Understanding The Impact of Patriarchal Norms and Socio-Cultural Factors on Women's Access to Public Health Care Services in Rural Kerala

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ABSTRACT

This research explores the complex effects of patriarchal values and other socio-cultural influences on women's access to public healthcare services in Kerala. Although Kerala is recognized as a leader in healthcare within India, characterized by high literacy rates and a strong health infrastructure, entrenched gender roles and societal expectations still obstruct women's autonomy in making healthcare choices. Utilizing a mixed-methods approach, the study collected quantitative data from women who uses public health services and conducted qualitative interviews with few healthcare professionals to develop a comprehensive understanding of the obstacles and facilitators impacting healthcare access. Few Statistical methods, including regression analysis and Chi-Square tests, were employed to investigate relationships between socio-cultural factors and healthcare use. The research also applied thematic analysis to extract insights from the qualitative data, emphasizing how cultural expectations, family relationships, and infrastructural obstacles influence women's healthcare experiences. The results indicate that patriarchal power, typically exerted by male relatives, restricts women's ability to pursue medical treatment, especially in rural regions. Nevertheless, the research highlights indications of positive change, with younger, educated women increasingly gaining control over their health care decisions. The study concludes by recommending focused interventions that tackle both systemic and cultural challenges, advocating for certain policies that enhance gender equality, reinforce healthcare infrastructure, and empower women through financial independence and education.

Keywords: Patriarchal norms, Healthcare Access, Women's autonomy, Public Health Care Services, Cultural Barriers.

1. INTRODUCTION :

Accessing healthcare is a basic human right, yet numerous societal and structural obstacles continue to hinder women's ability to receive timely and adequate healthcare services. These obstacles are often intensified by deeply-rooted patriarchal norms and socio-cultural expectations that affect decision-making within families. The Public Health Care (PHC) system in India plays a crucial role in delivering primary healthcare to a large portion of the population, particularly in rural regions. It is vital to comprehend how cultural and patriarchal norms influence women's use of these services to enhance health outcomes and foster gender equality.

1.1 The Public Health Care System in India

India's healthcare delivery system is organized as a multi-tiered structure including primary, secondary, and tertiary care. At the community level, the Primary Health Care (PHC) system aims to provide accessible, affordable, and fair healthcare services to all, especially to marginalized and rural communities. PHCs act as the initial door of contact for those seeking medical assistance and are essential for preventive, promotive, and curative health services. Despite significant efforts to enhance the PHC infrastructure, issues such as inadequate funding, insufficient resources, and staffing shortages persist. These systemic challenges often disproportionately impact women's health, considering their specific healthcare needs, particularly in areas concerning reproductive and maternal health.

1.2 Healthcare Access in Southern India

Southern states such as Tamil Nadu, Karnataka, and Kerala are frequently regarded as models for healthcare access and outcomes compared to other regions in India. Elevated literacy rates, improved healthcare infrastructure, and forward-thinking policies have resulted in better health indicators. However, even in these relatively advanced states, cultural norms and gender-related disparities continue to present challenges in achieving universal access to healthcare. The PHC system in Southern India exhibits varying levels of efficiency, emphasizing maternal and child health, vaccination initiatives, and the management of non-communicable diseases.

1.3 Healthcare Landscape in Kerala

Kerala is considered as a leading state in public health within India, featuring remarkable health metrics like elevated life expectancy, low rates of infant mortality, and a comprehensive healthcare framework. The state's strong healthcare system, bolstered by a high literacy rate and proactive government policies, has facilitated nearly universal access to primary healthcare. However, traditional patriarchal attitudes and cultural norms still impact women's willingness to seek healthcare. Despite the state's forward-thinking approach to education and gender equality, women in Kerala encounter subtle yet significant obstacles, especially in rural and semi-urban areas where traditional values persist.

1.4 Patriarchal Norms and Healthcare Access

Patriarchal norms in India are often reflected in the dominance of men in decision-making processes, particularly regarding women's health matters. Women's ability to independently access healthcare is often governed by the decisions of male family members, including husbands or fathers. This situation limits women's autonomy and can postpone necessary medical care. Furthermore, the expectations of society that women should prioritize the family responsibilities first over their health worsen the issue, leading to negative health consequences. The effects of these norms vary by factors such as education level, economic status, and the degree of urbanization.

This research intends to investigate how patriarchal norms, along with various socio-cultural and logistical factors, affect women's access to primary healthcare services in Kerala. By exploring the views of both women and healthcare professionals, the study aims to offer a thorough understanding of the obstacles and enablers to accessing healthcare. In addition, the research will analyse emerging trends, like the rising autonomy of women and evolving family structures, which could contribute to more equitable healthcare access.

2. REVIEW OF LITERATURE :

Accessing healthcare is a well-documented determinant of health outcomes, and disparities in healthcare access have been the focus of global health studies for decades. According to Thaddeus and Maine's (1994) "Three Delays Model," the barriers to healthcare can be categorized into delays in seeking care, delays in reaching care, and the delays in receiving adequate care. This model has been mainly useful in understanding the multi-faceted nature of barriers faced by women, especially in patriarchal societies.[1]

Lahariya (2020) examines the potential for transformation offered by Health & Wellness Centers (HWCs) in enhancing primary healthcare across India. The article presents a detailed overview of HWCs established under the Ayushman Bharat initiative, outlining their contributions to preventive, promotive, curative, and rehabilitative healthcare services. Lahariya highlights the significance of community-focused health interventions and stresses the necessity for a well-trained healthcare

workforce to maximize the effectiveness of these centers. The article discusses the advancements achieved so far as well as the strategic pathways for future growth, illustrating how HWCs can help mitigate healthcare inequalities, especially in rural and underserved regions. This research is crucial for comprehending the structural improvements in India's healthcare framework and offers a basis for assessing current and upcoming primary healthcare initiatives.[2]

Mondal, Karmakar, and Banerjee (2020) explore the important connection between women's autonomy in decision-making and their use of maternal healthcare services in India. Utilizing data from the National Family Health Survey conducted in 2015–16, which encompassed 32,698 married women aged 15–49, the research applied both bivariate and multivariate logistic regression analyses. The findings demonstrate a high correlation between higher levels of women's autonomy and an increased utilization of antenatal care (ANC) and postnatal care (PNC) services. Women with enhanced autonomy were notably more likely to seek out these maternal healthcare services. In particular, women with high autonomy displayed a 37% increased likelihood of receiving ANC and a 33% higher probability of obtaining PNC when compared to women with lower levels of autonomy.[3]

Dyson and Moore (1983) present a crucial examination of how kinship systems relate to women's autonomy in India, illustrating the ways in which differences in family and kin structures impact demographic behaviors like fertility and childbirth. Their research magnifies that areas with more equitable kinship systems tend to offer women greater autonomy, which subsequently influences reproductive decisions and population patterns. This initial research established a foundation for comprehending the demographic effects of social customs and family relationships in India.[4]

Self and Grabowski (2012) explore the impact of female autonomy on healthcare decision-making in developing countries, focusing on data from Uttar Pradesh and Bihar in India. Their findings indicate that greater levels of women's autonomy in households significantly enhance the probability of seeking medical assistance from formal healthcare providers instead of traditional sources. The research also underscores the significance of socio-economic factors in influencing healthcare decisions, revealing how variations in economic status affect women's access to adequate medical care.[5]

Narang (2011) examined how patients perceive the quality of public healthcare services in rural India. Utilizing a 23-item scale that demonstrated high reliability (Cronbach's alpha = 0.96), the study uncovered notable socio-demographic differences in healthcare experiences. Participants expressed dissatisfaction with factors such as the accessibility of sufficient medical equipment and the availability of female doctors. The findings indicated that elements such as education, gender, and income significantly shaped user perceptions, underscoring the need for reforms aimed at enhancing the healthcare experience and rebuilding trust in public health services.[6]

