# Women's Autonomy in Household Decision-Making: An Empirical Study within the Framework of the Capability Approach

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**DOI: https://doi.org/10.51584/IJRIAS.2026.11110004**

**Received: 31 October 2026; Accepted: 05 November 2026; Published: 20 November 2026**

## ABSTRACT

This paper presents a micro-level study to examine women's autonomy in household decision-making within the framework of Amartya Sen's capability approach. A fuzzy set was employed to evaluate the membership degree of autonomy in healthcare, cooking, household purchases, and visits to relatives to measure the degree of well-being. Data were collected from a primary survey in the South Salmara Mankachar district of Assam, India. Using a multistage random sampling procedure,400 households were selected, covering a sample of 506 married women in the 15–60 age group. The study employed binary multivariate logistic regression to identify variations in women's autonomy across individual, household, and social-level factors. The study's findings show that factors such as age, education, employment, and wealth significantly influenced women's autonomy, whereas family size, religion, and caste did not. Interestingly, younger women (15-24 years old) are less likely to have decision-making autonomy than middle-aged women (25-44 years old). Moreover, women belonging to the scheduled castes and the scheduled tribes experience lower autonomy. The study concludes that women from economically and socially disadvantaged backgrounds require a targeted empowerment program to achieve autonomy in their household decision-making. Proper education, employment opportunities, and legal awareness are essential requirements for enhancing women's households' decision-making autonomy and well-being.

**Key words**: Autonomy; Capability approach; Decision-making; Women; Well-being

## INTRODUCTION

Autonomy is defined as an individual's ability to obtain information and make decisions about one's concerns independently (Dyson, T., & Moore, M., 1983). Therefore, women's autonomy in household decision-making is significant for their own well-being, their children and the entire family (Asabu et al., 2021). Women's decision-making autonomy enhances the well-being of societies and countries (Asabu, M. D., & Altaseb, D. K., 2021). It means autonomy, as an indicator of women's empowerment, which enables them to acquire the ability and opportunity to change their lives (Moser, 1989). Hence, Gender equality is an important aspect for empowering women, which primarily focuses on 17 specified "Sustainable Development Goals" that aim to transform the world by improving women's quality of life and decision-making ability (Assembly, U.G., 2015, October). Similarly, previous research by Narayan (2002) and Narayan & Petesch (2005) focused on gender equality for women's freedom of choice and action through autonomy, self-confidence, and equal rights. Moreover, the World Development Report (WDR) in 2012, which emphasised 'Gender Equality and Development', led to significant progress in women's agency, including increased control over resources, greater mobility, and freedom from violence. However, previous studies have found gender disparities, particularly in economic opportunities and the reproduction of inequality across generations (Kazi, M. R., 2015).

Amartya Sen, in his articulation of "Development as Freedom" (1999), emphasised that development means expanding people's freedom and capabilities for personal concerns regarding health care, household decision making, and political participation that create the ability to do something. Therefore, women's household

decision-making autonomy becomes an important topic for understanding the present situation, especially in remote areas (Duah, H. O., & Adisah-Atta, I., 2017). Because women's decision-making autonomy is connected to the well-being of their families as well as the welfare of society (Angel-Urdinola & Wodon, 2010; Sharma et al., 2013). Empowered women contribute significantly to improved family welfare, economic productivity, community development, and social well-being (Malhotra & Schuler, 2005). They also play a crucial role in developing gender-sensitive policies that align with Sustainable Development Goal 5 on gender equality (United Nations, 2015). Women's decision-making power was significantly affected by the respondents' age (Osamor, P. E., & Grady, C., 2016), educational attainment (Osamor, P. E., & Grady, C., 2016; Thankian, K., 2020), occupation (Sultana, A. M., 2011; Thankian, K., 2020), income (Osamor, P. E., & Grady, C., 2016), and gender-based awareness (Sultana, A. M., 2011; Thankian, K., 2020).

However, in many societies, especially in rural areas, it is assumed that women with husbands or other marital partners are deprived of their right to participate in decision-making that shapes their futures (Ilesanmi, O. O., 2018), thereby experiencing a low level of autonomy in decision-making. Furthermore, traditional and patriarchal norms in rural areas frequently limit women's participation in key household matters, such as financial management, child education, healthcare, and agricultural activities (Kabeer, 1999; Agarwal, 1997), which can cause problems for their families, communities, and nations (Acharya et al.,2010).

With these fundamental ideas about women's autonomy in household decision-making, the study focuses on a district in Assam. It is evident that women's background in North East India, specifically in Assam, is a key consideration. It is assumed that women are independent in many states in the Northeast. However, in Assam, women's position is found to have a significant level of vulnerability and violence as compared to other states in the North East of India. Women's vulnerability in Assam is largely due to socioeconomic disadvantages, gender norms, and gender imbalances (Nayak, P., & Mahanta, B., 2015). Similarly, these types of vulnerabilities that women face in the South Salmara Mankachar district of Assam. These are the ones that the researchers intend to study in this district.

As far as we know, previous research on the three main areas of decision-making autonomy in the household (decisions on the woman's own health care, household purchases, and visits to family or relatives) among rural women in the district of South Salmara Mankachar, Assam, is limited. It is important to identify the determinants of decision-making autonomy. As directed by the UN, developing and implementing gender-responsive laws, policies, and strategies that account for women's lived realities is a priority (United Nations, 2022-2025).

