ISSN No:-2456-2165 https://doi.org/10.5281/zenodo.14576675

Women's Autonomy and its Associated Factors in Annapurna Rural Municipality, Kaski District, Nepal

Eknaran Paudel[1]; Bijaya Babu Adhikari[2]
[1]Department of Rural Development Studies, Kalika Multiple Campus, Tribhuvan University (TU), Nepal
[2]Department of Sociology and Rural Development, Prithvi Narayan Campus, Tribhuvan University (TU), Nepal
[2]Department of Rural Development Studies, Kalika Multiple Campus, Tribhuvan University (TU), Nepal

Abstract:- Autonomy is a broad concept that is challenging to measure. It can be defined as a person's capacity to behave autonomously and independently of desires, in conformity with objective morality (Bhandari, Kutty, & Ravindran, 2016). In the context of Nepal, there is a low level of autonomy among the women whose educational level and husband's educational status is low. The main objective of this study was to examine women's autonomy and its associated factors in Annapurna rural municipality. This cross-sectional analytical study was conducted among 360 Married Women aged 15-49 in Annapurna Rural Municipality of Kaski District, Nepal. Multistage Random sampling technique was used to select appropriate samples. Face to face interview with the respondents was done. Women's autonomy was assessed by using standard tools. Tools was adopted in English language and translated into simple and clear Nepali language and was back translated into English. The collected data was entered in EPI-DATA version 3.2 which was exported to Statistical Package for Social Sciences (SPSS version 22) for analysis. Informed consent was taken from the respondents both in verbal and written form. Finally, the result of the study was disseminated in an appropriate setting. Out of total 360 respondents, 53.3% (192) have a high level of autonomy, whereas 46.7% (168) have a low level of autonomy. This study shows that more percentage of women were autonomous. Women's employment was found to be associated with women's autonomy (P value= 0.008, i.e., P<0.05), whereas there was not any significant association with other variables.

Keywords:- *Women's Autonomy, Autonomy, Household Decision Making and Women.*

I. INTRODUCTION

➢ *Background*

Autonomy is a broad concept that is challenging to measure. It can be defined as a person's capacity to behave autonomously and independently of desires, in conformity with objective morality. It is described as the ability to make decisions on one's matters as well as those of one's close friends and family on a technical, social, and psychological level. (Bhandari, Kutty, & Ravindran, 2016)

It is clear from looking at the entire world population that women support half of it. Women therefore occupy a unique place in all communities. Women have a crucial role in every human community. The involvement of women in all spheres of life is vital to the advancement of any country and society. In developing nations, they are typically regarded as dependent. Low literacy rates, underpaid labor, and a constant cycle of childbirth surround women. Women are viewed as economically unproductive individuals in both urban and, for the most part, rural communities, and their roles are not acknowledged in either setting. As a result, women must work harder to have their roles acknowledged and to become autonomous.

The term "women's autonomy" is broad, complicated, and has a variety of definitions. It is influenced by the sociocultural norms and values of society as well as the individual characteristics of women. For measuring women's autonomy, earlier literature focused on factors like education, occupation, and demographics like age at marriage, age difference at marriage, number of children, sex of children, and other factors. (Bhandari et al., 2016)

Women's autonomy regarding healthcare decisions is an essential element for improving child and maternal health outcomes and measures women's empowerment. Due to gender disparities, open communication between couples regarding reproductive health and women's access to reproductive health services is restricted which may introduce negative health effects. (Dev, Bell, Simkhada, Van Teijlingen, & Regmi, 2010)

The main predictors of women's authority in decision-making are women's age and family structure, according to evidence from other emerging nations. Women in nuclear households and older women are more likely than other women to be involved in family decisions.(Dev et al., 2010)

In our society, there is a general practice of male supremacy and patriarchy is still existed. Women must depend on their husband or head of their family for deciding household matters. This means that women are denied possibilities in both the social and economic spheres that are profitable. Rarely do lucky women have the chance to work outside. Most have household boundaries all around them and they even need permission to go outside. They mostly work in agriculture, cooking, tending to animals, gathering firewood, managing grass and fodder, raising children, and other domestic tasks. They also have limited access to healthcare, work opportunities, and education. Despite

ISSN No:-2456-2165 https://doi.org/10.5281/zenodo.14576675

recent improvements, the status of women is still unsatisfactory. It is essential that the gender imbalance that exists in our culture be eradicated. If women are not included in the mainstream of development, neither can the country grow. (D. B. Thapa, 2003)

In Nepal, women's autonomy was positively correlated with their higher levels of education and employment as well as their spouses' support for accessing maternal healthcare. Similarly, freedom of movement, financial decision-making, and spousal communication autonomy all had a favorable impact on the use of maternal health care services.(D. K. Thapa & Niehof, 2013)

➢ *Problem Statement*

When discussing the world's population, we discovered that women support half of it. Therefore, a country cannot advance without simultaneously improving or elevating the status of women in home and society. Therefore, it is not only desirable but also necessary for them to participate equally in all developing activities in order to expedite the development process. Therefore, women are essential to become autonomous and for the prosperity of any nation.

Research has shown that, particularly in poorer nations, women have less autonomy in making decisions. However, increasing the role of women in decision-making results in better access to healthcare, poverty reduction, and household economic growth.(Kebede et al., 2021) Although women in underdeveloped nations contribute much to the welfare of the family, they are primarily viewed as simple housewives.(Kebede et al., 2021)

At the household level as well as in society, women typically had a lower status and had less autonomy than men in Southeast Asian countries. As a result, women are unable to access even their necessities or exercise their rights without the consent of their husbands or other adult family members.(Bhandari et al., 2016; D. K. Thapa & Niehof, 2013)

Health is an important aspect for all and autonomy in health care decisions is a crucial aspect. Mostly, women suffer more than in comparison to men. But many studies have shown that the low level of autonomy in women causes many health-related, and rights-related problems. A study has shown that the infant mortality rate was high among the women who were illiterate (56 per 1000 live births) and who were not involved in decision-making (54 per 1000 live births).(Adhikari & Sawangdee, 2011)

In developing nations, maternal and infant mortality continues to be a serious health issue. The number of maternal deaths was estimated to be 303000 in 2015. Around 99% of maternal deaths worldwide occur in developing nations, with Sub-Saharan Africa alone accounting for roughly 66% of these deaths, followed by South Asia at 22%.(Adhikari, 2016)

In the context of Nepal, there is a low level of autonomy which is directly associated with the utilization of maternal health services.(Adhikari, 2016) Also low level of autonomy among the women whose educational level and husband's educational status is low. Not even the study indicated the low level of autonomy among the women whose economic status is low.(Bhandari et al., 2016)

Although several initiatives were carried out to increase women's autonomy, many women in developing nations face barriers to their access to health care services, freedom of movement, access to financial and physical resources, and decision-making authority over home and societal matters. Many articles also show a similar situation in the context of Nepal.