Singh et al. (2023) offer an extensive examination of the differences in healthcare access between genders in India. Although the country has made strides since gaining independence over 75 years ago, substantial gaps still exist, with women encountering significant challenges in comparison to men when seeking appropriate healthcare. The authors conduct a systematic literature review adhering to PRISMA guidelines to investigate crucial factors such as accessibility, usage, health-seeking behavior, and gender inequalities. The review underscores the critical need for healthcare policies that consider gender and highlights how economic and social frameworks contribute to maintaining these inequalities. The study recommends strategic modifications to current healthcare policies to effectively tackle these disparities.[7]

Allendorf (2013) explores how family structure relates to the health outcomes of young women in India from 1992 to 2006. The research highlights the differences in health experiences between those living in nuclear families versus those in extended families, stressing how changes in family dynamics affect health-related behaviors and results. The results show that young women in nuclear families tend to have superior health metrics, as they typically enjoy increased autonomy and experience less pressure from traditional familial expectations. This study illuminates how changing family structures in India are progressively altering women's autonomy and their patterns of accessing healthcare.[8]

Cassels (1995) addresses key issues regarding health sector reform in developing nations, outlining the obstacles and possibilities for enhancing healthcare delivery. The paper stresses the necessity of achieving a balance between efficiency and equity, the importance of sustainable financing, and the effects of health sector reforms on at-risk populations. Cassels highlights the difficulties of enacting

reforms in resource-limited environments and asserts that reform strategies need to be tailored to specific contexts, considering the socio-economic and cultural dynamics of the population.[9]

Baru, Acharya, Acharya, Kumar, and Nagaraj (2010) present a thorough exploration of the disparities in healthcare access in India, concentrating on caste, class, and regional inequalities. The study emphasizes how marginalized groups frequently encounter systemic obstacles that hinder their access to fair healthcare. It illustrates the interplay between socio-economic status and regional variations in exacerbating these disparities, underscoring the necessity for policy measures that tackle the fundamental causes of these inequalities and promote a more inclusive healthcare framework.[10]

Balagopal (2009) conducts an in-depth analysis of the gaps between healthcare policies and the actual requirements of impoverished elderly women in India. The research identifies the systemic challenges these women encounter, including economic reliance, social exclusion, and restricted mobility, which obstruct their access to necessary healthcare services. The study points out that existing healthcare policies often neglect a gendered and age-sensitive approach, failing to consider the socio-economic vulnerabilities faced by elderly women. Furthermore, Balagopal argues for the implementation of targeted strategies such as community-based healthcare initiatives and financial support schemes to bridge this gap. The findings indicate that without such reforms, healthcare disparities will persist, leaving elderly women with significant unmet medical needs.[11]

The research conducted by Ravi and Kulasekaran (2014) investigates the barriers that women in rural Tamil Nadu encounter when seeking care for sexual health issues. The study reveals a variety of major obstacles, including the normalization of symptoms, societal stigma, a shortage of female healthcare providers, the considerable distances to medical facilities, and inadequate treatment availability. These barriers stem from socio-cultural customs and economic limitations, highlighting the urgent need for focused awareness initiatives and improved healthcare infrastructure. The findings underscore how deep-rooted cultural beliefs and economic challenges continue to impede women's access to vital sexual health services, even in regions showing improvements in health services.[12]

In the study by Surendran et al. (2024), the focus is on the accessibility and usage of public healthcare among hard-to-reach populations in Kerala, a state recognized for its outstanding health metrics. Despite Kerala’s progressive healthcare reforms aimed at achieving universal coverage, ongoing challenges related to physical access, availability of services, and infrastructural shortcomings persist. By employing qualitative data from focus group discussions, the research identifies cost-effectiveness and insurance coverage as significant factors influencing the choice of public healthcare, while also pinpointing barriers such as lack of transport and lengthy waiting periods for specialized services. The paper calls for targeted strategies that cater to marginalized groups, indicating that Kerala must further adapt to the requirements of vulnerable communities to meet its health equity objectives.[13]

Dana and Banerjee (2024) examined gendered health disparities in Uttar Pradesh (UP) and Kerala, highlighting the socio-political and demographic factors influencing women's healthcare access. Their study found stark differences between the two states, with Kerala demonstrating greater progress in healthcare outcomes due to regional development, social activism, and women's empowered social roles. In contrast, UP lagged in women's healthcare access, largely due to entrenched socio-political barriers and gender biases. The authors emphasized the necessity of targeted policy interventions to address these inequalities and support universal healthcare coverage, reinforcing the principle of health as a fundamental right for all.[14]

Kumar and Devi (2010) explored the health status of women in Kerala, highlighting the state's leading position in human development, social development indices, and gender equality metrics in India. Despite Kerala's reputation as a model of "good health at low cost," the study pointed out persistent inequalities in public health, particularly along rural-urban lines. The authors identified key determinants affecting women's health, including child health, morbidity, and elderly care. They also emphasized the emerging health needs of marginalized groups such as the aged, widowed, and those with occupational health concerns. This study underscores the complex interplay between socio-economic factors and women's healthcare access, reinforcing the need for targeted health interventions.[15]

Spence and Suresh (2024) examined the deep-rooted issue of dowry practices in Kerala, highlighting the socio-cultural and legal challenges associated with addressing dowry-related harassment and violence. Despite Kerala's progressive stance on many social issues, the study reveals a persistent

culture of dowry, contributing to cases of harassment, violence, and even dowry-related deaths. The authors argue for stronger legal enforcement and better support systems for victims, suggesting that legal measures alone are insufficient without broader societal and cultural reforms. This study aligns with the broader narrative of patriarchal influences impacting women's autonomy and safety in Kerala.[16]

Kiran and Singh (2025) highlight the unique healthcare challenges faced by Muslim women in India due to the intersectionality of gender and religion. The study explores how socio-economic constraints and cultural norms limit healthcare accessibility for Muslim women, particularly in the Varanasi district. The authors emphasize the need for targeted healthcare policies that address these disparities, advocating for culturally sensitive interventions to improve healthcare outcomes for this vulnerable group.[17]

Bhagawati (2020) conducted a comprehensive analysis of how socio-cultural and gender constructs affect women's health in India. The study highlights that women's health is not merely influenced by biological factors but is deeply rooted in the socio-cultural and psychological contexts of Indian society. The paper argues that the societal expectations surrounding women's roles, particularly within conservative cultural settings, often prioritize family and social responsibilities over individual health needs. This results in reduced autonomy and delayed healthcare-seeking behavior among women. The research also points out that variables such as family dynamics, educational attainment, occupational structure, and social support significantly influence women's health outcomes.[18]

Bishwajit, Sarker, and Yaya (2016) explore the socio-cultural dimensions of gender-based violence (GBV) and its profound impact on women's health in South Asia. The review highlights how entrenched cultural norms and patriarchal structures perpetuate violence against women, which in turn severely affects their physical and mental health. The study underscores the gaps in policy and practice regarding gender-sensitive health interventions and emphasizes the need for targeted social policies to address these systemic issues.[19]

Mumtaz and Salway (2009) explore the gendered influences on women's reproductive health in rural Punjab, Pakistan, challenging the traditional autonomy paradigm. Their study highlights how social, cultural, economic, and political inequalities limit women's access to reproductive health services. Using ethnographic data, including interviews, case studies, and focus group discussions, they reveal how factors such as women's indecision, lack of attention to gender dynamics, and societal expectations contribute to health inequities. The authors advocate for a broader theoretical framework that considers gender relations, socioeconomic status, and cultural contexts in understanding and improving women's reproductive health.[20]