Therefore, we conduct a micro-level study using a sample and evidence-based information to specify the decision-making autonomy of women in the South Salmara-Mankachar district, Assam, India, drawing on the academic literature. Therefore, the present study seeks to address this gap by conducting an empirical study on women's autonomy in household decision-making (women's own health care, household purchases, and visits to family or relatives) in the district of South Salmara-Mankachar and also to identify variations in women's autonomy across individual, household, and social-level factors to determine their autonomy and well-being.

## CONCEPTUAL FRAMEWORK

This research paper presents an empirical study of women's autonomy in household decision-making using the capability approach framework. The Capability Approach is a normative framework for evaluating individual well-being and social arrangements, advanced by Amartya Sen in the early 1980s as an alternative to standard welfare economics (Sen, 1985). Sen's capability approach emphasises human beings at the centre of development. In this approach, underdevelopment is not a deprivation of basic needs. However, it is a deprivation of basic capabilities or freedoms that would allow an individual to have the kind of life he or she desires. This approach primarily considers personal well-being as a set of functionings, which are the actual achievements of a person in terms of health, nutrition, education, and empowerment, etc. Since 1990, the United Nations Development Programme (UNDP) has empirically applied the fundamental ideas of the capability approach in development studies regarding individual well-being in society. In this way, the

capability approach (CA) has been developed by scholars from different disciplines, e.g., gender justice (Nussbaum, 2000; Robeyns, 2003a), education (Hart, 2019), health (Till et al., 2021), and poverty alleviation (Alkire, 2005; Mitlin, 2013).

In contrast to the utilitarian approach, the CA emphasises the substantive and real freedoms that an individual can choose and achieve, namely, what an individual is effectively able to do and be (Nussbaum, 2000; Sen, 1985; 1999). Researchers from a variety of fields have given the CA significant attention since it shifts the focus of development discourse from economic development to personal well-being (Naz & Bogenhold, 2018; Robeyns, 2017).

Agency and well-being intersect and constitute equally important aspects of human life (Sen,1999). These two concepts are crucial to understanding how well an individual's life is under certain control. Freedom, as both the end and means of the CA, is a key term in understanding these two concepts. Freedom means the process of acting and making decisions freely, as well as opportunity aspects, which are an individual's personal and social circumstances that contribute to people's capabilities (Sen,1999). Well-being is the actual, substantive freedoms that individuals are able to choose and achieve (Sen, 1985). Namely, well-being consists of two components: one is a person's achieved functions, and the other is the freedom or opportunity to choose what to do and who to be. In sum, the CA emphasises the functional capabilities that measure a human's well-being and level of agency under specific social circumstances. Sen's CA has been used widely in academia for its innovative assessments and conceptualisations of individual well-being (Robeyns, 2006). Sen's original ideas have been explored by capabilitarian theorists from other disciplines, including Sen himself, consistently or thoroughly, and the initial CA has been extended to a theoretical framework constituted by different capability theories (Alkire, 2005; 2008; Nussbaum, 2000; Nussbaum & Sen, 1993; Robeyns, 200, 2006; Sen, 1999; 2005). This aligns with Sen's (2005) suggested normative and open-ended characteristics of the original CA. Notwithstanding debates among theorists, capabilities and functions are core concepts adopted in analysis, further demonstrating the theoretical vitality of the CA (Kjellberg & Jansson, 2020; Robeyns, 2005). Meanwhile, the original CA proposed by Sen is general and open-ended, and other theorists develop it in different directions, each according to their purposes (Robeyns, 2017).

The capability approach (CA) is seen as useful for addressing feminist issues and concerns (Robeyns, 2003). Amartya Sen (1999), who first developed the approach, explained development not just as economic progress but as the expansion of people's real freedoms. Amartya Sen has extensively focused on women's well-being within the broader framework of development and freedom. According to Sen (1999), improving women's well-being requires special attention to factors that significantly influence their freedom, such as the ability to earn an independent income, employment opportunities, education facilities, and decision-making autonomy. A woman's capability is defined by her physical strength, economic stability, social connections, and inner well-being. With this goal, the capability approach (CA) focuses not only on what people try to achieve but also on what they are actually able to achieve, emphasising the aspects that make life meaningful. In this way, several scholars, like Martinetti (2000), Qizilbash (2002), Addabbo et al. (2004), Kukly (2005), Robyne's (2005), Alkire (2005), Qizilbash & Clark (2005), and Majumder (2009), have conducted their research by using the framework of the capability approach and applied it in empirical studies. However, it assumes that they have not only adopted Amartya Sen's concepts of well-being but also included other dimensions (an approach known as multidimensional), which are appropriate for assessing an individual's well-being. While Sen's capability approach was strongly influenced by the experiences of India and other developing countries, empirical research on women's well-being regarding household decision-making autonomy at the individual level in the Indian context is still comparatively limited, particularly in remote and marginalised regions (Drèze & Sen, 2002; Nussbaum, 2000; Majumder,2009).

Based on the concepts of women's freedom, agency, and autonomy outlined by Amartya Sen, Sabina Alkire, Nussbaum, and Robeyns, this paper develops a framework for measuring women's autonomy in household decision-making. This paper notes that it does not include all indicators due to limited data availability. In line with our research objectives, we selected four dimensions to measure women's autonomy in household decision-making: healthcare, cooking, household purchases, and visits to their own relatives or friends, as illustrated in Figure 1.

