# Who Decides? Reproductive Autonomy Among Married Rural Women in India: Evidence from 11 Villages

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**Abstract:** Reproductive autonomy is central to women's health, rights, and gender equality, yet many married women in rural India continue to have limited authority over decisions related to childbearing and healthcare. While prior research has linked women's autonomy to education, poverty, and social norms, fewer studies have examined how digital access, financial control, and collective participation intersect with structural disadvantage at the village level. This paper investigates the extent of reproductive decision-making autonomy among married rural women and examines its association with education, caste, economic vulnerability, digital use, financial control, and self-help group participation. A cross-sectional survey was conducted among 982 married women aged 18–49 years across 11 purposively selected villages in India. The questionnaire was structured using the Advancing Women's Empowerment through Systems-Oriented Model Expansion (AWESOME) framework. Descriptive statistics and chi-square tests were used to analyse patterns of decision-making and associations with key socio-demographic and empowerment variables. Only 20.3% of respondents reported sole decision-making authority over childbearing, while 44% reported that husbands or in-laws were the primary decision-makers. Sole authority over healthcare visits was reported by 28.8% of women. Education and self-help group participation were positively associated with reproductive autonomy, while caste and economic vulnerability were associated with lower autonomy. The findings further show that household access to phones, homes, or bank accounts does not necessarily translate into women's agency when independent control is absent. The paper contributes to gender research by showing that reproductive autonomy is shaped not only by household assets, but by the interaction of structural disadvantage, effective resource control, and collective support. The study argues that gender-transformative interventions must move beyond material provision toward strengthening women's independent digital and financial control and expanding collective platforms that support negotiation and agency.

**Keywords**: Reproductive decision-making, Structural barriers, Socio-economic disadvantage, Self-help group participation, Gender equity

## 1. Introduction

Sexual and reproductive health and rights (SRHR) are central to women's dignity, well-being, and gender equality. Global commitments such as the International Conference on Population and Development (UNFPA 2004) and Sustainable Development Goal 5.6 (United Nations 2018) affirm women's right to decide whether, when, and how many children to have. However, for many women in rural India, reproductive decisions continue to be shaped by unequal gender norms, limited access to resources, and restricted control over healthcare.

Postcolonial feminist scholars argue that women's autonomy must be understood within specific social and cultural contexts rather than as an abstract individual attribute. Women's decision-making is often constrained both by wider structural inequalities and by patriarchal control within households and communities, a process described as "double colonisation" (Petersen and Rutherford (1986; Tiwary 2020). In India, bodily and reproductive autonomy is frequently subordinated to marital and familial expectations, making reproductive decision-making a relational process shaped by caste, class, gender, and social norms (Sharma and Rani 2017).

In this context, reproductive decision-making is often dominated by husbands or elder family members, with many women having limited influence over childbearing or their own healthcare. National evidence shows that a substantial proportion of married women in India do not independently decide on contraception or healthcare use (IIPS and ICF 2021). Limited autonomy has been linked to adverse outcomes including lower contraceptive

uptake, unintended pregnancies, and delays in seeking care (Blanc 2001; Jejeebhoy and Sathar 2001). Although earlier studies identified education, mobility, and access to resources as important determinants of autonomy (Dixon-Mueller 1978; Dyson and Moore 1983), more recent work shows that autonomy is also shaped by intersecting forms of disadvantage such as poverty, caste, and unequal household power relations (Shroff et al. 2009; Agarwala and Lynch 2006; Darteh et al. (2019); Lailulo et al. 2015). In India, Scheduled Caste and Scheduled Tribe women continue to report lower reproductive autonomy than more socially advantaged groups (Tayal et al. 2024).

Recent literature also points to the growing relevance of digital access and financial inclusion. Mobile phones, internet access, and digital financial services may expand women's access to information, mobility, and decision-making opportunities (Rajkhowa and Qaim 2022; Showkat et al. 2024). However, the mere presence of devices or bank accounts does not ensure agency. Women often experience only secondary access, where resources exist at the household level but remain controlled by men (Barboni et al. 2018; Gurumurthy and Chami 2014). Similarly, formal financial inclusion may not lead to real decision-making power if women lack control over account use (Demirguc-Kunt et al. 2017; Field et al. 2019). At the same time, women's collectives such as self-help groups (SHGs) can widen decision space by building confidence, solidarity, and negotiation capacity (Gupta and Prennushi 2014; Sanyal 2009).