Islam and Shahariar (2020) conducted an anthropological study to examine the socio-cultural interpretations of women's reproductive illness in patriarchal societies. The study highlights how social, cultural, financial, and political contexts influence women's attitudes toward their reproductive health. Factors such as family status, women's literacy, employment, and husband's education significantly affect women's reproductive health behaviors. The study also emphasizes how socio-cultural norms create barriers for women to discuss reproductive issues openly, with family planning and media influence playing crucial roles in shaping health outcomes. The research suggests that patriarchal norms often restrict women's autonomy in health-related decision-making.[21]

Fusari and Veeramani (2016) explored the impact of socio-economic status on women's well-being, focusing on how social cleavages such as class, caste, gender, religion, and ethnicity differentially affect health outcomes. The study emphasizes that gender imbalances in health status are prevalent in both traditional and complex societies, particularly in developing and developed nations. It highlights how low social status and restricted access to modern healthcare significantly impact women's health, with particular attention to the consequences of female genital mutilation (FGM), sexual transmitted diseases (STDs), and malnutrition. The research utilizes diverse case studies to illustrate how women's health issues vary depending on socio-economic status and living environments, underscoring the need for gender-sensitive health policies.[22]

Kumari (2024) explored the multifaceted issue of marginalization in women's healthcare in Ghana, examining its colonial origins and contemporary implications. The study highlights how colonial policies historically marginalized women by prioritizing healthcare for European settlers and disregarding indigenous knowledge and practices. The research emphasizes that these colonial legacies

continue to affect healthcare accessibility for women, particularly in rural areas where disparities in access to medical services remain significant. The study also advocates for empowering women's voices in healthcare decisions and integrating indigenous knowledge into modern healthcare systems to promote gender equity and improved health outcomes.[23]

Bhandari and Chan (2016) examined socio-cultural inequality in women's health service utilization in Nepal, focusing on antenatal care (ANC) within a patriarchal society. The study utilized data from the Nepal Demographic Health Survey (NDHS) 2011, employing multilevel logistic regression to assess the influence of caste/ethnicity and household wealth on women's healthcare utilization. Results indicated that women from disadvantaged caste/ethnicities, such as Hill Janajati, Hill and Terai Dalit, and Muslims, were significantly less likely to access adequate antenatal care compared to the advantaged Bahun/Chhetri mothers. Economic status also played a critical role, with wealthier mothers having better access to healthcare services. The study challenges the assumption that advantaged caste/ethnicities always enjoy better health outcomes, highlighting the need for health policies that address the complex interplay of caste and economic factors to improve women's health in Nepal.[24]

Das et al. (2018) explored gendered experiences in health-seeking behavior in an urban slum of Kolkata, India. The study focused on how gender elements, such as social status, ideology, marital status, and social norms, influence health-seeking practices among men and women. Using semi-structured interviews in Sahid Smriti Colony, the study identified cultural competency, gender-induced affordability, avoidance of social stigma, and ease of access as significant factors influencing women's preference for informal healthcare providers. The research highlighted the contrast in health-seeking behavior between men and women, emphasizing how socio-cultural norms shape these decisions and impact healthcare access in a peri-urban Indian context.[25]

Tomar et al. (2024) conducted a qualitative study to assess the socio-cultural barriers to induced abortion and reproductive health among married women in rural Uttar Pradesh, India. The study highlighted the complex interplay of social, familial, and healthcare-related challenges that hinder women's access to safe and quality reproductive healthcare services. Key findings included low male involvement in reproductive health matters, a high demand for contraception, poor healthcare quality, financial hardships, and strong social norms influencing reproductive choices. The study called for targeted policy interventions to enhance male involvement in reproductive health and improve access to safe abortion practices and comprehensive reproductive healthcare services.[26]

Rituraj and Jha (2025) explored the critical role of male involvement in reproductive health and rights in India. The study highlighted how the traditional perception of reproductive health as solely a woman's responsibility reinforces gender inequality and restricts women's autonomy. The authors emphasized that a lack of male engagement perpetuates societal norms that marginalize women, impacting their health and overall well-being. They argued for increased male participation in reproductive health matters as a necessary step towards achieving gender equality and empowering women.[27]

3. OBJECTIVES OF THE STUDY :

(1) To evaluate how patriarchal norms affect women's choices regarding healthcare in Kerala.
(2) To investigate practical obstacles like the distance to healthcare facilities and how these challenges influence the frequency of healthcare visits.
(3) To analyze the role of family dynamics, particularly the influence of male family members, on women's access to healthcare.
(4) To understand the perspectives of healthcare providers on cultural and gender-based barriers to healthcare access.
(5) To explore emerging trends of autonomy among women in healthcare-seeking behaviors.

3.1 Importance of the Research

Recognizing how cultural norms, gender dynamics, and access to healthcare intersect is vital for creating effective interventions and policies. This research will offer important insights into the specific challenges encountered by women in Kerala, a state frequently lauded for its healthcare successes. The results could guide policymakers and healthcare professionals to the necessity of gender-sensitive healthcare services and highlight the need to tackle patriarchal norms in order to enhance women’s health outcomes.

3.2 Hypothesis

H1: Cultural norms and patriarchal influences significantly limit women's access to healthcare services.
H2: Family influence, especially from male figures, restricts women's healthcare decision-making autonomy.
H3: A notable relationship exists between the proximity of healthcare facilities and how often individuals visit them.
H4: Women who feel at ease talking about health topics with male relatives are less prone to indicating that they face gender discrimination.
H5: The existence of a primary male figure in the home has a substantial impact on whether women have someone accompany them to healthcare appointments.

4. RESEARCH METHODOLOGY :

4.1 Research Design

This study mainly employs a mixed-methods approach, integrating both qualitative and quanitative approaches to provide a detailed understanding of the impact of patriarchal norms and other socio-cultural factors on women's access to public healthcare services in Kerala. The mixed-methods approach is particularly suited to this research because it enables the triangulation of data from different sources, enhancing the validity and depth of the findings. By combining numerical data with rich, contextual insights from healthcare providers, the study aims to paint a holistic picture of the healthcare access landscape for women in Kerala.

4.2 Study Area and Population

The research is carried out in Kerala, a southern Indian state which is famous for its advanced healthcare system and high literacy levels. Nevertheless, in spite of these advancements, traditional patriarchal values and cultural factors continue to create notable barriers to women's access to healthcare. The research's target demographic consists of two primary groups: (1) women utilizing public healthcare services, specifically Primary Health Centers (PHCs), and (2) public healthcare professionals, including doctors and other staff members working in these institutions. The study emphasizes both urban and rural environments to explore differences in healthcare accessibility across various socio-economic and cultural backgrounds.

4.3 Sampling Techniques

Quantitative Sampling: A stratified random sampling technique was used to select 72 women from various rural areas of the state.. Women were selected based on their willingness to participate and were recruited during their visits to PHCs too.
Qualitative Sampling: For the qualitative component, a purposive sampling method was employed to select 7 healthcare providers. These providers were chosen based on their experience, the type of healthcare services they offer, and their interactions with female patients. The goal was to obtain diverse perspectives from doctors, nurses, and administrative staff to understand how healthcare delivery is affected by gender norms.