➢ *Rationale*

One of the eight official Millennium Development Goals established by the United Nations in the year 2000 is the promotion of gender equality and women's empowerment (Carlson, Kordas, & Murray-Kolb, 2015) and one of the goal to be accomplished by 2030 which is officially established by Sustainable Development Goals is to achieve gender equality and empower all women and girls.(Leal Filho et al., 2022) For achieving empowerment and gender equality, women's autonomy plays an important role.

Studies suggested that women's autonomy is greater in urban while compared with rural areas. (Dev et al., 2010)This study focuses on one of the rural municipalities of the Kaski district, which has a rural settings as well as located near the urban city with highways and roads passing through it. Although the study area is rural, but somewhat near urban with good transportation facilities in comparison with the other three rural municipalities of the Kaski district. So, women from this area are more likely to participate in employment or income income-generating sectors. This means the study areas represent the population giving the sense of both urban and rural, which is very helpful for finding the different outcome and eventually in the formulation of policies related to women's autonomy for promoting gender equality and women empowerment.

➢ *Research Question*

- What is the status of Women's autonomy in household decision-making?
- What is the relationship between Women's autonomy and its associated factors?

➢ *Hypothesis:*

- H1: Women's education level is associated with autonomy level.
- H2: Women's employment status is associated with autonomy level.
- H3: Husband's education level is associated with the autonomy level.
- H4: Husband's employment status is associated with autonomy level.
- H5: Economic status of household is associated with autonomy level.

ISSN No:-2456-2165 https://doi.org/10.5281/zenodo.14576675

➢ *Objectives*

- *General Objectives*

✓ To examine women's autonomy and its associated factors in Annapurna rural municipality.

- *Specific Objective*

✓ To determine the status of Women's autonomy in household decisions.
✓ To assess the relationship between Women's autonomy and their educational status.
✓ To assess the relationship between Women's autonomy and husband's educational status.
✓ To assess the relationship between Women's autonomy and economic status.
✓ To assess the relationship between Women's autonomy and their employment status.
✓ To assess the association between Women's autonomy and socio-demographic factors.

➢ *Operational Definition*

- *Women Autonomy*
  Women's involvement in household decision-making.

- *Economic Status*
  Refers to the financial capacity of the family of the participant which is measured by the International Wealth Index score.(Smits & Steendijk, 2015)

- *Ethnicity*
  A social group with a recognizable shared culture, religion, language, and background.

- *Women's Educational Status*
  The educational status of the women was assessed by the following criteria: illiterate – never attended school, primary level – grade 1 to 5, secondary level- grade 6 to 10, high school level grade 11 to 12, and above high school level- above grade 12.

- *Patriarchy*
  Patriarchy refers to a social system in which men hold primary power and predominate in roles of political leadership, moral authority, social privilege, and control of property.

- *Women's Autonomy*
  In this study, we defined autonomy according to the mean value of the sum of all the autonomy domains. Below the mean value is represented as a low level of autonomy whereas above the mean value is considered a high level of autonomy.

II. LITERATURE REVIEW

In this literature review process, I reviewed and organized online published articles related to women's autonomy in household decision-making with the different factors. All studies were found by searching through the electronic databases (PUBMED) using Endnote X7 software. All the articles related to the topic were included in the review. Only English languages were applied to the search strategy

➢ *Conceptual and Theoretical Review*
The ability and freedom of women to make decisions about their own lives, bodies, and choices on their own—free from outside pressure or influence—is referred to as women's autonomy. It includes social, economic, political, and individual autonomy, among other aspects. Autonomy for women involves the freedom to determine their own paths, make choices related to their bodies and reproductive health, pursue education and career goals, and participate in social and political spheres without discrimination or constraints. It is a fundamental aspect of gender equality and human rights, emphasizing the empowerment of women to shape their destinies and contribute actively to society on their terms.

Our knowledge of women's autonomy is aided by several theories and frameworks from the disciplines of sociology, gender studies, and feminist theory. Some of the important theories about women's autonomy were reviewed.

➢ *Feminist Theory:*

- *Liberal Feminism*
  A byproduct of the global movement for women's empowerment is feminist theory. One definition of feminism is the acknowledgement and criticism of male dominance together with actions taken to alter it. Feminism seeks to highlight the significance of women, demonstrate that historically men had a supremacy over women and to achieve gender equity. Feminists advocate for women's equality and contend that they ought to have equal access to opportunities and scarce resources in society. Sexism is the main barrier to equality. Sex is a factor in discrimination and devaluation, as seen by limited employment possibilities; prejudice against women is particularly prevalent in this regard. (Baehr, 2007) Liberal Feminism mainly focuses on achieving gender equality and women's autonomy through legal reforms and equal opportunities in areas such as education and employment.

- *Radical Feminism:*
  It is a perspective within feminist theory that emerged in the late 1960s and early 1970s as a response to the limitations and perceived inadequacies of other feminist approaches, particularly liberal feminism. Radical feminists argue that the roots of women's oppression lie in a patriarchal system deeply embedded in societal structures. Radical feminists view patriarchy, a social system that grants men more power and privilege than women, as the fundamental cause of women's oppression. They emphasize dismantling patriarchy as the primary goal. It emphasizes that women's personal experiences, such as relationships, sexuality, and family dynamics, are political issues. They argue that societal structures reinforce gender-based power imbalances in these personal aspects of women's lives. It's

ISSN No:-2456-2165 https://doi.org/10.5281/zenodo.14576675

important to note that radical feminism is a diverse and evolving perspective, and not all radical feminists hold the same views on every issue. The movement has contributed significantly to discussions about gender and power, challenging established norms and inspiring further exploration of the complexities of women's experiences in society. (Stoljar, 2013) It focuses on the patriarchal roots of women's oppression and advocates for fundamental societal changes to eliminate gender-based hierarchies for achieving women's autonomy.

In summary, radical feminism sees women's autonomy as intimately tied to challenging and transforming patriarchal structures on both personal and societal levels. Autonomy, in this context, is not only about individual choices but also about collective efforts to create a more just and egalitarian society for all women.