ISSN No. 2454-6194 | DOI: 10.51584/IJRIAS |Volume XI Issue XI November 2026

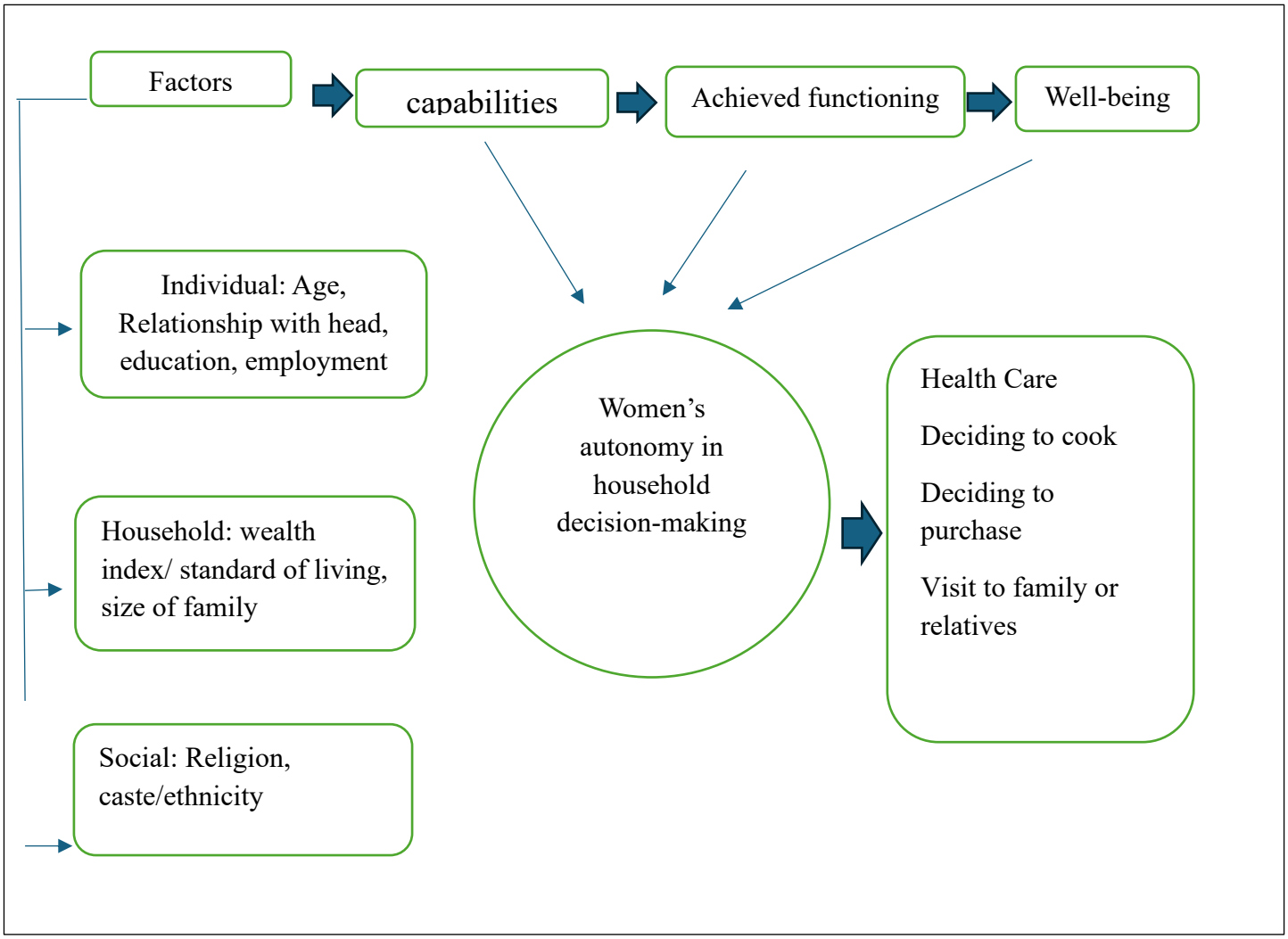


**Fig. 1:** Conceptual Framework linking conversion factors, functioning of women's household decision-making autonomy and well-being based on Sen's capability approach.

## METHOD

### Data Sources

The study was conducted in the South Salmara Mankachar district. Based on a primary survey, data were collected from married women in working-age groups (15-60 years) through semi-structured individual interviews conducted from June to August 2025.

### Sample Design

The study employed a multistage random sampling procedure to select the households from the entire district of South Salmara Mankachar. This district contains three development blocks: South Salmar, Mankachar, and Fekamari. A total of 400 households were selected, and the final sample included 506 married women of working age (15-60 years).

Data were collected on the women's socio-demographic characteristics at the individual level, as well as on aspects of their autonomy in household decision-making, including healthcare, household purchases, cooking, and visits to their own family or relatives.

ISSN No. 2454-6194 | DOI: 10.51584/IJRIAS |Volume XI Issue XI November 2026

**A short description of the study area**

The research is conducted in the South Salmara-Mankachar district of Assam. The state of Assam is divided into 34 districts, one of which is South Salmara Mankachar. This district is situated in the southern part of Lower Assam and is bordered by Bangladesh to the west and Meghalaya to the southeast. The total area of this district is 684.2 square kilometres, and the population density is 811.3 people per square kilometre. There is one subdivision in this district that encompasses three development blocks (Mankachar, Fekamari, and South Salmara). According to the 2011 census, the district's total population is 5,551,140, with 2,730,870 females and 2,820,270 males.