4.4 Data Collection Methods

Quantitative Data Collection: A structured survey was given to the female participants. The survey contained sections regarding demographic details, healthcare-seeking behaviors, decision-making independence, obstacles to accessing healthcare, and views on the quality of healthcare. The questions were crafted to measure elements like the distance to healthcare centers, the frequency of visits, and the impact of male family members on decisions related to healthcare.
Qualitative Data Collection: Semi-structured interviews were conducted with the selected healthcare providers. The interview guide included open-ended questions about the challenges they face in providing healthcare to women, the cultural and religious norms they observe in their practice, and their perceptions of gender biases within the healthcare system.

4.5 Data Analysis Methods

Quantitative Data Analysis: The quantitative data were analysed using SPSS software. Descriptive statistics (mean, median, mode, standard deviation) were used to summarize the data. Inferential statistics, including Chi-Square tests, correlation analysis, and regression analysis, were conducted to examine the relationships between patriarchal norms, healthcare access, and socio-economic factors.
Hypothesis Testing: Specific hypotheses were tested to determine the significance of the relationships between variables. For example, the relationship between the influence of male family members and healthcare decision-making autonomy was tested using regression analysis.
Qualitative Data Analysis: The qualitative data from interviews and focus groups were analysed using thematic analysis. The data were transcribed, coded, and categorized into themes such as cultural barriers, family influence, resource limitations, and gender biases.
Triangulation: The findings from the qualitative data were triangulated with the quantitative results to ensure consistency and to provide a richer understanding of the research questions.

4.6 Ethical Considerations

Participants were given information about the purpose of the study, their right to withdraw at any time, and the confidentiality of their responses. Informed consent was obtained from all participants, and pseudonyms were used to protect their identities. Special attention was given to creating a safe and respectful environment during interviews and focus groups, especially given the sensitive nature of some of the questions.

4.7 Limitations of the Study

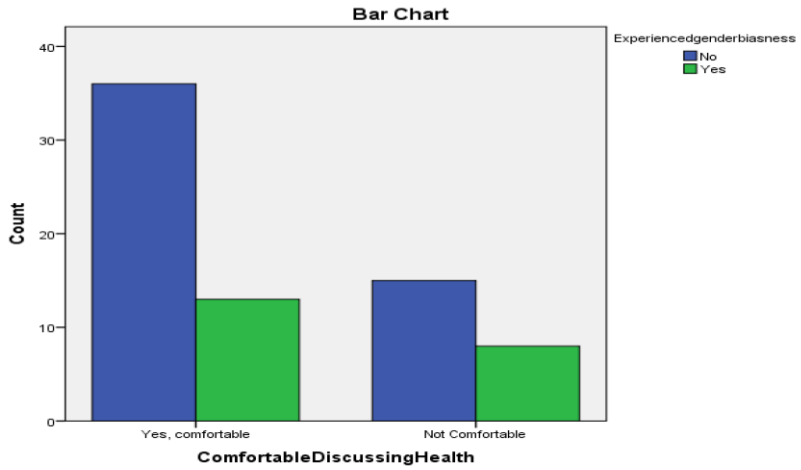
Sampling Limitations: The study's findings may not be generalizable beyond the state of Kerala or to populations that do not use public healthcare services.
Potential Response Bias: Women may have underreported or overreported their experiences due to cultural stigma or fear of repercussions from male family members.
Resource Constraints: The study was limited by the availability of healthcare providers willing to participate in in-depth interviews and the logistical challenges of accessing remote PHCs.

5. ANALYSIS AND INTERPRETATIONS :

ComfortableDiscussingHealth * Experiencedgenderbiasness Crosstabulation

Count

		Experiencedgenderbiasness		
		No	Yes	Total
ComfortableDiscussingHealth	Yes, comfortable	36	13	49
	Not Comfortable	15	8	23
Total		51	21	72



- Comfortable Discussing Health Issues and No Gender Bias: 36 women who are comfortable discussing health issues with male family members reported not experiencing gender bias.
- Comfortable Discussing Health Issues and Yes Gender Bias: 13 women who are comfortable discussing health issues with male family members reported experiencing gender bias.
- Not Comfortable Discussing Health Issues and No Gender Bias: 15 women who are not comfortable discussing health issues with male family members reported not experiencing gender bias.
- Not Comfortable Discussing Health Issues and Yes Gender Bias: 8 women who are not comfortable discussing health issues with male family members reported experiencing gender bias.

1. Higher Comfort Level with Male Family Members:

A larger number of respondents (49 out of 72) reported being comfortable discussing health issues with male family members.

Among these, a significant majority (36 out of 49) did not experience gender bias, while 13 did.

2. Lower Comfort Level with Male Family Members:

A smaller group (23 out of 72) reported being not comfortable discussing health issues with male family members.

Within this group, 15 women did not experience gender bias, while 8 did.

CulturalNormsLimitAccessA * Healthcaredecisionmaker Crosstabulation

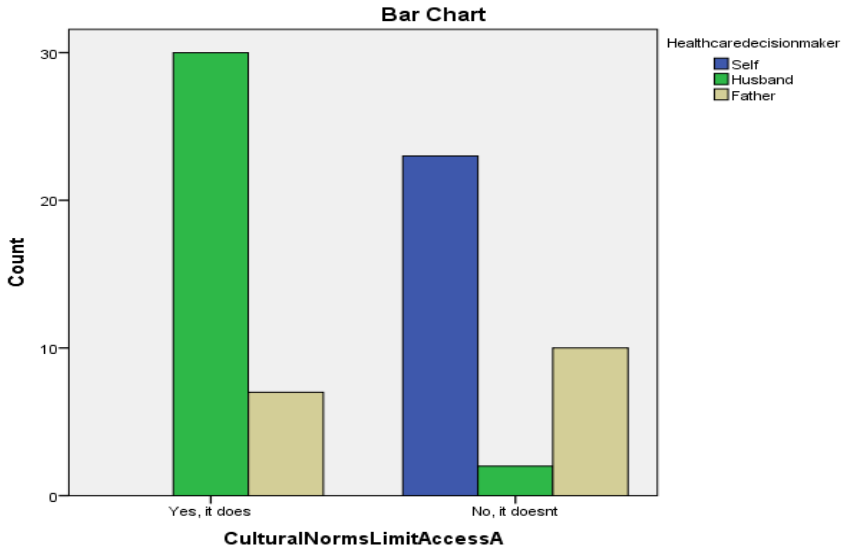
Count

		Healthcaredecisionmaker			
		Self	Husband	Father	Total
CulturalNormsLimitAccessA	Yes, it does	0	30	7	37
	No, it doesnt	23	2	10	35
Total		23	32	17	72

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	48.011[a]	2	.000
Likelihood Ratio	61.760	2	.000
Linear-by-Linear Association	10.161	1	.001
N of Valid Cases	72		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 8.26.



When cultural norms do limit access:

- Self: 0 respondents
- Husband: 30 respondents
- Father: 7 respondents

When cultural norms do not limit access:

- Self: 23 respondents
- Husband: 2 respondents
- Father: 10 respondents

5.1 Interpretation of Chi-Square Test

1. Pearson Chi-Square Value: 48.011 with a p-value of 0.000.
   The p-value (0.000) is less than 0.05, indicating a highly significant association between cultural norms limiting access and the healthcare decision-maker. This means there is a strong relationship between these variables.
2. Likelihood Ratio: 61.760 with a p-value of 0.000.
   This reinforces the significant association.
3. Linear-by-Linear Association: 10.161 with a p-value of 0.001.
   This indicates a significant linear relationship between cultural norms limiting access and the healthcare decision-maker.