Despite this growing literature, few studies in rural India examine how reproductive autonomy is shaped simultaneously by education, caste, economic vulnerability, digital use, financial control, and collective participation. Much of the available evidence relies on national or state-level datasets, which often mask local variation in village-level empowerment contexts. This study addresses that gap through a cross-sectional survey of 982 married women across 11 rural villages in India, guided by the Advancing Women's Empowerment through Systems-Oriented Model Expansion (AWESOME) framework (Gressel et al. 2020).

The paper addresses the following research questions:

***RQ1:*** *What proportion of married rural women report sole, joint, or limited authority over childbearing and healthcare decisions?*

***RQ2:*** *How is reproductive decision-making autonomy associated with education, caste, economic vulnerability, digital use, financial control, and self-help group participation?*

***RQ3:*** *How do these factors together reveal patterns of intersectional disadvantage and village-level variation?*

Given the quantitative nature of the study, the following hypotheses are proposed:

> ***H1:*** *Women with higher levels of education will report greater reproductive decision-making autonomy than women with lower educational attainment.*
>
> ***H2:*** *Women from Scheduled Caste/Scheduled Tribe households and economically vulnerable households will report lower reproductive decision-making autonomy than relatively advantaged women.*
>
> ***H3:*** *Independent digital use and greater financial control will be positively associated with reproductive decision-making autonomy.*
>
> ***H4:*** *Participation in self-help groups will be positively associated with reproductive decision-making autonomy.*

## 2. Methods

### 2.1 Study Design and Setting

A cross-sectional survey was conducted during November-December 2023 among married women in 11 purposively selected rural villages in India. The villages were selected to capture variation in caste composition, economic vulnerability, digital access, and women's collective participation, as these factors were considered relevant to reproductive decision-making and empowerment. The sites were not intended to be statistically representative of all rural India; rather, they were chosen to enable comparison across differing village contexts.

### 2.2 Participants

Eligible participants were married women aged 18-49 years residing in the selected villages who provided informed consent. Women were excluded if severe cognitive impairment prevented meaningful participation or if participation posed safety concerns. A total of 982 women were surveyed across the 11 villages.

### 2.3 Data Collection and Measures

Data were collected using a structured questionnaire developed with input from experts in gender studies, public health, and social work. The tool was informed by the Advancing Women's Empowerment through Systems-Oriented Model Expansion (AWESOME) framework, which examines empowerment through the domains of mental space, awareness, access, and opportunities (Gressel et al. 2020). The questionnaire included modules on reproductive decision-making, digital access, financial inclusion and control, community participation, and socio-demographic characteristics.

The primary outcomes were women's reported authority over decisions related to childbearing and their own healthcare. Explanatory variables included education, caste, ration card status, age, house ownership, mobile phone access and independent use, internet access, bank account ownership and control, and self-help group (SHG) participation. These variables were selected because prior research identifies them as important correlates of women's autonomy, especially in rural and socially stratified contexts. The questionnaire was translated into local languages, pre-tested for clarity, and administered orally by trained female fieldworkers. Where needed, community translators supported the process. Data were recorded on encrypted mobile devices using SurveyCTO.

### 2.4 Analysis

Data were exported into IBM SPSS Statistics version 23 for analysis. Descriptive statistics were used to summarise respondents' socio-demographic characteristics and patterns of reproductive decision-making. Chi-square tests were used to examine associations between childbearing decision-making and selected socio-demographic and empowerment variables, including education, caste, ration card status, age, village, and household assets. Given the cross-sectional design, the analysis identifies associations rather than causal relationships. Village-level comparisons were included to explore local variation in empowerment and decision-making patterns.

## 3. Results

### 3.1 Reproductive and Health Decision-making Autonomy

A total of 982 women were included in the analysis. With regard to childbearing decisions, only 22.5% of respondents reported that they decided by themselves, while 35.3% reported joint decision-making with their husbands and 28.5% reported that the husband was the main decision-maker. A further 10.3% were unsure who made the decision, and only small proportions reported that decisions were made by someone else, jointly with others, or by the whole household. Healthcare decision-making showed a similarly constrained pattern: 33.4% reported sole authority over their own healthcare, 18.4% reported joint decision-making with husbands, and 41.3% reported that husbands decided. Childbearing and healthcare decision-making were strongly associated, suggesting that women with limited voice in one domain often experienced similar constraints in the other.