- *Third-wave Feminism:*

It is a term used to describe the feminist movement that emerged in the late 20th century, roughly in the early 1990s. This wave of feminism is considered a response and continuation of the second-wave feminist movements that began in the 1960s and 1970s. Third-wave feminism is characterized by its focus on intersectionality, diversity, and the inclusion of a broader range of issues that affect women. Third-wave feminism emphasizes the intersectionality of identities, acknowledging that women's experiences are shaped not only by gender but also by factors such as race, class, sexual orientation, ability, and more. This recognition seeks to address the diverse and overlapping forms of oppression that individuals may face. The movement is more inclusive, welcoming a diverse range of voices and perspectives. It strives to incorporate the experiences of women from different cultural backgrounds, ethnicities, and socioeconomic statuses, recognizing that feminism should be accessible to and representative of all women. It's important to note that third-wave feminism is not a monolithic or universally agreed-upon movement. There are debates and variations within this wave, and some critics argue that the term "third wave" oversimplifies the diversity of feminist thought in this era. Despite this, third-wave feminism has made significant contributions to expanding the scope of feminist discourse and activism. It emphasizes intersectionality, recognizing that women's experiences of autonomy are shaped by multiple factors such as race, class, and sexual orientation. (Stoljar, 2013)

In summary, third-wave feminism views women's autonomy as a multifaceted concept, encompassing individual agency, intersectionality, sexual empowerment, and the ability to challenge and redefine traditional gender roles. It reflects a more inclusive and diverse understanding of feminism that recognizes and respects the autonomy of women in various aspects of their lives.

- *Marxist and Socialist Feminism:*

Marxist feminism and socialist feminism are two related but distinct branches of feminist theory that focus on the intersection of gender and economic systems. While both share common ground in their critique of capitalism and patriarchy, they have nuanced differences in their emphasis and approaches. Marxist feminism places primary emphasis on the economic structures and class relations within society, drawing from the theories of Karl Marx. It seeks to understand how capitalism and class struggle intersect with gender oppression. Socialist feminism integrates Marxist insights with a broader focus on social structures, recognizing that gender oppression is not solely the result of economic factors but is also deeply embedded in social relations and institutions. Both Marxist and socialist feminism have contributed significantly to feminist thought, providing insights into the complex interplay between economic systems and gender oppression. These perspectives underscore the importance of addressing both class and gender struggles in the pursuit of a more equitable and just society. (Armstrong, 2020; Stoljar, 2013)

In summary, Marxist and socialist feminists view women's autonomy as intricately linked to the broader structures of capitalism, patriarchy, and other intersecting forms of oppression. While Marxist feminism focuses more on the economic basis of autonomy and the collective struggle against capitalism, socialist feminism expands the scope to include a broader range of social structures and intersectional dynamics. Both perspectives recognize the need for systemic change to truly empower women and enhance their autonomy in various aspects of life.

➢ *Empirical Review*

- *Women's Autonomy*

A study in Ethiopia showed that although women's autonomy had increased to 19.1% in 2016, the trend for women's autonomy in healthcare decision-making had decreased from 18.7% in 2005 to 17.2% in 2011. Women's autonomy in urban areas was 98.7% higher than in rural areas, and it was 76.6%, 79.7%, and 95.7% higher in the Tigray region, the Somali region, and Addis Abeba than it was in Dire Dawa. Unemployed women, females between the ages of 15 and 24, and uneducated women had 45.1%, 32.4%, and 32.2% autonomy in making healthcare decisions, respectively.(Asabu & Altaseb, 2021)

A study was conducted in Varanasi, India to investigate women's autonomy and its related factors and examined the determinants of women's autonomy in three areas: decision-making power, control over finances, and freedom of movement. A much smaller percentage of the women were able to spend money independently; over 60% had unrestricted access to money through work or ongoing family assistance. Only 26% of women said they did not ask permission before leaving the house and 81% took most smaller choices in the home. Almost all women (92%) admitted to leaving the house alone to run errands and 58% said they were free to visit their birthplaces whenever they wanted.(Bloom, Wypij, & Das Gupta, 2001)

A study conducted in Senegal showed that 6.26% of women had decision-making autonomy regarding their health and for 80.33% of the women, their husbands or partners made decisions regarding their health.(Sougou,

ISSN No:-2456-2165 https://doi.org/10.5281/zenodo.14576675

Bassoum, Faye, & Leye, 2020) .Similarly study from Sub-Saharan Africa revealed that the percentage of married women who had health insurance was 21.3% (95% CI; 19.9-22.7%), with Ghana and Burkina Faso having the greatest and lowest percentages of coverage, respectively (66.7% and 0.5%). Compared to women who did not have any household decision-making autonomy, those who did had higher odds of enrolling in health insurance (AOR = 1.33, 95% CI; 1.03-1.72).(Zegeye et al., 2023)

A study conducted in Nepal revealed that there was variation in women's autonomy in across different development regions. Western women are more autonomous and women from rural area and the Terai region were less autonomous while deciding their health and purchasing household things.(Dev et al., 2010)

One of the studies was conducted in Kapilvastu, Nepal to find out the status of women's autonomy and its related factors and according to that the mean score for women's autonomy was 23.34± 8.06 out of the possible maximum 48 scores. It was found that women's autonomy was positively associated with a caste or ethnicity, better employment for the husband, a couple's education spanning more than ten years, and a higher household income status.(Bhandari et al., 2016)

Another study conducted in the western part of Nepal, Kaski district, showed that 87.3% of women took decisions for their health, 86.17 % made decisions for purchasing household items whereas 81.3% of women were autonomous while deciding to visit their relatives.(Poudel et al., 2022)

- *Socio-Economic Variables*

Various research shows that women's autonomy varies according to the different socio-economic variables such as the employment status of women, the economic status of the family, and the employment status of the husband.