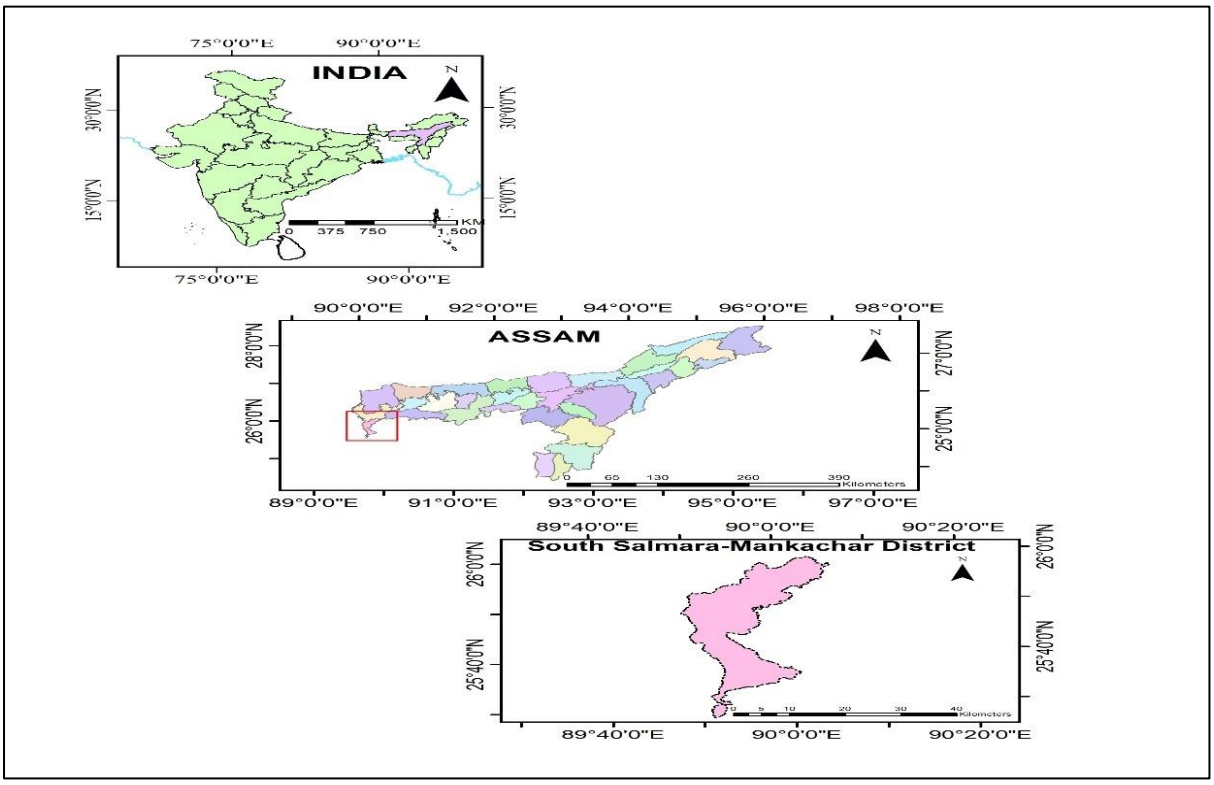


**Fig. 2:** Map of South Salmara Mankachar District

Source: Survey of India (not to scale)

**Variables and measurement**

**Dependent variables**

In this study, women's autonomy in household decision-making is assessed using four outcome variables derived from responses to the following questions:

- Who decided on women's health care?
- Who decided to cook?
- Who decided to purchase for the household? And
- Who decided to visit the women's family or relatives?

Each question offered four response options: (1) respondents alone; (2) both respondents and husband; (3) only husband alone; and (4) others, respectively. For descriptive analysis, we can assume that women were considered autonomous if they made decisions alone or jointly with their husbands, as indicated in the four responses. Otherwise, they were considered to have no degree of autonomy (Bitew et al., 2024). It was dichotomised as follows: yes (1) and no (0). Four domains of women's household decision-making were

categorised dichotomously, with "Yes" indicating that a woman makes decisions jointly or alone, and "No" indicating that she does not.

First, we determine the mean membership degrees (in Table 2) for each response to the four important questions describing the background characteristics, along with the membership degrees presented in Table 3. Furthermore, to examine variations in women's autonomy with respect to the background characteristics, we will use binary logistic regression. For all domains of women's autonomy, we have created a binary form that serves as the dependent variable after normalising the four responses for each domain to an ordinal scale. Therefore, four domains of women's autonomy were categorised as binary, with 0 indicating a lack of autonomy and 1 indicating autonomy.

**Predictable variables**

The predictable variables were the women's socio-demographic characteristics, which were described below

**Individual-level Factors**

Age of respondents: We have taken the working age group of women as (15-60 years) and categorised them into four groups: 15-24, 25-34, 35-44, and 45& above.

Level of Education: women's educational level is divided into six categories, like illiterate (0 schooling), primary (1-5 schooling), middle (6-8 schooling), secondary (9-10 schooling), higher secondary, and above higher secondary (≤ 12 schooling).