**Table 1: Childbearing decision-makers among respondents (N = 982)**

| Decision-maker | n | % |
|---|---|---|
| Jointly with husband | 347 | 35.3 |
| Husband only | 280 | 28.5 |
| Self only | 221 | 22.5 |
| Not sure | 101 | 10.3 |
| Everyone jointly | 17 | 1.7 |
| Jointly with someone else | 9 | 0.9 |
| Someone else | 7 | 0.7 |

**Table 2: Healthcare decision-makers among respondents (N = 982)**

| Decision-maker | n | % |
|---|---|---|
| **Husband only** | 406 | 41.3 |
| **Self only** | 328 | 33.4 |
| **Jointly with husband** | 181 | 18.4 |
| **Someone else** | 26 | 2.6 |
| **Everyone jointly** | 25 | 2.5 |
| **Not sure** | 9 | 0.9 |
| **Jointly with someone else** | 7 | 0.7 |

### 3.2 Socio-demographic and Empowerment Profile

**Table 3: Selected socio-demographic and empowerment characteristics of respondents (N = 982)**

| Variable | Category | n | % |
|---|---|---|---|
| **Caste** | SC/ST | 443 | 45.1 |
| | OBC | 219 | 22.3 |
| | General | 212 | 21.6 |
| | Other | 96 | 9.8 |
| | Prefer not to say | 12 | 1.2 |
| **Ration card status** | BPL | 438 | 44.6 |
| | PHH | 190 | 19.3 |
| | APL | 171 | 17.4 |
| | NPHH | 96 | 9.8 |
| | Don't know | 26 | 2.6 |
| | AAY | 11 | 1.1 |

| Variable | Category | n | % |
|---|---|---|---|
| | Prefer not to say | 4 | 0.4 |
| | Missing | 46 | 4.7 |
| **Education** | No formal education | 287 | 29.2 |
| | Below primary | 158 | 16.1 |
| | Below secondary | 313 | 31.9 |
| | Higher secondary | 102 | 10.4 |
| | Undergraduate | 84 | 8.6 |
| | Postgraduate | 36 | 3.7 |
| | Prefer not to say | 2 | 0.2 |
| **Phone ownership** | Smartphone | 399 | 40.6 |
| | Basic phone | 253 | 25.8 |
| | Does not own phone | 314 | 32.0 |
| | No response | 16 | 1.6 |
| **Internet use** | Uses internet | 651 | 66.3 |
| | Does not use internet | 322 | 32.8 |
| | Missing | 9 | 0.9 |
| **SHG participation** | SHG member | 281 | 28.6 |
| | Not an SHG member | 701 | 71.4 |

*Note.* AAY = Antyodaya Anna Yojana; APL = Above Poverty Line; BPL = Below Poverty Line; NPHH = Non-Priority Household; OBC = Other Backward Class; PHH = Priority Household; SC/ST = Scheduled Caste/Scheduled Tribe; SHG = self-help group.

The sample reflected substantial social and economic disadvantage. Nearly half of respondents belonged to Scheduled Caste or Scheduled Tribe households (45.1%). In terms of economic classification, 44.6% held Below Poverty Line ration cards and 19.3% held Priority Household cards. Educational attainment was also limited: 29.2% had no formal education, 16.1% had only primary or lower schooling, and 31.9% had education below the secondary level, while only 12.3% reported undergraduate or postgraduate education.

In relation to access-related variables, 40.6% reported owning a smartphone, 25.8% a basic phone, and 32.0% reported not owning a phone. Internet use was reported by 66.3% of respondents. Self-help group participation remained limited, with 28.6% reporting SHG membership. These descriptive results indicate that formal access

to some resources was present, but meaningful participation and independent decision-making remained unevenly distributed.

### 3.3 Factors Associated with Childbearing Decision-making

**Table 4: Chi-square associations between childbearing decision-making and selected variables**

| Variable | $\chi^2$ | df | p |
|---|---|---|---|
| **Village** | 332.06 | 54 | < .001 |
| **Ration card status** | 114.48 | 36 | < .001 |
| **Caste** | 96.31 | 24 | < .001 |
| **Phone ownership** | 75.52 | 18 | < .001 |
| **Education** | 51.17 | 36 | .048 |
| **SHG participation** | 31.04 | 6 | < .001 |
| **Internet use** | 4.45 | 6 | .616 |
| **House ownership** | 4.41 | 6 | .621 |

Childbearing decision-making varied significantly by village, caste, ration card status, education, SHG participation, and phone ownership. Village-level variation was particularly strong ($\chi^2$=332.06, p<0.001), indicating that decision-making patterns differed substantially across local contexts. Caste was also significantly associated with childbearing decision-making ($\chi^2$=82.44, p<0.001). Women from general-category households were more likely to report sole authority over childbearing (36.3%) than women from SC/ST households (19.9%) and OBC households (13.7%).