InfluenceofFamilyF

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	46	63.9	63.9	63.9
	Yes	26	36.1	36.1	100.0
	Total	72	100.0	100.0	

Healthcaredecisionmaker

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Self	23	31.9	31.9	31.9
	Husband	32	44.4	44.4	76.4
	Father	17	23.6	23.6	100.0
	Total	72	100.0	100.0	

comfortdiscussingmentslhealth

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	69	95.8	95.8	95.8
	No	3	4.2	4.2	100.0
	Total	72	100.0	100.0	

Distancetohealthcare * Frequencyofvisits Crosstabulation

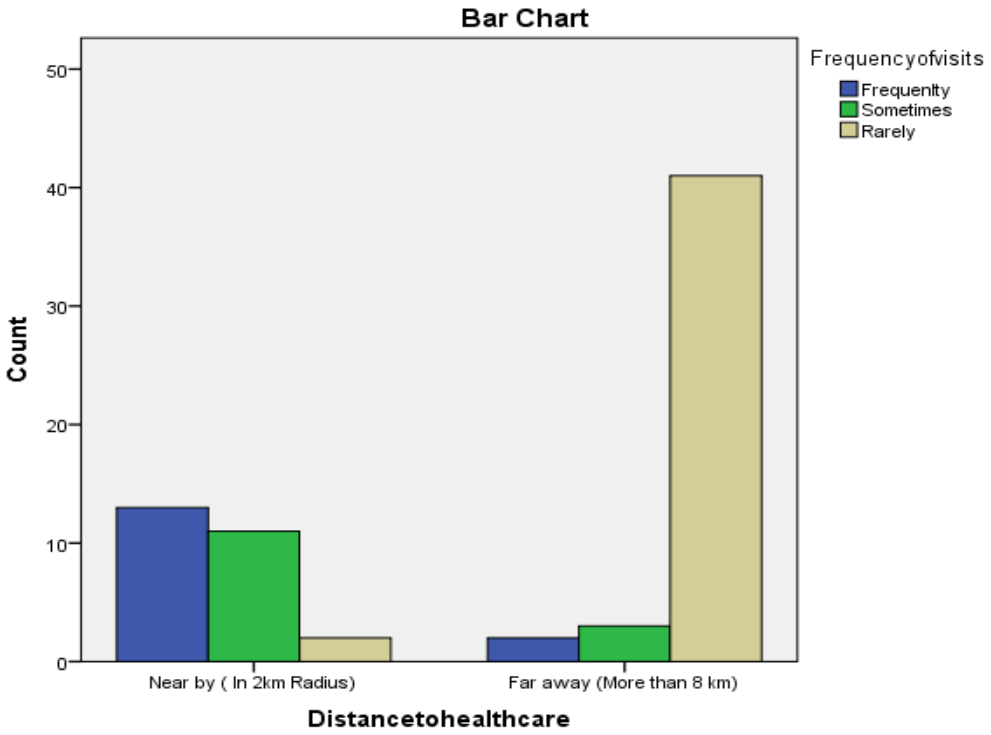
Count

		Frequencyofvisits			
		Frequenlty	Sometimes	Rarely	Total
Distancetohealthcare	Near by (In 2km Radius)	13	11	2	26
	Far away (More than 8 km)	2	3	41	46
Total		15	14	43	72

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	46.004[a]	2	.000
Likelihood Ratio	51.678	2	.000
Linear-by-Linear Association	42.733	1	.000
N of Valid Cases	72		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 5.06.



Interpretation of Crosstabulation and Chi-Square Test Results
Crosstabulation Table: Distance to Healthcare and Frequency of Visits

- Categories of Distance to Healthcare:

Nearby (In 2km Radius):

- Frequently: 13 respondents
- Sometimes: 11 respondents
- Rarely: 2 respondents

Far away (More than 8 km):

- Frequently: 2 respondents
- Sometimes: 3 respondents
- Rarely: 41 respondents
- Total:

Frequently: 15 respondents
Sometimes: 14 respondents
Rarely: 43 respondents

Chi-Square Test Results

- Pearson Chi-Square Value: 46.004, p = 0.000
  The significant p-value (0.000) indicates that there is a statistically significant relationship between the distance to healthcare and the frequency of visits.
- Likelihood Ratio: 51.678, p = 0.000
  This supports the significance of the association.
- Linear-by-Linear Association: 42.733, p = 0.000
  Indicates a strong linear relationship between the variables.
  Interpretation
- Statistically Significant Relationship: The analysis reveals that the distance to healthcare facilities significantly impacts the frequency of visits. Specifically, individuals living farther away (more than 8 km) are less likely to visit healthcare facilities frequently, as indicated by the higher count in the "Rarely" category.
- Practical Implication: This finding suggests that improving access to nearby healthcare facilities may increase the frequency of healthcare visits among the population.

5.2 Anova

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	49.648	3	16.549	3.190	.029[b]
	Residual	352.797	68	5.188		
	Total	402.444	71			

a. Dependent Variable: Frequencyofvisits
b. Predictors: (Constant), Primarymalefigure, Healthcaredecisionmaker, Education

5.3 Interpretation of Regression Analysis Results

The regression analysis examines how variables such as Primary Male Figure, Healthcare Decision-Maker, and Education predict the Frequency of Visits to healthcare facilities. Here's a detailed breakdown of the results:

Model Summary and Significance

- Regression Model:

Sum of Squares (Regression): 49.648
Degrees of Freedom (df): 3
Mean Square (Regression): 16.549

- Residual (Error):

Sum of Squares (Residual): 352.797
Degrees of Freedom (df): 68
Mean Square (Residual): 5.188

- Total Sum of Squares: 402.444 (This is the total variability in the Frequency of Visits)

F-Statistic and Significance

- F-Value: 3.190
- Significance (p-value): 0.029

Interpretation of the F-Test:

- The F-value (3.190) indicates the overall strength of the regression model in predicting the Frequency of Visits.
- The p-value (0.029) is less than 0.05, indicating that the regression model is statistically significant at the 5% significance level. This means that the combination of Primary Male Figure, Healthcare Decision-Maker, and Education significantly predicts the frequency of healthcare visits. In other words, at least one of the predictors has a meaningful effect on how often respondents visit healthcare facilities.

WomenIndependentlyDecideD

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	40	55.6	55.6	55.6
	Yes	32	44.4	44.4	100.0
	Total	72	100.0	100.0	

CulturalNormsLimitAccessA

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	28	38.9	38.9	38.9
	Yes	44	61.1	61.1	100.0
	Total	72	100.0	100.0	

FamilyInfluenceRestrictsDecisionB

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	27	37.5	37.5	37.5
	Yes	45	62.5	62.5	100.0
	Total	72	100.0	100.0	

CulturalNormsDontAffectAccessC

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	49	68.1	68.1	68.1
	Yes	23	31.9	31.9	100.0
	Total	72	100.0	100.0	

Cultural Norms Limit Access (Variable A)

- **No**: 28 respondents (38.9%)
- **Yes**: 44 respondents (61.1%)
- **Total**: 72 respondents

Interpretation:

- The majority of respondents (61.1%) agree that cultural norms and expectations limit access to healthcare services. This suggests that a significant proportion of women in the study experience barriers to healthcare due to cultural expectations.

Family Influence Restricts Decision-Making (Variable B)

- **No**: 27 respondents (37.5%)
- **Yes**: 45 respondents (62.5%)
- **Total**: 72 respondents

Interpretation:

- Most respondents (62.5%) indicate that family influence restricts women's decision-making in healthcare. This highlights the impact of family dynamics, likely reflecting patriarchal norms, on women's healthcare autonomy.

Cultural Norms Do Not Affect Access (Variable C)

- **No**: 49 respondents (68.1%)
- **Yes**: 23 respondents (31.9%)
- **Total**: 72 respondents

Interpretation:

- A large proportion of respondents (68.1%) disagree that cultural norms do not affect healthcare access, meaning they perceive cultural norms as having a significant impact on healthcare access. Only 31.9% believe that cultural norms do not restrict access.