A study conducted on Ethiopian women showed despite declining to 41.8% in 2016, the status of employed women in healthcare decision-making increased from 31.64% in 2005 to 43.9% in 2011. Also, women from low-income households' autonomy in making healthcare decisions fell from 37.5% in 2005 to 32.5% in 2011.(Asabu & Altaseb, 2021)

A study conducted in Kapilvastu, Nepal also revealed that the mean score of autonomy was (23.34± 8.06) out of the possible maximum 48 and showed that autonomy is positively associated with the better employment of the husband and the economic status of the husband. A study found that there was a strong direct effect of the economic status of the household (OR = 1.42, CI = 1.01–2.03) on women's autonomy.(Bhandari et al., 2016)

A study conducted in Varanasi, India with 300 samples, for investigating women's autonomy shows no significant association with the economic status. The percentage of employed women having high financial control (OR = 3.04, 95% CI = 1.63, 5.68), high decision-making power (OR = 4.06, 95% CI = 2.24, 7.37), and a propensity for high freedom of movement (OR = 1.95, 95% CI = 0.88, 4.34) were all significantly higher.(Bloom et al., 2001)

A demographic study conducted in Nepal shows higher autonomy in the women who were employed for cash earning and whose family's economic status is good.(Dev et al., 2010)

- *Socio-Demographic Variables*

A study conducted on Ethiopian women shows that the autonomy of women between the ages of 35 and 49 also decreased, from 38.7% in 2005 to 37.6% and 36.4%, respectively, in 2011 and 2016. Additionally, the autonomy of low-educated women in making healthcare decisions has decreased from 68.5% in 2005 to 52.5% and 51.6% in 2011 and 2016, respectively.(Asabu & Altaseb, 2021) Regarding the relationship with the age, Ghanaian women who were older seem to have high autonomy in decision making.(Budu et al., 2020)

A Study conducted in Kapilvastu Nepal found that there was a strong direct effect of women's education (OR = 8.14, CI = 3.77–17.57) and husband's education (OR = 2.63, CI = 1.69–4.10) on women's autonomy.(Bhandari et al., 2016)

A study was conducted in Varanasi, India with 300 samples, to investigate whether women's autonomy shows a significant association with the educational status of women. Based on a 10-year difference in educational attainment, highly educated women had a higher likelihood of having high freedom of movement (OR = 2.44, 95% CI = 1.22, 4.88) than less educated women.(Bloom et al., 2001)

A demographic study conducted in Nepal shows higher autonomy in the women with higher age and higher level of education.(Dev et al., 2010)

III. RESEARCH METHODOLOGY

The study design was a cross-sectional analytical study, and it was community-based as the data was collected in a single cross-section and the data was in descriptive as well as in inferential statistics. The study was quantitative as all the values of dependent and independent variables were calculated in numeric forms including nominal and ordinals. The study period was 6 months. All married women of reproductive age (15-49 years) were the target population, and the study area was Annapurna rural municipality of Kaski, district, Nepal. Primary data was collected from the community. Secondary data was not collected. The sampling technique was Multistage random sampling (MRS). Stage 1: For selection of Ward, simple random sampling was used. Out of total, 3 clusters were selected randomly through Microsoft Excel program. Stage 2: The final number of women at each ward was fixed by population proportionate sampling. Stage 3: For selection of household in each ward, WHO epi-method was followed.(UNICEF, 2015) Sample

ISSN No:-2456-2165 https://doi.org/10.5281/zenodo.14576675

Size for finite population was 360. All women aged between 15- 49 years who were married were included. All women aged between 15-49 who were unmarried were excluded. Women who were not available at the time of data collection.

➢ *Data Collection Techniques, Tools, and Processes*

Table 1 Techniques and Purpose of Various Tools

S.N	Techniques	Tools	Purpose
1.	Interview	Interview schedule	To access the socio demographic variables, socio economic variables and women autonomy level.

The questionnaire was pretested among 10% of the total sample i.e., 35 women of Rupa rural municipality, Kaski district. After pretesting, necessary, the structured questionnaire was rephrased considering the responses of the participants.

To ensure the validity and validity of the study, reliable and valid questionnaire tools were used which were already constructed by the researcher and applied in another setting of Nepal.(Bhandari, Dangal, Sarma, & Kutty, 2014) The questionnaire in the research was developed only after an extensive review of related literature and was prepared under the guidance of a supervisor.

Data was entered in EPI-DATA which prevented the error that existed beyond the limit. Ten percent of the entered data was rechecked manually to minimize the limit to enhance the validity and reliability of the study. Data for measuring the economic status of a family, the International Wealth Index was used in which 12 questions were asked and the household's IWI score was obtained from IWI Excel calculation. To maintain interpreter reliability orientation to the data collectors was provided before the data collection and all the collected data was checked on the day after a thorough discussion session with the data collector. Since this study covers the status of women's autonomy who were 15-49 years age group only, so the women autonomy status of women aged above 49 years was not able to analyze by this study.

The data was entered into Epi-Data version 3.2 and the entered data was transferred into the Statistical Package for Social Sciences (SPSS 20 version) for further analysis. Categorical variables were described using numbers and percentages. Frequency distribution and cross tabulation between dependent and independent variables were used to describe the basic background and characteristic of respondent. The chi- square test was used to test the association between dependent and independent variables.

All the data was exported from Epi-Data to SPSS for further analysis. All the data was transformed into SPSS. According to obtained data nature various inferential statistics were used including Bivariate or Multivariate Analysis and the data was interpreted using Tables and Graphic representation. Associations between various variables i.e., dependent, and independent both the statistical test used was mainly Chi-square test was used to understand the association between the variables. Frequency and percent of independent variables like socio-economic and socio-demographic variables were calculated. For the calculation of women's autonomy, it was calculated using valid tested tools. There we have 24 domains segregated into three sections (Decision-making autonomy, Freedom of movement autonomy and financial control autonomy). For every domain we have given scores 3, 2 and 1 score. While asking on the different domains of autonomy, participants mainly answered three types of answer like they depend on someone while taking decision(dependent), they don't need anyone for deciding (Independent) and jointly they decide (Joint). The score system was given as "1" is for dependent, "2" is for joint and "3" is for independent. Likewise, the sum of score of all the domain and their mean value was calculated to measure the autonomy level. Below the mean value of sum of all the domain was considered as low level of autonomy(score≤49.10) and above the mean value of sum of all the domain was considered as high level of autonomy (Score > 49.10). The mean value of sum of all the domain was found to be 49.10.

The research approval was taken from the Master of Rural Development Studies program, Kalika Multiple Campus. Informed consent was taken from the participants, and they were not forced to participate and were allowed to withdraw from the study at any time during the study. Confidentiality of the collected information and participants was maintained. Also, before starting the data collection, application(letter) from the college was submitted in the Municipality office for getting approval.