Working Status: It has been categorised as "Yes" or "No" to indicate whether women participate in economic activities.

**Household-level factors**

Size of Family: We have made two categories of size of family, i.e., less than or equal to five (≥5) and more than five (<5).

Index of Wealth: We constructed a wealth index using principal component analysis (PCA) to assess the standard of living of households in the study area. It is classified into three groups: Poor, Middle, and Rich, by merging the poorest with the poorer and the richest with the richer (Bitew et al., 2024).

**Social Level Factors**

Religion: In the study area, there are two communities: Hindu and Muslim. We have categorised religions into two main groups.

Caste / Ethnicity: There are four categories of caste found in the study area: Scheduled Castes (SC), Scheduled Tribes (ST), General Category (GC), and Other Backwards Classes (OBC).

**Statistical Analysis**

**Fuzzy Set**

Using primary data, we will apply the fuzzy set technique to evaluate the degree of membership in four dimensions of autonomy, following the work of Enrica Chiappero Martinetti and Majumder (Martinetti, 1994, 2000; Majumder, 2007, 2009)**,** who used this method to study poverty and well-being within the capability approach. The fuzzy set technique generalises the characteristic function of a crisp set, which traditionally assigns a value of 1 or 0 to each element in the universal set. In contrast, a general characteristic function (also known as a membership function) ranges from 0 to 1. If X represents the universal set, the membership

function μA, typically used to create a fuzzy set A, is of the type μAX→ [0, 1]. When μA(x) = 0 if the element x ϵ X does not belong to A, it means no membership; μA (x) = 1 means full membership, and 0 < μA(x) < 1 indicates partial membership. The subset A determines each individual's position based on the degree of achievement, which is considered a functional assessment. When we study to measure quantitative variables or qualitative variables in an ordinal scale with linguistic attributes (as in the case of health or self-perception, own decision-making), intermediate values are especially useful as they express between success (if $\mu_a$=1) and failure ($\mu_a$=0) (Martinetti, 2000; Majumder, 2007, 2009). Following these procedures, we can rearrange the answers/modalities/values of the question mentioned in Table 1 and obtain the membership degrees (for all intermediate positions) by assuming a linear membership function, as shown in Table 1. For that, we calculate the value of all indicators of each dimension by converting them into an ordinal normalised [0,1] scale:

$$\mu(x) = \frac{x - x_{min}}{x_{max} - x_{min}} \qquad (1)$$

It is noted that, due to the limited application of fuzzy set theory in this study, our method may appear relatively similar to standard approaches that utilise qualitative data on an ordinal scale. However, applying this specific technique alongside primary data can improve our results. It also facilitates comparisons with other studies in the field of women's autonomy and well-being at both the regional and international levels.

**Table 1:** Characteristic functions and degrees of women's autonomy

| Characteristics Function | Modalities/ values | Degree of well-being | Membership degree | Frequency | Per cent (%) |
|---|---|---|---|---|---|
| Who decides about their own health care ($\mu_1$) | 1. other | 0 | 0.00 | 10 | 2.0 |
| | 2. Only husband | 1 | .33 | 62 | 12.3 |
| | 3. Both husband and respondent | 2 | .67 | 229 | 45.3 |
| | 4. Respondent | 3 | 1.00 | 205 | 40.5 |
| Who decides about household purchases ($\mu_2$) | 1. Other | 0 | .00 | 20 | 4.0 |
| | 2. Only husband | 1 | .33 | 184 | 36.4 |
| | 3. Both husband and respondent | 2 | .67 | 111 | 21.9 |
| | 4. Respondent | 3 | 1.00 | 191 | 37.7 |
| Who decides about what to cook ($\mu_3$) | 1. Other | 0 | .00 | 34 | 6.7 |
| | 2. Only husband | 1 | .33 | 8 | 1.6 |
| | 3. Both husband and respondent | 2 | .67 | 14 | 2.8 |
| | 4. Respondent | 3 | 1.00 | 450 | 88.9 |
| | 1. No | 0 | .00 | 194 | 38.3 |

| | | | | | |
|---|---|---|---|---|---|
| Permission needed to visit friends or relatives ($\mu_4$) | 2. Yes | 1 | 1.00 | 312 | 61.7 |
| | Total | | | 506 | 100.0 |

Source: Primary Survey

Binary Multivariate Logistic Regression Analysis

To examine the variation in women's household decision-making autonomy with respect to explicative factors, which include individual, household, and social level factors, we used binary multivariate logistic regression analysis (Retherford & Choe, 1993), which is expressed as

$$\Omega = \exp(\beta_0 + \sum\beta_{1i}X_{1i} + \sum\beta_2X_{2i} + \sum\beta_{3i}X_{3i} + e_n) \quad (2)$$

Where $\Omega$ (uppercase omega) $\equiv \frac{p}{1-p}$ (is called the odds); $\beta_0$ is intercept; $\beta_1$, $\beta_2$, $\beta_3$ represents the coefficient of each independent variables; $X_{1i}$, $X_{2i}$, $X_{3i}$ are conversion factors; $e_n$ is error term.