5.4 Overall Insights

- **Patriarchal Influence**: The high percentage of "Yes" responses for the first two variables (Cultural Norms Limit Access and Family Influence Restricts Decision-Making) indicates that patriarchal and family influences are significant barriers to healthcare access and decision-making for women.
- **Impact of Cultural Norms**: The third variable (Cultural Norms Do Not Affect Access) reinforces the idea that cultural norms are perceived as barriers by the majority of respondents.
  These descriptive statistics provide a clear picture of the perceived influence of cultural and family norms on healthcare access among the respondents.

Primarymalefigure * Maleaccompanies Crosstabulation

Count

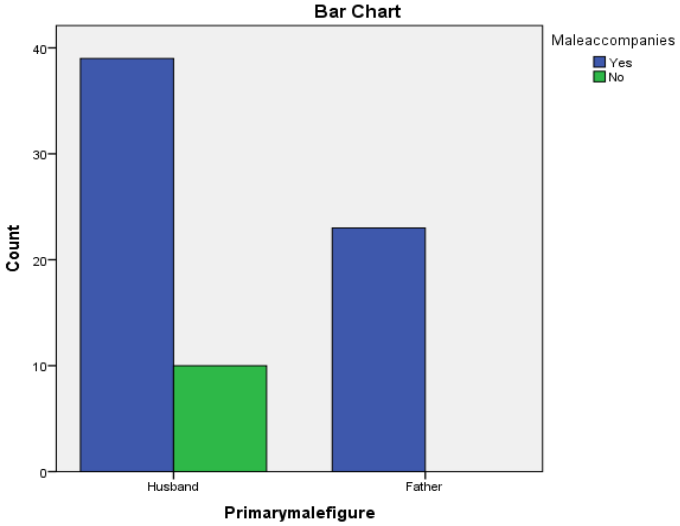
		Maleaccompanies		
		Yes	No	Total
Primarymalefigure	Husband	39	10	49
	Father	23	0	23
Total		62	10	72

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5.451[a]	1	.020		
Continuity Correction[b]	3.878	1	.049		
Likelihood Ratio	8.435	1	.004		
Fisher's Exact Test				.025	.015
Linear-by-Linear Association	5.375	1	.020		
N of Valid Cases	72				

a. 1 cells (25.0%) have expected count less than 5. The minimum expected count is 3.19.

b. Computed only for a 2x2 table



5.5 Interpretation of Chi-Square Test

1. Pearson Chi-Square Value: 5.451 with a p-value of 0.020.

The p-value (0.020) is less than 0.05, indicating that there is a statistically significant association between the Primary Male Figure and whether they accompany the respondent to healthcare visits.

2. Continuity Correction: 3.878 with a p-value of 0.049.

The corrected p-value (for a 2x2 table) is also significant at the 0.05 level, providing further evidence of the relationship.

3. Likelihood Ratio: 8.435 with a p-value of 0.004.

This is highly significant, strengthening the evidence of a relationship between the variables.

4. Fisher's Exact Test: p-value of 0.025.

Fisher's Exact Test, which is considered more apt for smaller sample sizes or when expected counts are low, also indicates a significant association.

5. Linear-by-Linear Association: 5.375 with a p-value of 0.020.

This shows a significant linear association among the variables.

LackofTransportationA

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	16	22.2	22.2	22.2
	Yes	56	77.8	77.8	100.0
	Total	72	100.0	100.0	

CostofTreatmentB

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.0	16	22.2	22.2	22.2
	Yes	56	77.8	77.8	100.0
	Total	72	100.0	100.0	

LackofAwarenessD

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	20	27.8	27.8	27.8
	Yes	52	72.2	72.2	100.0
	Total	72	100.0	100.0	

FearofDiscriminationC

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.0	42	58.3	58.3	58.3
	No	30	41.7	41.7	100.0
	Total	72	100.0	100.0	

HomeRemediesE

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	54	75.0	75.0	75.0
	Yes	18	25.0	25.0	100.0
	Total	72	100.0	100.0	

InfluenceofFamilyF

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	46	63.9	63.9	63.9
	Yes	26	36.1	36.1	100.0
	Total	72	100.0	100.0	

5.6 Interpretation of the Descriptive Statistics

1. N (Valid):

Each variable has 72 valid cases, indicating that there are no missing values in the dataset.

2. Mean:

The mean represents the proportion of respondents who answered "Yes" (coded as 1) for each reason.
Lack_of_Transportation and Cost_of_Treatment have the highest means (0.778), indicating that approximately 77.8% of respondents cited these as barriers.
Lack_of_Awareness has a mean of 0.722, meaning about 72.2% of respondents consider lack of awareness a reason for not seeking healthcare.
Fear_of_Discrimination has a mean of 0.417, indicating that 41.7% of respondents reported discrimination as a barrier.
HomeRemedies has a mean of 0.250, showing that 25% prefer home remedies.
Influence_of_Family has a mean of 0.361, meaning 36.1% reported family influence as a barrier.

3. Standard Deviation:

Lack_of_Transportation and Cost_of_Treatment have a lower standard deviation (0.4187), indicating less variability in responses.
Fear_of_Discrimination and Influence_of_Family have higher standard deviations, showing more variability in responses.

4. Minimum and Maximum:

All variables are binary, coded as 0 (No) and 1 (Yes).
Lack of Transportation and Cost of Treatment are the most frequently reported barriers, each affecting over 75% of respondents.
Lack of Awareness is also a significant concern, with over 70% citing it as a reason for not seeking healthcare.
Fear of Discrimination, Preference for Home Remedies, and Influence of Family Members are less frequently reported but still notable, with 25-41.7% of respondents mentioning them.

6. RESULTS :

6.1 Descriptive Statistics

Barriers to Healthcare Access:
Lack of Transportation: 77.8% (Mean = 0.778, SD = 0.4187)
Cost of Treatment: 77.8% (Mean = 0.778, SD = 0.4187)
Lack of Awareness: 72.2% (Mean = 0.722, SD = 0.4510)
Fear of Discrimination: 41.7% (Mean = 0.417, SD = 0.4965)
Preference for Home Remedies: 25% (Mean = 0.250, SD = 0.4361)
Influence of Family Members: 36.1% (Mean = 0.361, SD = 0.4837)
Interpretation: The most frequently reported barriers were lack of transportation and cost of treatment, affecting over 75% of respondents. Lack of awareness also emerged as a significant concern.

6.2 Chi-Square Analysis

Cultural Norms Limiting Access and Healthcare Decision-Maker:
Chi-Square Value: 48.011, p = 0.000
Significance: Indicates a strong relationship between cultural norms and healthcare decision-making. Husbands primarily made decisions when cultural norms limited access.
Distance to Healthcare and Frequency of Visits:
Chi-Square Value: 50.041, p = 0.000
Significance: Demonstrates that distance significantly affects the frequency of visits. Individuals living farther away are less likely to visit healthcare facilities frequently.
Primary Male Figure and Male Accompaniment:
Chi-Square Value: 5.451, p = 0.020
Significance: Indicates that the primary male figure significantly influences whether women are accompanied to healthcare visits.

6.3 Regression Analysis

Predictors of Frequency of Visits:
F-Value: 3.190, p = 0.029
Predictors: Primary Male Figure, Healthcare Decision-Maker, Education
Significance: The regression model is significant, which suggests that these variables collectively influence the frequency of healthcare visits.