IV. RESULTS

This section contains analysis and interpretation of the study findings. Data analysis was done after transferring the data entered in EPI DATA version 3.2 to SPSS version 20 as per the objectives. The data were presented using tables, figures, and statistical statements by each objective. All computations were based on a 95% level of confidence. The response rate was 100%. Mainly the Chi-square test was applied to check for the significant associations between the variables.

➢ *Socio-Demographic Characteristics of Respondents:*

Table 2 illustrates the socio-demographic characteristics of the respondents. The study population was characterized by different religions and ethnic groups. Most of the respondents were from the age groups of Above 35 years i.e., 183 (50.8%) and minorities were from the age groups of below 20 years i.e., 12(3.3%). Majority of the respondents followed Hindu religion i.e., 299(83.1%) and minorities of the respondents followed Muslim religion i.e. 1 (0.3%). The number of upper caste among ethnic groups

ISSN No:-2456-2165 https://doi.org/10.5281/zenodo.14576675

was highest i.e. 144 (%) and fewest were disadvantaged non Dalit terai i.e. 1 (0.3%). Most of the Respondents have only two children i.e. 145(40.3%). 146(40.6%) of participants attended secondary & higher level of education, 156(43.3%) attended primary level of education whereas 58 (16.1%) did not attended. Regarding the education level of the respondent's husband, 183(50.8%) of participants had attended secondary & higher level of education, 157(43.6%) attended primary level of education whereas 20 (5.6%) of did not attend.

Table 2 Socio-Demographic Characteristics of Respondents

Characteristics	Frequency	Percent(%)
Age Category		
20 and below	12	3.3
21 to 34 years	150	41.7
35 and above years	198	55.0
Ethnicity		
Dalits	130	36.1
Disadvantage janajatis	26	7.2
Disadvantage non dalit terai caste	1	.3
Relatively advantaged janajatis	59	16.4
Upper caste	144	40.0
Religion		
Hindu	299	83.1
Buddhist	47	13.1
Muslim	1	.3
Christian	13	3.6
Number of children		
0	21	5.8
1	71	19.7
2	145	40.3
3	78	21.7
4	31	8.6
5	10	2.8
6	2	.6
8	2	.6
Education status of Participant		
Attended secondary and higher	146	40.6
Attended primary education	156	43.3
Did not attend school	58	16.1
Education status of Husband		
Attend secondary and higher	183	50.8
Attend primary education	157	43.6
Did not attend school	20	5.6

➢ *Socio-Economic Characteristics of Respondents*

Table 3 illustrates the socio-economic characteristics of the respondents. Here we have researched three different aspects as a socio-economic part. Most of the respondents were engaged in agriculture and that is their main occupation i.e., 199 (55.3%) and minorities were migrant workers i.e., 5(1.4%). The majority of the respondent's husbands were also engaged in agricultural occupation i.e., 145(40.3%) and minorities of them were engaged as migrant worker i.e., 20 (5.6%). Economic status calculated based on Internal Wealth Index and classified into 5 quintiles. In this study major respondents found to be fall under third quintile i.e., 127 (35.3%) and fewer falls under first quintile i.e., 4 (1.1%).

Table 3 Socio-Economic Characteristics of Respondents

Characterstics	Frequency	Percent
Ocuupation of Respondent		
Agriculture	199	55.3
Service	26	7.2
Own Business	62	17.2
Migrant Worker	5	1.4
Housewife	68	18.9
OCCUPATION OF HUSBAND		

ISSN No:-2456-2165 https://doi.org/10.5281/zenodo.14576675

Agriculture	145	40.3
Service	49	13.6
Own Business	46	12.8
Migrant Worker	20	5.6
Overseas Employee	100	27.8
Wealth quintile		
first quintile (POOREST)	4	1.1
second quintile (POOREST)	74	20.6
third quintile (mIDDLE)	127	35.3
fourth quintile (RICHER)	115	31.9
Fifth quintile (RICHEST)	40	11.1

➢ *Autonomy Domains:*

Table 4 Illustrates the autonomy domains of the respondents. This table illustrates that how the women make decision over certain activities and task in the home. Also, this table illustrates about in what sort of things they need permission to do in the respective activities. Respondents are likely to take their decision in three ways i.e., independently, jointly, and dependent on someone. It shows that in most cases they decide jointly to do activities like purchasing goods, clothes, food, child health care and inviting host. It shows that the in most of the cases, women need permission to do certain task like, going outside of home, going for health care facility, going relatives' home, going to public places, visiting friend's house, and going to children's school. Not even this, they need permission to open a bank account, to do lend/borrow activities, spend money, and control over property. But they were independent regarding saving their money.

Table 4 Autonomy Domains

Characterstics	**Frequency**	**Percent**
Section 1: (Decision making autonomy) How do you make decision on;		
What food should be cooked?		
Independent	246	68.3
Joint	112	31.1
Dependent	2	.6
Daily Household expenditure/purchase?		
Independent	137	38.1
Joint	176	48.9
Dependent	47	13.1
Children's cloths and food?		
Independent	134	37.2
Joint	205	56.9
Dependent	21	5.8
Children's education?		
Independent	79	21.9
Joint	264	73.3
Dependent	17	4.7
Children's and female health care and medicine?		
Independent	78	21.7
Joint	267	74.2
Dependent	15	4.2
Inviting and hosting guests?		
Independent	83	23.1
Joint	253	70.3
Dependent	24	6.7
Use of contraceptives		
Independent	50	13.9
Joint	300	83.3
Dependent	10	2.8
Having baby or another baby?		
Independent	42	11.7
Joint	310	86.1

ISSN No:-2456-2165 https://doi.org/10.5281/zenodo.14576675

Dependent	8	2.2
purchasing major goods in household such as land, house, computer, TV?		
Independent	40	11.1
Joint	286	79.4
Dependent	34	9.4
Being a member of public organization?		
Independent	50	13.9
Joint	284	78.9
Dependent	26	7.2
Section 2: (Freedom of movement Autonomy) Do you need permission to -		
going outside the house/compound?		
Independent	46	12.8
Joint	72	20.0
Dependent	242	67.2
going for marketing / shopping?		
Independent	139	38.6
Joint	47	13.1
Dependent	174	48.3
going for hospital or health care facility?		
Independent	60	16.7
Joint	66	18.3
Dependent	234	65.0
going to children's School		
Independent	138	38.3
Joint	58	16.1
Dependent	164	45.6
visiting to natal family or relative/s' house?		
Independent	54	15.0
Joint	34	9.4
Dependent	272	75.6
visiting friend's house?		
Independent	66	18.3
Joint	49	13.6
Dependent	245	68.1
going to public places/programmes such as temple, church, other religious places, public programmes?		
Independent	94	26.1
Joint	43	11.9
Dependent	223	61.9
Section 3: (Financial related Autonomy) Do you need permission to-		
work outside house for income?		
Independent	158	43.9
Joint	40	11.1
Dependent	162	45.0
spend money for household affairs?		
Independent	150	41.7
Joint	64	17.8
Dependent	146	40.6
lend/spend money as per personal need and interest?		
Independent	122	33.9
Joint	61	16.9
Dependent	177	49.2
saving money for your future use?		
Independent	176	48.9
Joint	45	12.5
Dependent	139	38.6
handle separate bank account?		
Independent	152	42.2

