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Gender Norms and Healthcare Decision-Making: Barriers to Autonomy for Married Women in Ahmedabad

Mitulkumar Chaudhari[1] & Dr. T Shukkoor[2]

[1]*PhD Scholar of Sociology Discipline, Department of Humanities and Social Sciences, Institute of Infrastructure, Technology, Research And Management (IITRAM), Ahmedabad, Gujarat.*

[2]*Assistant Professor of Sociology, Department of Humanities and Social Sciences Institute of Infrastructure, Technology, Research And Management (IITRAM), Ahmedabad, Gujarat.*

Corresponding Author – Dr. T Shukkoor

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Abstract:

This study examines the influence of gender norms and patriarchal structures on healthcare decision-making among married women in Ahmedabad, India. Through structured questionnaires and focus group discussions (FGDs) with 220 women, the research explores how patriarchal norms, male family influence, and socio-cultural barriers limit women's autonomy in healthcare decisions. The findings reveal that women's healthcare choices are often constrained by male family members, low health literacy, and societal expectations. Despite the availability of digital health solutions, barriers such as mistrust, privacy concerns, and limited digital literacy hinder their adoption. The study underscores the need for gender-sensitive healthcare policies, community education programs, and secure digital health platforms to empower women and promote health equity. By addressing these barriers, the study advocates for a reorientation of healthcare systems to ensure equitable access and autonomy for women.

Keywords: Gender norms, Healthcare decision-making, Patriarchal structures, Women's empowerment, Health equity

Introduction:

Healthcare decision-making is deeply influenced by entrenched gender norms and patriarchal structures, particularly in societies like India, where women's autonomy is often restricted. Patriarchal systems dictate that women's health decisions are frequently mediated by male family members, such as husbands, fathers, or in-laws, leading to disparities in healthcare access and outcomes (Jejeebhoy, 2000; Nainar, 2013). This study investigates the barriers to healthcare decision-making faced by married women in Ahmedabad, with a focus on the role of patriarchal norms and the potential of digital health solutions to empower women. For instance, Jejeebhoy (2000) explored women's autonomy in rural India and highlighted the male family members' dominant influence over women's health decision-making, a foundation for understanding the patriarchal dynamics that involve women's health behaviors within the South Asian context. In a similar tone, Nainar (2013) put forward an analysis of gender norms in South Asian societies, noting the pervasiveness of patriarchal effects and a challenging context for women's decision-making.

Digital health stretches itself as a potential solution to expand the access of healthcare for women and make them subjects with greater authority over their own health choices. With

mHealth, or mobile health, and telemedicine platforms, women can access health information, have remote consultations, and deal with their health issues much more autonomously (Udisha & Philomina, 2024; Rajkhowa & Qaim, 2022). Yet, the slow uptake of digital health solutions by women when placed in the context of a patriarchal society is bounded by a myriad of socio-cultural limitations. Earlier research identified factors hindering the adoption of digital health among women. Core impediments are due to male family member influences, skepticism towards electronic health because of fear of getting financially scammed and privacy breach, and scarce knowledge of electronic health devices (Sinha & Schryer-Roy, 2018). To emphasize further the exogenous character of the problem, gender socialization consists of a mechanism whereby family necessity serves more like a priority rather than women's health.

World Health Organization (WHO) has distinguished the significance of equity for the participation and inclusion of women in healthcare provision and decision-making. Gender equity means the assurance that various genders could achieve the greatest possible health (WHO, n.d.). The Declaration of Alma-Ata, which was adopted in 1978, rhetorically called for healthcare to be available for all and for an end to all health inequalities (WHO, 1978). SDG Goal 3 stands out, focusing on living well and ensuring the well-being of everyone at every age in life, underscores the importance of universal health coverage and addressing health inequities (United Nations, 2015).