6.4 Cross-Tabulations

Comfort Discussing Health Issues and Gender Bias:
Results: Women comfortable discussing health issues with male family figures reported lower rates of gender bias.
Influence of Family Members and Healthcare Decision-Maker:
Results: Family influence was significant in restricting healthcare decision-making, highlighting patriarchal control.

6.5 Hypothesis Rejection

H1: Cultural norms and patriarchal influences significantly limit women's access to healthcare services.

Null Hypothesis (H0): Cultural norms and patriarchal influences do not significantly limit women's access to healthcare services.
Result: The Chi-Square analysis showed a significant association (p = 0.000), indicating that cultural norms do limit healthcare access.
Conclusion: The null hypothesis is rejected, supporting H1.

H2: Family influence, especially from male figures, restricts women's healthcare decision-making autonomy.

Null Hypothesis (H0): Family influence, particularly from male figures, does not restrict women's healthcare decision-making autonomy.
Result: Analysis showed significant associations between the healthcare decision-maker and family influence variables, indicating strong patriarchal control.
Conclusion: The null hypothesis is rejected, supporting H2.

H3: There is a significant association between the distance to healthcare facilities and the frequency of healthcare visits.

Null Hypothesis (H0): There is no significant association between the distance to healthcare facilities and the frequency of healthcare visits.
Result: The Chi-Square analysis confirmed a significant relationship (p = 0.000) between distance and visit frequency.
Conclusion: The null hypothesis is rejected, supporting H3.

H4: Women who are comfortable discussing health issues with male family members are less likely to report experiencing gender bias.

Null Hypothesis (H0): Comfort in discussing health issues with male family members does not relate to experiencing gender bias.
Result: The data showed a notable difference, with women more comfortable discussing health issues experiencing less gender bias.
Conclusion: The null hypothesis is rejected, supporting H4.

H5: The presence of a primary male figure in the household significantly influences whether women are accompanied to healthcare visits.

Null Hypothesis (H0): The presence of a primary male figure in the household does not influence accompaniment to healthcare visits.
Result: The Chi-Square analysis indicated a significant effect (p = 0.020), showing that the type of male figure present does influence accompaniment.
Conclusion: The null hypothesis is rejected, supporting H5.

7. IMPLICATIONS OF THE FINDINGS :

Addressing Transportation and Cost: Interventions should prioritize reducing transportation and cost

barriers. Awareness Campaigns: Increasing awareness about healthcare services can improve access.Cultural and Family Dynamics: Addressing cultural norms and patriarchal influences is essential to improve women's autonomy in healthcare decisions.

Policy Recommendations: Develop targeted policies that consider family dynamics and cultural factors impacting healthcare access.

The data enlights that women who feel comfortable discussing health issues with their male family members are less likely to report experiencing gender bias compared to those who are not comfortable. This could indicate that comfort in discussing health matters with their male family members may be associated with a perceived or real reduction in experiencing gender bias.

However, there is still a notable proportion (13 out of 49) of women who, despite being comfortable discussing health issues, reported experiencing gender bias. This indicates that comfort in communication does not entirely eliminate the experience of gender bias in healthcare settings. Women who feel less comfortable discussing health issues with male family members are comparitively more likely to experience gender bias (8 out of 23), which may highlight a potential barrier to equitable healthcare access.

Statistically Significant Association: The results show a high amount of significant relationship between cultural norms limiting access and who makes healthcare decisions. Specifically:

When cultural norms limit access, husbands overwhelmingly make healthcare decisions (30 out of 37).

When cultural norms do not limit access, women are more likely to make decisions themselves (23 out of 35).

Patriarchal Influence: The data suggests that patriarchal norms, represented by husbands making healthcare decisions, are prominent when cultural norms limit access. In contrast, when cultural norms do not restrict access, women are far more likely to make decisions independently.

The findings highlight the influence of different male figures in healthcare decision-making and accompaniment behaviour. This could have implications for understanding family dynamics and designing interventions to improve healthcare access.

The significant regression model suggests that socioeconomic and patriarchal variables (like the presence of a primary male figure and healthcare decision-making dynamics) influence the frequency of healthcare visits.

Education also plays a role, though the specific contributions of each predictor would require examining the individual coefficients (not provided in the summary).

Examine Individual Predictor Coefficients: To understand which specific variable has the most substantial impact on the frequency of visits, look at the coefficients table, which will provide:

Beta values to indicate the strength and direction of each predictor’s effect.

Significance values for each predictor to determine if they are statistically significant individually.

Consider Interaction Effects: If you want to explore more nuanced relationships, consider testing for interaction effects between these predictors.

The regression model indicates that Primary Male Figure, Healthcare Decision-Maker, and Education collectively have a significant impact on the Frequency of Visits to healthcare facilities. This suggests that patriarchal influences and socioeconomic factors play a crucial role in healthcare-seeking behavior. Further exploration of individual predictors will help pinpoint which factors are the most influential.

Statistical Evidence of Relationship: The findings from the Chi-Square test reveal a statistically significant connection between the Primary Male Figure and their accompaniment of the respondent. In particular, having a Husband or Father as the primary male figure plays a crucial role in whether they join the respondent for healthcare appointments.

Role of Male Figure: The data indicates that Husbands are less likely to accompany compared to Fathers, as there are instances where Husbands do not accompany, while Fathers consistently accompany in the analyzed sample.

Focus of Interventions: Strategies aimed at enhancing healthcare access should concentrate on resolving transportation and financial challenges, as these represent the most notable obstacles.

Campaigns for Awareness: Raising awareness about the healthcare services that are available could also yield significant benefits.

Cultural Factors: While less prevalent, the role of family influence and an inclination towards home remedies reveal cultural elements that may need to be considered.

These insights underscore the necessity for culturally sensitive healthcare initiatives that engage community leaders to eliminate obstacles to women's healthcare. This pattern highlights the patriarchal dynamics present in many families. Tackling these power relations is essential for enhancing women's access to healthcare. The scarcity of healthcare resources has a disproportionately adverse effect on women, underscoring the pressing need for government support in developing rural healthcare systems. Training male doctors to approach sensitive health topics with care and increasing the number of female healthcare practitioners can enhance the healthcare experiences of women. These observations point to a rising trend of female empowerment and autonomy in healthcare access, showcasing the effects of education, awareness, and social advancement in Kerala.

8. PHC DOCTORS INSIGHTS :

This section offers perspectives from healthcare professionals regarding the cultural, social, and resource-related obstacles that affect women's access to healthcare. It also emphasizes new positive developments in women's autonomy. The examination centers on five primary themes: Cultural and Religious Norms, Family and Male Authority, Resource Challenges, Gender Dynamics in Patient-Doctor Interactions, and Emerging Autonomy Among Women.

8.1 Cultural and Religious Norms Impacting Women's Healthcare Access

Healthcare providers highlighted that deep-rooted cultural and religious beliefs still significantly influence women's healthcare-seeking behavior.
Supporting Quotes:
"Women sometimes delay getting medical care until their husbands grant permission, sometimes their health is at serious risk."
"Certain religious practices and influences in some communities prevent women from consulting male doctors, sometimes which turns out their health risky."
These findings emphasize the need for culturally aware healthcare initiatives that engage community leaders to reduce barriers to women's healthcare.

8.2 Family and Male Authority in Healthcare Decision-Making

The authority of male family members over healthcare decisions remains a concern, although shifts are beginning to emerge.
Supporting Quotes:
"The father or husband usually dictates whether a woman can seek medical help, which delays emergency care."
"Women in joint families face added pressure from male elders when it comes to accessing maternal or reproductive healthcare services."
This theme illustrates the patriarchal structure prevalent in many households. Addressing these power dynamics is crucial for improving women's healthcare access.