$X_{1i}$= individual (age, education, employment)

$X_{2i}$= household level (Family size, relation with the head of household, wealth index)

$X_{3i}$ = Social level (Religion- Hindu/Muslim/Jain and Caste/Ethnicity – SC/OBC/GEN)

Four dimensions are treated as observed or dependent variables: own health, care, deciding to cook, deciding to purchase, and deciding to visit family or relatives. Therefore, four models will be estimated for each of the four evaluative dimensions/spaces (after aggregating all indicators for each dimension). Binary-multivariable logistic regression was employed to construct odds ratios (ORs) and confidence intervals (95% CIs), which were significantly associated with the four outcome measures (at a 5% level; $p < 0.05$) and further to assess goodness of fit, we have displayed Nagelkerke R Square (Nagelkerke,1992), which presents a logistic equivalent to R Square in OLS Regression. Nagelkerke's R-squared ranges from 0 to 1. Four models will be estimated for each survey round, covering each domain of women's autonomy (aggregated values of the specific questions within each domain) to analyse their achievement levels in household decision-making. We used SPSS software version 27.0 for statistical analysis of the data.

## RESULTS AND DISCUSSION

We have computed four indices of women's autonomy, intended to reflect the degree of freedom women enjoy when making decisions with their husbands compared to other household members. We are also concerned with examining variations in the degree of autonomy across respondents' background characteristics. If the indicator value is 1.00 for a particular question on a specific dimension, we may assume that the highest level of women's autonomy is achieved (with respect to that issue) and that women are capable of engaging in discussions on that issue with those around them. On the contrary, an index value of 0 indicates an opposite situation or an extreme case of women's oppression. Table 2 presents the mean membership degrees for four key questions. We can compare these values with the membership degrees shown in Table 1 and reach meaningful conclusions. It is noted that higher values are associated with greater autonomy. From Table 2, we see that women enjoy the highest level of autonomy in deciding what to cook (.9132). Regarding the decision to obtain healthcare ($\mu$1), women exhibit a higher level of autonomy (.6752) than in household purchases ($\mu$2) (.6449) and visits to their own relatives ($\mu$3). It assumes that women enjoy a low degree of autonomy in

ISSN No. 2454-6194 | DOI: 10.51584/IJRIAS |Volume XI Issue XI November 2026

deciding to visit their own relatives (.6166); on the other hand, they enjoy a higher degree of autonomy in deciding to cook.

**Table 2: Mean value of the indicators of autonomy**

| | Women's autonomy in household decision-making | | | |
|---|---|---|---|---|
| Membership degree | Health care ($\mu_1$) | Purchasing ($\mu_2$) | Cooking ($\mu_3$) | Visit to friends or relatives ($\mu_4$) |
| Mean value | 0.6752 | 0.6449 | 0.9132 | 0.6166 |

**Source:** Author's estimation based on field survey

Table 3 displays the mean membership degree of women's background characteristics. Women's decision-making autonomy increases gradually with age across all four domains. suggesting that the 35-44 age group of women may have more autonomy or influence in household decisions, particularly in cooking and healthcare**.** Younger women (15–24) appear to have the least autonomy, particularly when it comes to visiting relatives. This pattern may reflect sociocultural norms in which decision-making power increases with age and the assumption of family roles (e.g., becoming a mother-in-law or head of the household). The largest group was women aged 25–34 (42%), followed by those aged 35–44 (29.6%), indicating that the majority of women were younger**.** Interestingly, as education increases, women's decision-making autonomy decreases, especially in healthcare, except during visits to relatives. In general, as educational attainment rises, women's autonomy tends to increase. However, this descriptive analysis reveals a decline in women's autonomy in healthcare, particularly among those with higher levels of education. Therefore, we will analyse this education level using regression, controlling for other variables, to assess the degree of autonomy in the respondent's relationship with the household head. Women enjoy the highest level of autonomy in household decision-making across all domains when they head their own households. Family size does not make a big difference; women show strong decision-making power, especially in cooking, in both small and large families. Women in both small and large families have similar decision-making power. Slightly more autonomy is observed in large families, particularly in healthcare settings. In cooking**,** women have the highest control regardless of family size. When visiting relatives, it has the lowest autonomy overall. Similarly, non-working women exhibit greater decision-making power across all areas. The biggest gap is in health care decisions. Both groups have high control over cooking**,** and are low in visiting relatives. Surprisingly, non-working women have slightly more say in household decisions, possibly because they are more involved in household activities.

The findings indicate that women's decision-making autonomy varies across different socio-demographic backgrounds. Women from low-wealth households exhibit greater autonomy in health care decisions**.** In contrast, those from high-wealth households have more freedom in household purchases, visits to friends, and cooking decisions, which consistently indicate high autonomy. Similarly, the data reveal variations in women's decision-making autonomy across religions. While Muslim women demonstrate slightly higher autonomy in health care decisions**,** Hindu women consistently report greater autonomy in household purchases, cooking, and, particularly, social decisions related to visiting relatives. However, the degree of autonomy does not vary significantly across castes/ethnicities. These differences reflect cultural, familial, or structural factors associated with religious identity that shape women's roles and agency within the household.