ISSN No:-2456-2165 https://doi.org/10.5281/zenodo.14576675

Joint	28	7.8
Dependent	180	50.0
own and control personal property?		
Independent	135	37.5
Joint	24	6.7
Dependent	201	55.8
give money or goods to native family?		
Independent	139	38.6
Joint	19	5.3
Dependent	202	56.1

➢ *Women Autonomy*

Table 5 illustrates the level of autonomy of the respondents. This shows that 53.3%(192) have a high level of autonomy ,whereas 46.7%(168) have a low level of autonomy. This study shows that more percentage of women were autonomous.

Table 5 Women's Autonomy

Charactersticts	**Frequency**	**Percent**
High Level of Autonomy	192	53.3
Low Level of Autonomy	168	46.7

➢ *Association between Variables*

This section presents associations in between various variables i.e., dependent and independent. Chi square test was used to understand the association between the variables.

➢ *Socio Demographic Factors and Women's Autonomy:*

Table 6 shows that factors such as age, religion, type of family, ethnicity, number of children, education status of women and education status of husband do not have any significant association with women's autonomy.

Table 6 Socio Demographic Factors and Women's Autonomy

Charactersticts	**Level of Autonomy**		**Chi Square Value**	**P-Value**
	Low Level	**High Level**		
Age Category			2.553	0.279
20 and below years	3	9		
Between 21-34 Years	69	81		
35 and above Years	96	102		
Ethnicity			7.668	0.105
Dalits	63	67		
Disadvantage Janajatis	11	15		
Disadvantage non dalit terai caste	1	0		
Relatively advantaged janajatis	35	24		
Upper caste	58	86		
Family Type			5.072	0.079
Nuclear	102	96		
Joint	50	66		
Expanded	16	30		
Religion			4.864	0.182
Hindu	133	166		
Buddhist	28	19		
Muslim	0	1		
Christian	7	6		
Number of Children			6.795	0.450
0	6	15		
1	33	38		
2	71	74		
3	36	42		
4	16	15		
5	3	7		
6	2	0		
8	1	1		
Educational Status of Husband				

ISSN No:-2456-2165 https://doi.org/10.5281/zenodo.14576675

Attended secondary and higher	77	106	3.267	0.195
Attended primary education	80	77		
Did not attend school	11	9		
Educational status of Women			3.890	0.143
Attended secondary and higher	59	87		
Attended primary education	80	76		
Did not attend school	29	29		

Table 7 shows that factors such as occupation of husband, economic status (wealth quintile) do not have any significant association with women's autonomy whereas occupation of respondents (Women) have significant association with women's autonomy.

Table 7 Socio Economic Factors and Women's Autonomy

Characterstics	**Level of Autonomy**		**Chi Square Value**	**P-Value**
	Low Level	High Level		
Occupation of participants			13.681	0.008*
Agriculture	97	102		
Service	14	12		
Own Business	31	31		
Migrant Worker	5	0		
Housewife	21	47		
Occupation of your husband			4.515	0.341
Agriculture	59	86		
Service	25	24		
Own Business	24	22		
Migrant Worker	12	8		
Overseas Employee	48	52		
Wealth Quintile			1.538	0.820
First quintile (Poorest)	2	2		
Second quintile (Poorer)	36	38		
Third quintile (Middle)	63	64		
Fourth quintile (Richer)	51	64		
Fifth quintile (Richest)	16	24		

*Denotes significant at <0.05

V. DISCUSSION

The study was carried out to find the autonomy level of the women and the relationship with the socio-economic variable and socio demographic variables. The findings of this study show that the overall women's autonomy status was slightly high in Annapurna rural municipality, Kaski district, Nepal. Out of total 360, 53.7% women have high level of autonomy whereas 46.3% have low level of autonomy. Decision making autonomy scored better than financial autonomy of women and freedom of movement autonomy. It shows that in most cases they decide jointly to do activities like purchasing goods, clothes, food, child health care and inviting host. Results shows that the in most of the cases, women need permission to do certain task like, going outside of home, going for health care facility, going relatives' home, going to public places, visiting friend's house, and going to children's school. Not even this, they need permission to open a bank account, to do lend/borrow activities, spend money, and control over property. They have to depend on others (husband or other family head) for making decisions and do different activities. This means patriarchy is still practicing in our society and every household though they have the minimum level of education. Most of the women were unable to decide independently although they were from good economic class, and they have good education level. We found that they were only independent regarding saving their money.

We found that women's occupation is directly associated with the level of autonomy. There is not any significant association of autonomy with the others socio economic and demographic variables.

- *Autonomy Level and Socio Demographic Variables*

One of the studies conducted in Ethiopian women, show that the autonomy of women between the ages of 35 and 49 also decreased, from 38.7% in 2005 to 37.6% and 36.4%, respectively, in 2011 and 2016. Also, the autonomy of low-educated women in making healthcare decisions has decreased from 68.5% in 2005 to 52.5% and 51.6% in 2011 and 2016, respectively.(Asabu & Altaseb, 2021) Regarding relationship with the ages, Ghanian women who were older seems to have high autonomous in decision making.(Budu et al., 2020)

A study was conducted in Varanasi, India with 300 sample, for investigating women's autonomy shows

ISSN No:-2456-2165 https://doi.org/10.5281/zenodo.14576675

significant association with the educational status of women. Based on a 10-year difference in educational attainment, highly educated women had a higher likelihood of having high freedom of movement (OR = 2.44, 95% CI = 1.22, 4.88) than less educated women.(Bloom et al., 2001)

In Kapilvastu district ,Nepal, study found that there was a strong direct effect of women's education (OR = 8.14, CI = 3.77–17.57) and husband's education (OR = 2.63, CI = 1.69–4.10) on women's autonomy.(Bhandari et al., 2016)

A demographic study conducted in Nepal shows higher autonomy in the women with higher age and higher level of education.(Dev et al., 2010)

According to a study conducted in south India, the number of children, the husband's education, the women's education, the age at marriage, the length of the marriage, the kind of marriage (love marriage), and the membership in self-help groups were strongly correlated with the autonomy of women.(Gunasekaran, 2010).