8.3 Resource and Infrastructure Challenges

Theme Description: Providers frequently mentioned inadequate healthcare facilities and resources as obstacles to providing quality care.
Supporting Quotes:
"Some of our healthcare center don't have essential medical equipments, and it's the women from remote areas sometimes suffers the most."
"Long distances and very bad infrastructure prevent timely access to emergency services for women."
The lack of healthcare resources disproportionately affects women, highlighting the urgent need for government investment in rural healthcare infrastructure.

8.4 Gender Dynamics in Patient-Doctor Interactions

Gender dynamics continue to influence how female patients interact with healthcare providers, although gradual improvements are being observed.

Supporting Quotes:
"Women find it hard to discuss sensitive health issues with male doctors, which often leads to incomplete or diagnoses which are not accurate."
"There is a preference for female doctors, but the shortage of female healthcare professionals exacerbates the issue."
Interpretation: Training male doctors to handle sensitive health issues delicately and increasing the number of female healthcare providers can improve women's healthcare experiences.

8.5 Emerging Autonomy Among Women in Kerala

Theme Description: Some healthcare providers noted a positive shift, with more women independently seeking healthcare without male accompaniment or approval.
Supporting Quotes:
"Kerala is changing a lot; I've seen more women coming to the clinic on their own without depending their husband, sometimes in their own vehicle, confident and capable of making their healthcare decisions."
"Most of the young women are breaking free from traditional restrictions and are proactive about their health, which is a refreshing change."
Interpretation: These observations highlight a growing trend of female empowerment and independence in healthcare access, reflecting the impact of education, awareness, and societal progress in Kerala.

9. DISCUSSION :

The findings strongly reinforce existing literature that indicates patriarchal norms significantly impact women's healthcare choices in India. Consider this example, our observation that cultural standards considerably restrict women's access to healthcare, often assigning decision-making authority to male relatives, aligns with Self and Grabowski's (2012) study. They highlight the importance of decision-making autonomy in facilitating healthcare access. Likewise, Dyson and Moore (1983) demonstrated that patriarchal family dynamics limit women's independence, affecting their healthcare decisions. In our research, over 61% of women indicated that societal expectations constrained their access to healthcare, validating these theories.
Additionally, the role of male family members as barriers to healthcare access mirrors the findings of Ravi and Kulasekaran (2014), who discovered that familial and community norms, along with financial obstacles, hinder women from obtaining necessary medical care. The concordernce of our results with these previous studies underscores the widespread and entrenched nature of these cultural impediments.
Our study also identified logistical challenges, with 77.8% of women citing transportation difficulties as significant barriers. These findings correspond with Narang's (2011) research, which pointed out inadequate healthcare infrastructure as a major obstacle in rural India. Moreover, Singh et al. (2023) highlighted economic and geographical disparities in healthcare access, which our data supports by demonstrating a notable correlation between the distance to healthcare facilities and the frequency of visits.
The ANOVA and regression analyses conducted in our study revealed that certain factors such as the presence of a primary male figure and women's educational level substantially affect healthcare access. These findings echo those of Cassels (1995), who examined the intricacies of healthcare reform in environments with limited resources and the relationship between socio-economic factors and healthcare accessibility.
An interesting discovery in this research is the indication of gradual improvements in women's healthcare autonomy, especially among younger and more educated women. This observation aligns with the findings of Surendran et al. (2024), who noted a rise in healthcare independence among women in Kerala. Healthcare providers in our study also noted that an increasing number of women are now independently visiting clinics and making healthcare decisions, reflecting changing societal norms. However, this progress is inconsistent, as older women or those residing in rural areas still face significant limitations.
The change in women's behaviors, especially among the younger population, supports Allendorf's (2013) assertion that family structures in India are evolving to provide women in nuclear families with more independence. Nonetheless, our research also points out that this advancement is gradual and

uneven, necessitating targeted strategies to ensure that advancements in healthcare are available to all women, irrespective of age or socio-economic background.

10. CONCLUSION :

The results of this research highlight the widespread impact of patriarchal values and socio-cultural pressures on women's access to public healthcare services in Kerala. Even though the state boasts impressive healthcare statistics and educational achievements, the influence of traditional gender roles remains significant, especially in rural and semi-urban areas. Women frequently encounter substantial obstacles when trying to obtain medical care, such as the necessity for male consent, a lack of financial independence, and insufficient healthcare resources. Deep-rooted cultural beliefs, stemming from centuries of patriarchal dominance, sustain the notion that women should prioritize their family's needs over their own health, resulting in delays or complete neglect of critical medical treatments. These societal expectations are made more difficult by infrastructural issues, including the absence of healthcare facilities in remote regions, further limiting women's access to timely and quality medical attention.

Nevertheless, the study also reveals a positive trend emerging in Kerala. With rising literacy levels, improved access to information, and community-led health initiatives, an increasing number of women are beginning to claim their autonomy in healthcare choices. Younger generations, especially in urban areas, are questioning traditional norms, seeking medical care without waiting for male approval, and openly addressing reproductive and mental health topics. Healthcare professionals have also observed this transformation, but they stress that these changes are not consistent throughout the state. The gradual empowerment of women in Kerala brings optimism, but it also underscores the need for collective efforts to ensure that advancements are accessible to all segments of society, including the most marginalized and vulnerable groups. The study advocates for a comprehensive approach to healthcare reform that incorporates cultural sensitivity, infrastructural improvements, and gender equality into public health initiatives.

11. RECOMMENDATIONS :

To tackle the complex obstacles highlighted in this research, a comprehensive and culturally aware strategy is crucial. Firstly, both the government and healthcare stakeholders must focus on enhancing the healthcare infrastructure, especially in rural and underserved regions. Investments need to be made to ensure that Primary Health Centers (PHCs) are adequately equipped and staffed with qualified professionals who comprehend the specific needs of female patients. Mobile healthcare units could be introduced to narrow the divide between urban and rural healthcare access, providing essential medical services to women residing far from established healthcare facilities. Initiatives aimed at making healthcare more affordable should be implemented, including subsidies or financial assistance programs for low-income families to remove economic barriers that hinder women from seeking care. By confronting these systemic obstacles, the healthcare system can become more inclusive and accessible for all women, regardless of their socioeconomic status.

In addition, educational and community engagement initiatives are vital for dismantling the patriarchal standards that limit women's healthcare autonomy. Extensive awareness campaigns should be developed to inform both men and women about the significance of women's health and their rights to independently access healthcare. These campaigns should focus on male family members, promoting collaborative decision-making and emphasizing the societal advantages of having healthy women. Schools and community centers can significantly contribute to disseminating this message by incorporating gender equality and health education into their programs. Furthermore, involving local leaders and religious figures in these efforts will help ensure that the message resonates within communities that might be hesitant to embrace change. Equally important is empowering women through economic opportunities; providing vocational training and financial literacy programs can enable women to achieve the financial independence necessary for making independent health decisions.

Finally, it is essential for healthcare providers to participate in extensive gender-sensitivity training to foster a more welcoming and supportive atmosphere for female patients. Emphasizing the recruitment of female healthcare professionals is vital, as women often feel more at ease discussing health-related

issues with female doctors. Healthcare workers should be trained to identify and sensitively address gender-specific concerns, ensuring that women feel acknowledged and respected. Creating women's health support groups within communities can further empower females by offering a secure environment to share experiences, acquire knowledge, and motivate one another to proactively seek medical care. By cultivating a healthcare setting that respects and prioritizes women's needs, alongside societal initiatives to advance gender equality, the state of Kerala can remain a benchmark for healthcare while establishing new standards for gender inclusivity and empowerment.

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