Economic vulnerability showed a similarly patterned relationship. Ration card status was significantly associated with childbearing decision-making ($\chi^2$=101.04, p<0.001). Women in APL households were more likely to report sole authority (33.9%) than women in BPL households (20.1%) or AAY households (9.1%), indicating that reproductive autonomy was lower among more economically vulnerable households.

Education was modestly but significantly associated with childbearing decision-making ($\chi^2$=49.93, p=0.013). Women with no formal education were least likely to report sole authority (18.1%), whereas women with postgraduate education reported the highest level of sole authority (30.6%), although the number in this category was small. House ownership was not significantly associated with childbearing decision-making ($\chi^2$=4.41, p=0.621), suggesting that household asset ownership alone does not meaningfully differentiate women's reproductive authority.

Digital access showed a mixed pattern. Phone ownership was significantly associated with childbearing decision-making ($\chi^2$=72.74, p<0.001). Women who owned smartphones were much more likely to report sole authority over childbearing (33.6%) than women who owned basic phones (18.2%) or no phone (11.5%). By contrast, internet use as a binary variable was not significantly associated with childbearing decision-making ($\chi^2$=4.45, p=0.616). This suggests that simple connectivity may matter less than the form of device access and, potentially, the extent of personal control over it.

Collective participation also mattered. SHG participation was significantly associated with childbearing decision-making ($\chi^2$=31.04, p<0.001). Women who were SHG members were more likely to report either sole or joint decision-making with husbands than non-members, indicating that collective participation may widen women's involvement in reproductive decisions even when it does not always translate into sole authority.

### 3.4 Village-level Variation and Intersectional Disadvantage

The strongest association in the dataset was village-level variation, pointing to the importance of local empowerment contexts. The proportion of women reporting sole authority over childbearing ranged from as low as 3.9% in Kanti and 4.0% in Dongarampur to 45.3% in Thirupalaikkudi and 42.6% in Murad Garhi. In contrast, husband-dominated decision-making was especially high in villages such as Morasia, where 55.9% reported husbands as the main decision-maker. These differences suggest that reproductive autonomy is shaped not only by individual characteristics, but also by village-level social environments and norms.

The results address all three research questions. Overall, women were more likely to report joint or husband-dominated decision-making than sole authority over childbearing and healthcare. Reproductive autonomy was significantly associated with education, caste, economic vulnerability, phone ownership, and SHG participation, supporting H1, H2, and H4, while H3 received only partial support because smartphone ownership was associated with greater autonomy but internet access alone was not. The strong variation across villages, together with lower autonomy among socially and economically disadvantaged women, highlights the role of intersectional inequality and local empowerment contexts in shaping reproductive decision-making.

Taken together, the findings point to a layered pattern of disadvantage. Lower autonomy was concentrated among women facing caste-based marginalisation, economic vulnerability, limited education, and weaker access to enabling resources such as smartphones and collective platforms. At the same time, the absence of a significant relationship for house ownership and internet use suggests that nominal household assets do not automatically translate into women's reproductive authority.

## 4. Discussion

This study examined reproductive decision-making autonomy among married rural women across 11 villages in India and found that independent authority over childbearing remains limited. Only a minority of women reported sole decision-making power over childbearing, while a substantial proportion reported that husbands were the primary decision-makers or that decisions were made jointly. Although sole authority over healthcare was somewhat higher, the overall pattern still suggests that women's reproductive agency remains constrained within household and relational power structures. These findings are consistent with earlier research showing that reproductive autonomy in South Asia is often negotiated within marriage and family rather than exercised as an individual right (Blanc 2001; Jejeebhoy and Sathar 2001).

The results also show that reproductive autonomy is shaped by inequality rather than by resource presence alone. Women from Scheduled Caste and Scheduled Tribe households and women from economically vulnerable households reported lower autonomy than more socially and economically advantaged groups. This supports existing evidence that caste and poverty continue to structure women's ability to make decisions regarding their own bodies and health (Agarwala and Lynch 2006; Shroff et al. 2009; Tayal et al. 2024). The findings therefore reinforce an intersectional understanding of autonomy, in which gender disadvantage is compounded by social and material inequalities rather than experienced in isolation.

