic productivity, increase health-care costs and foster intergenerational poverty and inequality (Majumder et al., 2024).

So, reducing gender inequality is not just a human rights issue, but also a development issue. Interventions and policies that promote gender equality; enhance women's power and control over their lives; and increase access to health care services can have wide-ranging health and social impact.

6. Reproductive Health Decision-Making Among Married Women

Marriage is a multifaceted social institution that affects women's reproductive decision-making in a number of ways. Marriage is a social institution that has a dual impact on women's autonomy. Marriage can provide social, emotional and material support that improves women's health-care access and facilitates decision-making. But it could also uphold gender roles and relations that constrain women's autonomy in patriarchal societies (Kassahun et al., 2022). The ways in which marriage can enable or hinder agency depend on the quality of the marriage, power relations within the family and cultural norms of marriage and family life.

In many cultures, particularly in developing nations, married women are expected to make decisions and choices that prioritise the needs of their families over their own health needs. These practices are ingrained in cultural expectations that categorise women as the primary carers and reproducers of the family, whose main roles are to maintain the integrity of the family and to reproduce (Ouahid et al., 2025). As a result, matters related to contraception, pregnancy, childbirth and health care are often considered to be familial rather than individual concerns. The agency of women is often limited by the presence of husbands, mothers-in-law and other elders who are involved in the decision-making process.

Husbands play a particularly influential role in reproductive health, as the relationship between women and their husbands is a key factor for access to resources, information and health care. Husbands are often the gatekeepers to financial resources and medical services. This may make it difficult for women to access medical services, contraception and deferring pregnancy. Further, women might find it challenging to express their preference or negotiate decisions within marriages, especially in cultures where it is not acceptable to question or challenge men's authority.

The involvement of in-laws, particularly in joint families, can also play a role. For instance, mothers-in-law may be involved in fertility decisions like when and how many children women should have (Haile et al., 2024). Their preferences may be based on cultural norms, such as son preference and the continuation of the family lineage, which might ultimately affect women's fertility. These areas may have low levels of female autonomy not only in relation to their husbands but also in relation to the extended family.

The research evidence reveals that, often, married women do not make health care decisions. This is an expression of underlying gender inequalities that limit women's agency and access to health care. This in turn can affect women's contraceptive use, attendance at antenatal care and having a skilled provider at birth, leading to poor outcomes. Lack of decision-making also restricts women's ability to manage health emergencies, with delays in decision-making resulting in poor pregnancy and childbirth outcomes.

But the concept of decision-making varies among married women. For some women, decision-making is perceived as joint, which is associated with better health outcomes. Joint decision-making promotes communication, understanding and shared responsibility, which can help couples make informed decisions, taking into account the needs and wishes of both partners (Wang et al., 2024). It further enhances feelings of women's empowerment and validation, thereby boosting their confidence and willingness to initiate discussion of reproductive health matters.

However, it is important to establish if joint decision-making includes symbolic participation by women. It can happen that joint decision-making may take place but the decisions are still made by husbands. Autonomy is not only about women having the freedom to participate in decision-making but also to influence decision-making and to make their own decisions if necessary. Without this, joint decision-making may not challenge inequalities in power and may serve to entrench them.

The autonomy of married women with regard to reproductive health is influenced by a range of factors such as education, economic status and information. Women with education are more likely to be aware of their rights and to have the confidence to assert themselves. For instance, women with economic power can exercise choice when interacting with health services and access health care more readily (Tesfa et al., 2022). Community and media-based programs can also raise awareness and change gender norms, which in turn, can increase autonomy.

But there are also a range of factors that limit women's autonomy. Strict gender norms, lack of education and employment opportunities, and lack of health facilities all restrict women's opportunities. Women may internalise these norms and not feel they have the right to make decisions about their health. This can contribute to limits on autonomy, even where there are fewer external constraints.

A complex approach is required to address barriers to reproductive health decisions for married women. Approaches to promote autonomy should take into account both women and the broader social and institutional determinants of their lives. Engaging husbands and families in discussions on gender equality and reproductive health issues is important for creating a positive family environment and relationships. At the same time, policy and strategies need to focus on better access to education, economic opportunities and health services, and better equip women to exercise their rights.