Srinivasan et al. (2024) argue that there is potential in mHealth for rural women's empowerment in India. The authors present evidence based on data obtained from mobile health platforms since these would allow women easy access to healthcare services where they also have further power in making decisions about their own health. Unfortunately, however, there are a number of socio-cultural barriers that influence men's girlfriend-power and women's low digital literacy; hence they limit the effectiveness of such platforms. Sinha and Schryer-Roy (2018), on the other hand, investigated how digital health would bring about gender equity in low- and middle-income countries. They concluded that while indeed, digital health could fill the healthcare gap, other barriers could still be in place, among which are gender norms, mistrust in digital health services themselves, and a lack of awareness of what tools are available. To overcome the said barriers and hence facilitate the adoption of digital health by women, targeted intervention is, therefore, necessary.

This study examines the barriers to healthcare decision-making and digital health adoption among married women in Ahmedabad. Using a survey of 220 respondents, along with structured questionnaires and focus group discussions, the research explores the socio-economic factors influencing women's healthcare behaviors. The findings aim to promote gender equity in healthcare through digital health solutions. These insights will inform the development of gender-responsive healthcare policies and interventions that empower women and promote health equity.

Methodology:

This study employed a mixed-methods approach, combining structured questionnaires and focus group discussions (FGDs) to collect data from 220 married women residing in the Ahmedabad Municipal Corporation area. The study was conducted from September 2023 to June 2024. Participants were selected through random sampling, ensuring representation from diverse socio-economic backgrounds, including daily wage workers, domestic workers, self-employed women, and housewives. Women below 18 and above 60 years of age were excluded, as healthcare decisions for these groups are often made by family members.

The questionnaires covered topics such as healthcare decision-making, access to digital health, and societal influences. Informed consent was obtained, and participants were assured of

confidentiality and privacy. Focus Group Discussions: Six FGDs were conducted, each with 8-10 participants, to gain deeper insights into the challenges women face in making healthcare decisions. Themes included male family influence, cultural norms, and perceptions of digital health. The study adhered to ethical guidelines, ensuring informed consent, confidentiality, and the right to withdraw at any time. Participants were informed about the study's purpose and their role in it.

Analysis:

This study, therefore, aims to understand how gender norms and patriarchy influence married women's healthcare decision-making in Ahmedabad. The responses of the 220-headed samples through structured questionnaires and FGD established how deeply rooted patriarchal values and social norms restrict a woman's autonomy in making health decisions. These findings document various barriers in the way of women and point to the need for the establishment of gender-responsive policy frameworks in health provision, aimed at empowering and ensuring health equity. By bringing to light these hindrances, this work calls for a reorientation of the healthcare system around women to ensure equitable access to healthcare for all.

The study was conducted among 220 respondents aged between 18 and 59 (M = 38.9, SD = 11.87). Of this group, 54.5% resided in joint family settings, while 45.5% lived in a nuclear family arrangement. Household income levels were classified into four categories, with the peak earning between ₹20,000 to ₹50,000 (36.8%). In terms of education, around 30% of them did not receive formal education, 25% had primary education, 24.5% had secondary education, and 20.5% had higher education. In terms of occupation, the housewives made up the greatest number (38.2%), self-employed workers comprised 30.9%, and employed workers also made up 30.9%.
Sixty-three respondents reported other family members (parents-in-law, parents, or extended family) as the primary decision-makers of healthcare. Definitely, this promotes familial collectivist play in decision-making, a hallmark of collectivist culture within Indian families where even personal decisions involves collective input (Kamra et al., 2016).

Table-1 Healthcare Decision Maker of a family

Healthcare Decision Maker	**Respondents**
Other family members	63
Myself	58
My husband	55
A combination of family members	44

Analysis revealed that 58 respondents selected themselves as the primary decision-makers concerning their healthcare. Some extent of autonomy in healthcare decisions abides in the choice of several women, given that a majority of them have been in a position to decide about their own health. However, previous studies show that it is women's autonomy in health decisions that brings about improved health outcomes and satisfaction (Bloom et al., 2001).

A contrast with 55 respondents who indicated that their husbands were the main decision-makers: this reflects the overt influence of patriarchy in healthcare decisions made in these households. The husband's role as the primary decision-maker should be indicative of the persistence of traditional gender roles and male authority within Indian society (Osamor & Grady, 2018). Some 44 other respondents reported the practice of family members making decisions together on healthcare, indicating the nature of joint family systems in which collective decisions are the norm (Thomas et al., 2017).