A key contribution of the study is its distinction between access and control. While household ownership of phones and other assets was not uncommon, these did not automatically translate into greater reproductive decision-making power. Smartphone ownership was associated with higher autonomy, but simple internet access was not. This suggests that the empowerment potential of digital resources depends less on nominal connectivity and more on the nature of women's personal access and control. This aligns with earlier work showing that women often experience only "secondary access" to digital and financial resources, where devices or accounts formally exist but remain controlled by male family members (Barboni et al. 2018; Gurumurthy and Chami 2014).

Collective participation also emerged as important. Women who were members of self-help groups were more likely to report involvement in childbearing decisions than those who were not members. Although the cross-sectional design does not permit causal claims, this pattern suggests that SHGs may widen women's decision space by providing peer support, information, confidence, and opportunities for collective negotiation (Gupta

and Prennushi 2014; Sanyal 2009). At the same time, participation itself remained uneven, indicating that collective empowerment opportunities are also shaped by broader structural constraints.

The strong variation across villages is another important finding. Differences in women's reported autonomy across the 11 sites suggest that local gender norms, social environments, and community-level opportunities matter alongside individual and household characteristics. This is significant because national and state-level analyses often flatten such variation, masking how local "empowerment regimes" shape women's reproductive agency. The present study therefore adds value by showing that reproductive autonomy is not only an individual or household issue, but also a context-dependent outcome shaped by village-level conditions.

These findings should be interpreted in light of the study's limitations. The cross-sectional design identifies associations rather than causality, and self-reported responses may be influenced by social desirability or differing interpretations of what counts as "joint" decision-making. In addition, the purposive selection of villages limits generalisability beyond similar rural contexts. However, the study's multi-site design, relatively large sample, and use of a multidimensional empowerment framework offer an important contribution to gender research by showing how reproductive autonomy is structured across intersecting domains of disadvantage, access, and collective opportunity.

Overall, the study shows that reproductive autonomy in rural India cannot be understood solely through household asset ownership or formal inclusion. What matters is whether women have meaningful control over resources, supportive collective spaces, and room to act within unequal social settings. Gender-transformative interventions must therefore move beyond provision alone and focus on strengthening women's independent digital and financial control, expanding collective platforms such as SHGs, and addressing the caste- and poverty-based inequalities that continue to constrain reproductive agency.

## 5. Contribution, Policy and Practice Implications, and Conclusion

This study contributes to gender research by showing that reproductive autonomy in rural India is shaped not only by household resources, but by the interaction of structural disadvantage, effective control, and collective support. By examining education, caste, economic vulnerability, digital access, financial control, and self-help group participation together, the study demonstrates that women's access to assets does not automatically translate into agency. In particular, the findings highlight the importance of distinguishing between the presence of resources within households and women's independent ability to use them meaningfully.

The findings also have clear implications for policy and practice. Interventions aimed at improving women's sexual and reproductive health and rights should move beyond asset provision alone and focus on strengthening women's control over digital and financial resources. Policies that promote private phone access, personal SIM ownership, PIN literacy, and independent bank account use may be more meaningful than simple inclusion in household-level infrastructure. At the same time, programmes should prioritise women facing compounded disadvantage, particularly those from SC/ST and economically vulnerable households, through targeted outreach, mobility support, and context-specific behaviour change strategies.

The association between self-help group participation and reproductive decision-making further suggests that collective platforms can play an important enabling role. SHGs may serve not only as financial or livelihood spaces, but also as platforms for rights awareness, peer support, and negotiation skill-building. Integrating SRHR information and gender dialogue into such community-based platforms may therefore help widen women's decision space. Since reproductive decisions are also shaped by family and community gatekeepers, interventions should engage husbands, elders, and community leaders in norm-shifting dialogue rather than focusing on women alone.

In conclusion, reproductive autonomy among rural women in this study remained constrained, particularly among those facing caste- and poverty-based disadvantage. The results show that access without control is a weak pathway to empowerment, and that collective participation may help women convert access into agency. Strengthening women's reproductive autonomy therefore requires approaches that combine resource access with independent control, collective support, and attention to the local social contexts in which decisions are made.

**Ethics Declaration:** Ethical approval was obtained from the Institutional Human Ethics Committee (Approval #028 - IEC_SSBS_AL_CWEGE-AVV_028) of Amrita Vishwa Vidyapeetham, Amritapuri Campus. Written and verbal informed consent was obtained from all participants. Interviews were conducted in private settings to ensure confidentiality. No personally identifying data were collected.

**AI Declaration:** During the preparation of this work the author(s) used ChatGPT 4 in order to edit and orient the article. After using this tool/service, the author(s) reviewed and edited the content as needed and take(s) full responsibility for the content of the published article

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