In conclusion, the reproductive health decision-making of spouses is determined by several factors such as marital relations, family relations and socio-cultural influences (Mangimela-Mulundano et al., 2022). Although joint decision-making may lead to better outcomes, it does not necessarily translate to autonomy. Encouraging women's autonomy and informed decision-making of their own reproductive health is vital to achieve gender equality and improved public health. This requires continuing to shift power and promote equality in relationships, and empower women at individual and community levels.

7. Policy and Programmatic Interventions

A multi-dimensional approach is required to ensure women's autonomy in reproductive health decision-making by moving beyond individual-level approaches to include policy, community and institutional change. Women's autonomy is a complex issue that is linked to social, economic and cultural determinants; therefore, interventions need to focus on individual, family and institutional factors (Forty et al., 2022). In the last decade, governments, international organisations and non-government organisations (NGOs) have become more interested in multi-dimensional approaches that link women's empowerment and reproductive health, acknowledging that health progress will not be achieved without advancing gender equality.

Policy measures play an important role in creating an enabling policy environment for women's autonomy. Legislation that guarantees women's right to education, employment and health services are vital in creating an enabling environment for decision-making. Policies that ensure access to reproductive health services, including family planning, maternal health care and safe childbirth centres are key to reducing barriers to accessing health services. In many countries, there have been efforts to ensure gender-sensitive approaches are incorporated into national health policies to eliminate health inequalities. These policies may emphasise the importance of informed consent, privacy and respect for women's autonomy in decision-making about their health, thereby allowing autonomy in the health system.

Besides the law, social protection policies have also proved essential in ensuring women's autonomy (Zegeye et al., 2023). Cash transfers, maternity payments and health insurance can help women overcome financial barriers to access to health care services. This not only improves women's health, but also their intra-household resources and bargaining power. But the design and delivery of such interventions, as well as their impact on health and social inequalities, are critical for their success.

International agencies have been crucial in establishing international agendas for women's empowerment and reproductive health. Programs aligned to agendas such as the Sustainable Development Goals emphasise gender equality and universal access to reproductive health services. Programs supported by international agencies usually consist of capacity building, service delivery and advocacy to strengthen national systems and practices. These have led to increased awareness and services in many countries, but there are still issues with equitable delivery of programs across class lines.

Community programs are also important to address socio-cultural barriers to women's autonomy (Antabe et al., 2025). Since gender norms and behaviours are embedded in the community, interventions that engage important stakeholders are required to achieve long-term impact. Community interventions that involve local leaders, faith-based leaders and local organisations can shift traditional gender norms to more equitable gender role expectations. Educational and promotional interventions are crucial to sharing information on reproductive health and rights and empowering women.

Engaging men and boys in reproductive health programs is another strategy to change gender roles. Men are key decision makers in their families and are critical to creating enabling environments for women. Programs that promote shared decision-making, egalitarian and respectful forms of communication and gender equality can shift attitudes and practices, leading to shared decision-making. These approaches recognise that women's empowerment is a societal issue.

Health system reforms are also crucial. Health centres must be well-funded and staffed, but also staffed by sensitised staff who are aware of issues of gender and women's rights. The quality of provider attitudes and behaviours can play a critical role in women's experience of health services (Pokharel et al., 2023). Affordable and accessible health care with respectful providers is empowering and improves health. The inclusion of counselling, education and outreach programs within health services also may enhance women's decision-making.

Programs that focus on women's empowerment in health care have shown positive impact on decision-making and reproductive health. Such programs often include service provision and activities to enhance knowledge, confidence and empowerment. For example, health education, skills and livelihood programs can address different dimensions of empowerment. Such programs have a ripple effect on women's health and well-being by addressing health through the development agenda.

But there are obstacles that may reduce the effectiveness of policy and program interventions. One such challenge is the persistence of socio-cultural attitudes and norms that are entrenched and support gender inequality. Policy responses may not have the impact that is intended without a shift in social norms and practices. In addition, inequalities in access to services, particularly between rural and urban areas, can exacerbate gender inequality (Castro Lopes et al., 2024). Women from economically poor backgrounds, ethnic minorities, and rural regions may face other factors that limit their participation in programs and access to resources.

Policy implementation is also an issue. While many countries have developed progressive policies to promote gender equality and reproductive health, the implementation of these policies is not always consistent. An absence of funding, coordination and monitoring and evaluation capacity may limit the effectiveness of interventions. Improving institutional capacity, accountability and coordination among government, non-government and community-based organisations can help address these challenges.