**Table 3:** Average membership degree by background characteristics of the women

| Explicative Factors | N (506) | Health Care | Household purchase ($\mu_2$) | Cooking ($\mu_3$) | Visit to relatives ($\mu_4$) |
|---|---|---|---|---|---|

| | | ($\mu_1$) | | | |
|---|---|---|---|---|---|
| **Age** | | | | | |
| 15-24 | 82 (16.20%) | 0.589 | 0.585 | 0.776 | 0.512 |
| 25-34 | 213 (42.09%) | 0 .755 | 0.632 | 0.909 | 0.601 |
| 35-44 | 150 (29.64%) | 0 .815 | 0.682 | 0.987 | 0.627 |
| 45 and above | 61 (12%) | 0.765 | 0.677 | 0.929 | 0.786 |
| **Education** | | | | | |
| Illiterate | 100 (19.76%) | 0.840 | 0.606 | 0.944 | 0.610 |
| Primary | 78 (15.41%) | 0.777 | 0.606 | 0.927 | 0.513 |
| Middle | 98 (19.37%) | 0.740 | 0.585 | 0.906 | 0.535 |
| Secondary | 159 (31.42%) | 0.700 | 0.687 | 0.926 | 0.667 |
| Higher Secondary | 37 (7.31%) | 0.684 | 0.765 | 0.900 | 0.703 |
| Post Higher Secondary | 33 (6.52%) | 0.717 | 0.686 | 0.768 | 0.788 |
| **Relationship with the head** | | | | | |
| Head (self) | 29 (5.73%) | 0.724 | 0.621 | 0.793 | 0.621 |
| Wife | 477 (94.22%) | 0.749 | 0.647 | 0.920 | 0.646 |
| **Family Size** | | | | | |
| Small (≤ 5) | 317 (62.64%) | 0.735 | 0.644 | 0.912 | 0.615 |
| Large (>5) | 189 (37.35%) | 0.769 | 0.645 | 0.915 | 0.619 |
| **Employment** | | | | | |
| Working | 242 (47.82%) | 0.697 | 0.616 | 0.893 | 0.612 |
| Not working | 264 (52.17%) | 0.794 | 0.672 | 0.931 | 0.621 |
| **Wealth Index** | | | | | |
| Low | 174 (34.39%) | 0.803 | 0.578 | 0.927 | 0.529 |
| Medium | 183 (36.2%) | 0.707 | 0.658 | 0.931 | 0.585 |
| High | 149 (29.43%) | 0.734 | 0.706 | 0.875 | 0.758 |
| **Religion** | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Hindu | 294 (58.10%) | 0.742 | 0.670 | 0.924 | 0.674 |
| Muslim | 212 (41.9%) | 0.756 | 0.610 | 0.898 | 0.538 |
| **Caste / Ethnicity** | | | | | |
| General | 224 (44.27%) | 0.759 | 0.615 | 0.899 | 0.615 |
| OBC | 79 (15.61%) | 0.717 | 0.705 | 0.898 | 0.705 |
| Scheduled Caste | 188 (37.15%) | 0.745 | 0.645 | 0.929 | 0.645 |
| Scheduled Tribe | 15 (2.96%) | 0.778 | 0.778 | 1.000 | 0.778 |

**Source:** Author's estimation based on field survey

**Results of Binary-Multivariate Analysis**

Table 4 shows the results of logistic regression analyses. Factors such as age, education, and wealth index are significant to women's decision-making autonomy. Other predictor variables, such as family size, religion, and caste, are insignificant. The model includes six independent variables (age of the respondent, education, wealth index, religion, and caste) and four dependent variables (i.e., healthcare, household purchases, cooks, and visits to a relative). The first predictor variable is the respondent's age. In Table 4, we observe that age shows a positive relationship with decision-making autonomy in four outcomes (own healthcare, purchases, cooking, and relatives); younger women (15-24 years old) are less likely to participate in decision-making than the middle-aged group of women (25-34 and 35-44 years old). It revealed that when the age group changes from 15-24 to 34-44, well-being conditions tend to increase women's autonomy. Similarly, education is also positively associated with women's decision-making autonomy in three outcomes, such as healthcare, household purchases, and visits to relatives or family, but not in the case of cooking decisions. However, women with a higher secondary level of education have more decision-making autonomy than illiterate women, leading to less autonomy. On the other hand, women from middle- and upper-class backgrounds have more decision-making power regarding healthcare, household purchases, and visits to family or relatives than women from lower-class backgrounds. Working status depends on women's autonomy. Women who work for income are more likely to have decision-making autonomy over their health care and household purchases than those who are not economically active. Other predictor variables, such as family size, negatively impact women's autonomy. A large family is a household with more than five members, where women often have less autonomy than in households with fewer than five members. The household purchases variable is statistically significant. On the other hand, if we look at religion, it does not affect all autonomy variables except for relatives. The results show that, as compared to Muslim women, Hindu women are more likely to have autonomy to go to their relatives or family members. Similarly, in the case of caste, the scheduled caste (SC) household purchases and the Scheduled Tribe (ST), in the case of their health care, women get less autonomy than the General Category (GEN). Therefore, the women belonging to these caste categories tend to have less autonomy and well-being.