The findings of the study shows that the most of women and their husband had attended the school's education and most of them were literate so there we can't see the association. Also, the study area is near the main city so most of them were educated and attained primary or secondary level education as the district is considered the most literate district. In this study, more percentage of women and their husband were educated, and the results shows that they jointly decide most of the activities carried out in home. This might be the due education status of respondents and their husband. Religiously most of the respondents were Hindu religion and most of the women were aged 35 years and above. So, due to this unequal division of respondents there seems to be no association. Community consists of a greater number of dalits and upper caste people while there is low number of other ethnic group's people. There is not any significant association of autonomy with ethnicity, that means in our study area ethnicity did not affect the women's autonomy level.

Previous studies shows that the women with higher age and high number of children were more autonomous than other. (Dev et al., 2010) But in today's context, people were more educated, and use of contraceptives make aware about having low number of children. So, there we can't see the difference in autonomy level with regards to the number of children. In our study most of the respondents had two children and they were aged 35 and above and there is not any association with these variables with the autonomy level.

- *Autonomy Level and Socio-Economic Variables*

Research shows that the women's autonomy level varies according to the different socio-economic variables such as employment status of women, economic status of family and employment status of husband.

This study shows that there is not any significant association between women's autonomy level and their economic status. These findings of the study were consistent with the another study that was conducted in Varanasi, India for investigating women's autonomy and that also concluded that there was no significant association with the economic status. The percentage of employed women having high financial control (OR = 3.04, 95% CI = 1.63, 5.68), high decision-making power (OR = 4.06, 95% CI = 2.24, 7.37), and a propensity for high freedom of movement (OR = 1.95, 95% CI = 0.88, 4.34) were all significantly higher.(Bloom et al., 2001)

In this study there was a significant association in between women's autonomy and employment status of women. This result was consistent with another study conducted in Ethiopia. A study conducted in Ethiopian women, showed despite declining to 41.8% in 2016, the status of employed women in health care decision-making increased from 31.64% in 2005 to 43.9% in 2011. Also women from low-income households' autonomy in making healthcare decisions fell from 37.5% in 2005 to 32.5% in 2011.(Asabu & Altaseb, 2021). Similarly the same results of employed with high autonomy level were found in the another study conducted in Nepal.(Bhandari et al., 2016)

A demographic study conducted in Nepal shows higher autonomy in the women who were employed for cash earning and whose family's economic status is good.(Dev et al., 2010) which was found to be consistent with our study's findings.

A study conducted in Kapilvastu, Nepal also revealed that the mean score of autonomy was (23.34± 8.06) out of the possible maximum 48 and showed that the autonomy is positively associated with the better employment of husband and the economic status of husband. Study found that there was strong direct effect of economic status of household (OR = 1.42, CI = 1.01–2.03) on women's autonomy.(Bhandari et al., 2016) In our study we did not found the significant association in between economic status and autonomy level because most of the respondent were lies in third and fourth quintile, which means middle level and above. We found that there was not any association of respondent education, husband education and husband occupation with women autonomy which is inverse to the study conducted in Kapilvastu Nepal.

This study was cross sectional study and we collected quantitative information of the respondents, but the women's autonomy is the broad and comprehensive thing which we need to go in depth and need to do various subjective(qualitative) information collection as well to make our result more accurate and precise. It is better to cover more numbers and percentages of population to get better results but due to various issues like low time and resources, I have covered some percentage of population representing the whole population. The information which I have collected is as per the information of respondents and we have done multistage random sampling for calculating the sample size.

ISSN No:-2456-2165 https://doi.org/10.5281/zenodo.14576675

VI. CONCLUSION

Autonomy for women involves the freedom to determine their own paths, make choices related to their bodies and reproductive health, pursue education and career goals, and participate in social and political spheres without discrimination or constraints. It is a fundamental aspect of gender equality and human rights, emphasizing the empowerment of women to shape their destinies and contribute actively to society on their terms.

We learned that women sustain half of the world's population when we talked about it. Consequently, without concurrently enhancing or elevating the standing of women in the home and in society, a nation cannot progress. Thus, in order to speed up the growth process, it is not only desired but also required that they participate equally in all developing activities. Women are therefore necessary for any country to flourish and for people to become independent.

Research indicates that women have less decision-making autonomy, especially in developing countries. However, increased access to healthcare, a decrease in poverty, and rise in household income are the outcomes of expanding the role of women in decision-making. Many women in developing countries confront obstacles to their access to health care facilities, freedom of movement, financial and material resources, and decision-making authority over household and societal concerns, despite the implementation of various projects aimed at enhancing women's autonomy. Many articles also show a similar situation in the context of Nepal.

Women’s employment status is the key predictor of women’s autonomy. This research is successful in finding the status of women’s regarding household decision making, financial control and freedom of their moment. Despite the other study showing there is an association with the other variables and various factors effect on the women’s autonomy level, but this study shows that the employment status and to be employed is the foremost things to become independent and autonomous.

We can see that most of the respondents and their husbands were well educated, but self-employment is very necessary to become more autonomous and independent in daily life. Education a human right of every citizen, most people attain the minimum level of education but vocational education, training, and doing certain small-scale business or doing some jobs is very important to gain knowledge and to become more practical. So, program and project for empowering women and helping them to become employed is very necessary. Unemployment leads to a low level of autonomy, so I suggest local government focus and allocate their budget regarding women’s employment, entrepreneurship, and micro level small scale businesses.

Our findings will provide policymakers with evidence-based insights to develop effective and targeted policies. Understanding the factors that enhance or hinder women's autonomy allows for the creation of interventions that promote gender equality. Women's autonomy is a critical aspect of gender equality. This study can shed light on the disparities and challenges that women face, may help to formulate strategies to dismantle barriers and foster a more equitable society. This study highlighted the connection between economic empowerment and women's decision-making power. Empowered women contribute to economic development through increased workforce participation and entrepreneurship. This research emphasized the role of employment in enhancing women's autonomy and helps on understanding how employment opportunities impact women's decision-making abilities.