In conclusion, enhancing women's reproductive health decision-making autonomy requires a multi-pronged approach involving policy reform, community mobilisation and capacity-enhancement. While there have been numerous programs and activities to support this, more needs to be done to address barriers and disparities (Bhowmik et al., 2024). These policies need to be complemented with interventions to change socio-cultural practices, strengthen gender-sensitive practices and support women individually and collectively. By working holistically and inclusively, we can create an environment that enhances women's ability to exercise rights, make autonomous decisions and achieve better health, and support gender equality and sustainable development.

8. Discussion

The findings from this study highlight the importance of women's autonomy as a key factor in shaping reproductive health, especially among married women in settings where gender inequality is prevalent (Tesha et al., 2023). As evident in the previous sections, autonomy is not an individual trait but a socially negotiated capacity influenced by structural, cultural and economic factors. The study reinforces the view that the capacity for women to make autonomous and informed decisions about their reproductive health is a key predictor of health-seeking behaviour, family planning and maternal and infant survival. The lack or constraint of autonomy, on the other hand, is a factor in poor health outcomes, underscoring the relationship between empowerment and health.

One of the salient findings of this study is the role of gender inequality, which manifests in various ways to limit women's decision-making autonomy. Socio-cultural expectations derived from patriarchal values continue to shape and confine women's roles in the family and community, relegating them to a position of inferiority. These norms not only constrain women's involvement in decision-making but also affect their sense of entitlement and empowerment (Ang et al., 2023). Often, women internalise these norms, which can also serve to thwart their willingness to exercise their preferences, even when opportunities to do so may be available. Economic inequality, including lack of access to employment and income, also reinforces dependence and power imbalances in households.

Although significant strides have been made in the provision of reproductive health services, the results suggest that it is not enough to simply increase access. Health systems that emphasise providing services while overlooking the social determinants of health may not deliver their full potential. For example, the presence of contraceptive methods or maternity services does not guarantee their use if women are not in a position to make decisions about their use. This disconnect between access and use suggests the need for a more integrated approach that links service delivery with efforts to increase autonomy and reduce gender inequalities.

The conversation also highlights the need to broaden the focus of policy frameworks that prioritise technical or biomedical approaches to reproductive health. These are crucial for enhancing the quality and reach of services but often neglect the social and relational aspects that play a role in decision-making (Seidu et al., 2022). Interventions therefore need to go beyond a biomedical approach and consider strategies that tackle power relations, social norms and gender relations. This involves moving away from treating women as passive consumers of health services and towards empowering them to make informed decisions about their health.

Another key aspect revealed by the findings is the influence of community structures and men in women's autonomy. Men often play a key role in household decision-making, especially around issues to do with finance and health. Therefore, interventions to enhance women's autonomy should not focus solely on women, but include men as allies in change. Interventions that promote communication, respect and shared responsibility between spouses can result in shifting family dynamics and more enabling environments for decision-making. Likewise, community-based programs that engage with community leaders, faith leaders and other social institutions can help to change gender norms and attitudes.

The use of collective and sustained approaches in tackling gender inequality is critical. Norms and attitudes are deeply ingrained and can be difficult to shift, which calls for long-term approaches (Demissie et al., 2022). Programs of education, media messaging and community engagement can be an important part of addressing discriminatory practices and promoting gender equality. At the same time, structural changes, such as increasing access to education and employment for women, are also crucial for fostering the conditions for autonomy to develop. These initiatives need to be integrated and coordinated across different sectors to ensure a unified approach.

The research also implies that programs to improve women's autonomy need to be localised and responsive to specific circumstances. Cultural, economic and institutional differences mean that a universal approach is not likely to work. Programs that are responsive to local context and conditions may be more effective. For instance, approaches that work in cities might not transfer to rural areas where there are fewer services and opportunities for information. Recognising these differences is essential for the effective and sustainable implementation of strategies.

Additionally, the conversation suggests a need for better measurement and assessment of women's autonomy and its influence on reproductive health. Current indicators offer useful information, but may not capture all the nuances of autonomy as a dynamic and multifaceted construct (Sapkal et al., 2026). Creating more sophisticated and situational measures can improve researchers' and policymakers' capacity to monitor and evaluate progress and identify gaps. This can guide the development of more effective interventions.