**Table 4:** Results of binary-multivariate logistic regression analyses: odds ratios [exp (β)] of attaining four variables of women's decision-making autonomy

| Predictor Variables | Health Care<br><br>Odds ratio (95% C.I) | Household Purchase<br><br>Odds ratio (95% C.I) | Cooking<br><br>Odds ratio (95% C.I) | Visit to Relatives<br><br>Odds ratio (95% C.I) |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| **Age of the respondent (rc: 15-24)** | | | | |
| 25-34 | 5.713*** (2.826, 11.550) | 1.213 (.693, 2.120) | 3.170*** (1.405, 7.151) | 1.224 (.668, 2.243) |
| 35-44 | 12.000***(4.679, 30.777) | 1.949**(1.043, 3.642) | 23.950*** (4.943,116.042) | 1.479 (.756, 2.896) |
| 45 & above | 3.065**(1.183, 7.941) | 1.771(.834, 3.762) | 5.869* (1.629, 21.144) | 3.572*** (1.466, 8.705) |
| **Education (rc: Illiterate)** | | | | |
| Primary | .777 (.269, 2.250) | 1.123 (.596, 2.115) | 1.860 (.522, 6.632) | .676 (.357, 1.282 |
| Middle | .880 (.31, 2.490) | .922 (494,1.722) | 1.636 (.522,5.133) | .722 (.386, 1.349) |
| Secondary | .543 (.203, 1.450) | 1.404 (.776, 2.540) | 2.9169* (.901, 9.445) | 2.004** (1.059, 3.793) |
| Higher secondary | 1.009** (.251, 4.052) | 1.040* (.429, 2.523) | 3.520 (.695,17.823) | 4.678** (1.431, 15.293) |
| HS & above | .463 (.103, 2.090) | 1.570 (.620, 3.975) | .790 (.196, 3.184) | 5.040** (1.302, 19.509) |
| **Wealth index (rc: low)** | | | | |
| Medium | .629 (.316, 1.251) | 1.018* (.646, 1.606) | 1.102(.451, 2.692) | 1.280 (.802, 2.044) |
| High | 1.556** (.621, 3.898) | .895 (.498,1.608) | .460(.172,1.231) | 3.047*** (1.472, 6.308) |
| **Family Size (rc: Small ≤5)** | | | | |
| Large (>5) | .765 (.413, 1.416) | .673* (.447, 1.013) | .239 (.306, 1.343) | .840 (.537, 1.312) |
| **Employment** (rc: not working | | | | |
| Working | 2.883***(1.568, 5.302) | 1.511** (1.029, 2.218) | 1.435 (.703, 2.931) | .859 (.563, 1.311) |
| **Religion (rc: Muslim)** | | | | |

| | | | | |
|---|---|---|---|---|
| Hindu | 1.034 (.570, 1.877) | 1.951 (.642, 5.927) | .758 (.105, 5.469) | 3.530* (.922, 13.519) |
| **Caste (rc: GEN)** | | | | |
| SC (Scheduled Caste) | .725(.121, 4.336) | .247** (.079, .779) | .704 (.092, 5.376). | .452 (.108, 1.895) |
| OBC | .492(.086, 2.807) | .420 (.139, 1.271) | 1.347 (.183, 9.942) | .558 (.136, 2.279) |
| ST (Scheduled Tribe) | .841*(.056, 12.604) | 1.009 (.222, 4.579) | 87454342.618 (.000) | .884 (.132, 5.912) |
| Constant | 1.730 | .511* | 5.543 | .377 |
| -2 log likelihood | 336.767 | 647.974 | 245.432 | 554.499 |
| Pseudo (Nagelkerke) R Square | .242 | .069 | .190 | .208 |

**Note: rc:** reference category; ***p<0.01, **p<0.05, * p<0.10, 95% C. I for the odds ratio**(β)**

**Source:** Author's estimation based on field survey

## CONCLUSION

The main focus of this paper is to examine women's autonomy in decision-making regarding their own healthcare, household purchases, cooking, and visits to relatives. In this study, the results revealed that predictable factors, such as age, education, employment, and wealth index, have a positive impact on women's decision-making autonomy as compared with other factors such as family size, religion, and caste. There is a variation in predictable factors affecting women's household decision-making autonomy to achieve well-being across all outcome measures in the region.

The findings indicate that employed women are more likely than non-employed women to make decisions about their own healthcare and purchase daily household necessities. Similarly, women's education plays a crucial part in empowering them by expanding their decision-making capabilities and promoting gender equality within households. The results showed that educated women are more capable of enhancing their autonomy in various aspects of household decision-making than women with education below the HSLC level, and indeed those who are illiterate. This suggests that higher education enhances women's autonomy.

However, in the study areas, the percentage of women in higher education appears to be lower. Moreover, Women belonging to lower and middle-class backgrounds are less likely to have the autonomy to make decisions than women who belong to upper-class families. Similarly, if we see the caste level, SC and ST categories of women are really lagging in decision-making autonomy and well-being, as their autonomy seems poor, especially in health care. Also, they lack the freedom to visit their own relatives. Gender equality and women's empowerment are necessary to achieve the third Millennium Development Goal (MDG). They are the primary financial resources for accelerating progress toward the equal benefit and empowerment of both men and women (United Nations, MDG, 2015). From this perspective, Employment and education are both important factors in enhancing their capability and decision-making autonomy in rural regions (Mumtaz, Z., & Salway, S. M., 2007), which, in turn, reduces inequality. However, women in the district of South Salmara Mankachar experience a poor socio-economic status, belong to low-income families and have the least decision-making power. Therefore, the study suggests that women, particularly those from economically and

socially disadvantaged backgrounds, require a targeted empowerment program to become more independent in their decision-making. Proper education, promoting income-generating activities, strengthening self-help groups (SHGs), and legal awareness programs are essential for enhancing women's autonomy in household decision-making and overall well-being.

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ISSN No. 2454-6194 | DOI: 10.51584/IJRIAS |Volume XI Issue XI November 2026

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