In conclusion, research on women's autonomy is essential for shaping policies, fostering gender equality, promoting individual empowerment, and contributing to positive societal changes. This provides the foundation for evidence-based decision-making and actions that aim to create a more equitable environment.

ACKNOWLEDGEMENT

At this moment, I would like to express my sincere thanks to those who supported me in every step of making this thesis. First of all, my sincere thanks go to my thesis supervisor, Mr. Bijaya Babu Adhikari, for the guidance, inspiration, and constant encouragement throughout the research study. I heartily appreciate his invaluable supervision and useful guidance and no words can fully express my feeling of gratitude to him.

I would also like to thank all my teachers for helping me during the preparation of this thesis and who inspired me by showing keen interest in my work. I would like to express my sincere thanks to my friends and especially Miss. Aakriti Dhungana and Miss. Sushmita Dahal, who supported me in crucial times and helped in the data collection.

I am obliged to my family members for their cooperation and support during the entire period of study. Also, I would like to thank my beloved wife Mrs. Laxmi Nepal, and my dear friends Mr. Sujan Poudel and Mr. Dhurba Khatri for their continuous support in writing of this thesis.

REFERENCES

[1]. Adhikari, R. (2016). Effect of Women's autonomy on maternal health service utilization in Nepal: a cross sectional study. BMC Womens Health, 16, 26. doi: 10.1186/s12905-016-0305-7

[2]. Adhikari, R., & Sawangdee, Y. (2011). Influence of women's autonomy on infant mortality in Nepal. Reprod Health, 8, 7. doi: 10.1186/1742-4755-8-7

[3]. Armstrong, E. (2020). Marxist and socialist feminisms. Companion to Feminist Studies, 35-52.

ISSN No:-2456-2165 https://doi.org/10.5281/zenodo.14576675

[4]. Asabu, M. D., & Altaseb, D. K. (2021). The trends of women's autonomy in health care decision making and associated factors in Ethiopia: evidence from 2005, 2011 and 2016 DHS data. BMC Womens Health, 21(1), 371. doi: 10.1186/s12905-021-01517-9

[5]. Baehr, A. R. (2007). Liberal feminism. FEMINIST INTERPRETATIONS Of john rawls, 150.

[6]. Bhandari, T. R., Dangal, G., Sarma, P. S., & Kutty, V. R. (2014). Construction and Validation of a Women's Autonomy Measurement Scale with Reference to Utilization of Maternal Health Care Services in Nepal. JNMA J Nepal Med Assoc, 52(195), 925-934.

[7]. Bhandari, T. R., Kutty, V. R., & Ravindran, T. K. (2016). Women's Autonomy and Its Correlates in Western Nepal: A Demographic Study. PLoS One, 11(1), e0147473. doi: 10.1371/journal.pone.0147473

[8]. Bloom, S. S., Wypij, D., & Das Gupta, M. (2001). Dimensions of women's autonomy and the influence on maternal health care utilization in a north Indian city. Demography, 38(1), 67-78. doi: 10.1353/dem.2001.0001

[9]. Budu, E., Seidu, A. A., Armah-Ansah, E. K., Sambah, F., Baatiema, L., & Ahinkorah, B. O. (2020). Women's autonomy in healthcare decision-making and healthcare seeking behaviour for childhood illness in Ghana: Analysis of data from the 2014 Ghana Demographic and Health Survey. PLoS One, 15(11), e0241488. doi: 10.1371/journal.pone.0241488

[10]. Carlson, G. J., Kordas, K., & Murray-Kolb, L. E. (2015). Associations between women's autonomy and child nutritional status: a review of the literature. Matern Child Nutr, 11(4), 452-482. doi: 10.1111/mcn.12113

[11]. Dev, A., Bell, J., Simkhada, P., Van Teijlingen, E., & Regmi, P. (2010). Women's autonomy in household decision-making: A demographic study in Nepal. Reproductive health, 7, 15. doi: 10.1186/1742-4755-7-15

[12]. Gunasekaran, S. (2010). Women's autonomy and reproductive behaviour: Gyan Publishing House.

[13]. Kebede, A. A., Cherkos, E. A., Taye, E. B., Eriku, G. A., Taye, B. T., & Chanie, W. F. (2021). Married women's decision-making autonomy in the household and maternal and neonatal healthcare utilization and associated factors in Debretabor, northwest Ethiopia. PLoS One, 16(9), e0255021. doi: 10.1371/journal.pone.0255021

[14]. Leal Filho, W., Kovaleva, M., Tsani, S., Țîrcă, D.-M., Shiel, C., Dinis, M. A. P., . . . Tripathi, S. (2022). Promoting gender equality across the sustainable development goals. Environment, Development and Sustainability. doi: 10.1007/s10668-022-02656-1

[15]. Poudel, S., Adhikari, C., Yadav, R. K., Yadav, D. K., Thapa, D. K., & Jakovljevic, M. (2022). Disempowered Mothers Have Undernourished Children: How Strong Is the Intrinsic Agency? Front Public Health, 10, 817717. doi: 10.3389/fpubh.2022.817717

[16]. Smits, J., & Steendijk, R. (2015). The international wealth index (IWI). Social Indicators Research, 122(1), 65-85.

[17]. Sougou, N. M., Bassoum, O., Faye, A., & Leye, M. M. M. (2020). Women's autonomy in health decision-making and its effect on access to family planning services in Senegal in 2017: a propensity score analysis. BMC Public Health, 20(1), 872. doi: 10.1186/s12889-020-09003-x

[18]. Stoljar, N. (2013). Feminist perspectives on autonomy.

[19]. Thapa, D. B. (2003). Gender disparity in Nepal. Unpublished Dissertation, TU, Kirtpur.

[20]. Thapa, D. K., & Niehof, A. (2013). Women's autonomy and husbands' involvement in maternal health care in Nepal. Soc Sci Med, 93, 1-10. doi: 10.1016/j.socscimed.2013.06.003

[21]. UNICEF. (2015). Multiple Indicator Cluster Survey (MICS).

[22]. Zegeye, B., Idriss-Wheeler, D., Ahinkorah, B. O., Ameyaw, E. K., Seidu, A. A., Adjei, N. K., & Yaya, S. (2023). Association between women's household decision-making autonomy and health insurance enrollment in sub-saharan Africa. BMC Public Health, 23(1), 610. doi: 10.1186/s12889-023-15434-z