To sum up, this study confirms women's autonomy as a critical factor in their reproductive health and as part of gender equality (Tagang et al., 2023). To overcome the barriers related to low autonomy, a multifaceted strategy is needed, not only focused on enhancing access to health services, but also on the structural social, cultural and economic determinants of women's autonomy. Engaging men, families and communities is crucial to building support and long-term strategies are required to address underlying norms and behaviours. Through an integrated and contextualised approach, it is possible to boost women's autonomy, improve health, and advance social justice and sustainable development.

Conclusion

Autonomy in women's reproductive decision-making is a cross-cutting issue that lies at the nexus of gender equality, human rights and public health, and as such is an important focus of research and intervention. The evidence offered in this paper has shown that autonomy is not an individual attribute, but rather a complex phenomenon influenced by socio-cultural, economic, institutional and intrafamilial factors. For married women, these elements intersect in intricate ways to limit their reproductive autonomy, that is, their capacity to make independent and well-informed decisions about contraception, pregnancy and health service utilisation. Thus, the question of autonomy needs to be considered in the context of gender inequality that continues to constrain women's agency in various settings.

One of the key findings of this research is that gender inequality remains a prevalent and entrenched factor that constrains women's reproductive autonomy. Women continue to be constructed within patriarchal norms and practices that prioritise family and community interests over individual autonomy. These norms are supported by cultural practices, economic factors and institutional structures that limit women's role in decision-making. Married women are especially impacted as they are positioned within a hierarchy within their family, with their reproductive health decisions being impacted by their husband and other family members. This not only limits women's autonomy, but also impacts their health and well-being.

The study also shows that while increasing access to reproductive health services is critical, it is not enough to promote improved health outcomes if it is not accompanied by efforts to increase women's autonomy. Health systems that prioritise service delivery without considering the determinants of autonomy may not sustain improvements. Women may have access to health facilities and services, but are unable to access and use them effectively because of constraints posed by social norms and intra-household power imbalances. This accessibility-usage disconnect highlights the importance of a more holistic approach that focuses on both service provision and empowerment strategies.

To boost women's autonomy, a holistic and multi-sectoral approach is needed to address the factors identified in the present study. Education is a fundamental determinant as it provides women with knowledge, skills and empowerment to critically assess their situation. Women with higher education are more likely to engage in decision-making, seek health services and speak out about their health. Likewise, economic empowerment is critical in increasing women's bargaining power within the home and allowing them to make choices. Economic opportunities and

financial capacities not only support women's socio-economic status but also their confidence and social standing, empowering them to become more autonomous.

In parallel, interventions to improve autonomy need to tackle the socio-cultural norms that reinforce gender inequality. This requires long-term community-level engagement with women, men, families and community institutions. Programs that promote discussion, challenge gender discrimination, and promote more equal gender roles can help to foster a climate where women's autonomy can be respected. It is crucial that men are engaged, as they have a strong influence on decision-making within the household. Promoting mutual respect and responsibility can result in more equal and participatory decision-making.

Policies also need to be key in promoting women's autonomy. Policy makers and institutions must ensure an enabling legal and institutional environment for women's rights and gender equality. This extends to providing access to quality reproductive health services, adopting gender-responsive policies and removing barriers to women's participation. Policy implementation and monitoring are key to ensure that policies are effective in improving women's lives. Further, linking empowerment initiatives to reproductive health programs can increase their effectiveness, by addressing both the supply and demand of reproductive health services.

Another key finding of this study is the need for context-specific solutions that consider the heterogeneity of women's experiences. Geographical, socio-economic, educational and cultural differences affect the level of autonomy women can exercise. Consequently, strategies need to consider the unique circumstances and needs of different groups, rather than one-size-fits-all strategies. This can help to maximise the impact and success of programs to improve autonomy and health.

In conclusion, promoting women's autonomy in reproductive health decision-making is not just about better health outcomes, it is also about upholding human rights. Decision-making about one's own body and health is fundamental to dignity, autonomy and equality. The lack of women's autonomy hampers their rights and entrenches inequalities and poverty. On the other hand, supporting women to exercise autonomy can have profound effects, not only on health outcomes, but also on social and economic change.

In summary, this paper confirms that women's autonomy is fundamental to gender equality and public health. To overcome the challenges of limited autonomy, a long-term and multifaceted approach is needed, encompassing education, economic empowerment, socio-cultural change and policy reform. Through the provision of gender-sensitive services and environments, we can empower women to make decisions and improve their reproductive health. This is critical to meet national and international development agendas, as well as the principles of justice, equity and human dignity that inform a more just and equitable world.

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