Half the respondents had to face delays because of family opinions. To escape from this predicament, some women resort to utilizing home remedies or medicines that can be purchased without a prescription. This behavior shows that family health is prioritized above personal health, as evinced by the fact that 119 respondents reportedly purchased medicine for family members without a doctor's consultation. Additionally, 130 respondents expressed that it is expected in society that women's health would always come last in the queue.

It has oftentimes been argued that family dynamics and social norms regulate women's healthcare-seeking behavior. Empirical evidence provided by Ratnapradipa et al. (2023) and Ain & Rasool (2024) corroborates this by demonstrating that constraints imposed by family, reduced finances, or traditional gender roles frequently restrict women's access to healthcare, pushing them to either alternative treatments or unregulated medication purchase.

Figure 1 shows the distribution of healthcare decision-makers in joint and nuclear families. The bar chart distinguishes between four categories: multiple family members, husband's decision, women's own decision, and other family members' decision. Joint families, depicted in blue, more frequently involve multiple family members in decision-making, reflecting the collectivist nature of such families. This is in contrast to nuclear families (represented in red), where decision-making is less often shared among family members.

In the case of nuclear families, the husband is more likely to be the primary decision-makers on healthcare, indicating more of a patriarchal decision style compared with joint families. Research indicates that in the nuclear family setup, the authority of husbands is quite evident due to the small size of nuclear families in comparison to the larger families wherein both parents spread their responsibilities (Osamor & Grady, 2018).

The "myself" category, where women independently make decisions about their health, had the highest participation in both family structures. Joint families showed a slightly higher count, indicating that extended family members may provide more support and empower women to make healthcare decisions. Studies have shown that women's autonomy in healthcare decisions is linked to better health outcomes and greater satisfaction (Bloom et al., 2001).

In the "other family member" category, nuclear families had a slightly higher proportion; thus, decisions in some families are perhaps also influenced by extended family or non-immediate family. This may reflect the smaller portray for the support in nuclear families, thus putting extended relatives with greater power in decisions over healthcare (Thomas et al., 2017).

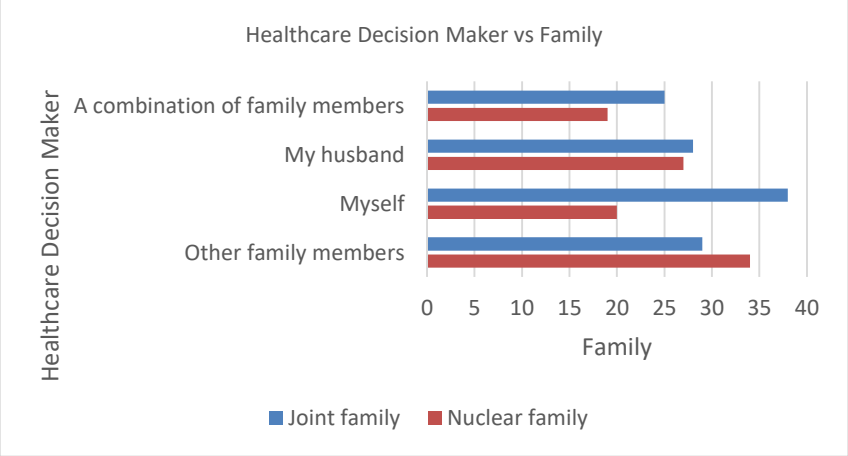

Figure-1

Figure 2 illustrates the relationship between healthcare decision-makers and occupation. The four decision-maker categories are: a mix of family members (0), my husband (1), myself (2), and other family members (3), while occupations are divided into employed (0), housewife

(1), and self-employed (2). The data reveals several patterns. For the "combination of family members" category, the highest representation is among employed individuals, followed by the self-employed, and the lowest among housewives. This suggests that employed and self-employed women are more likely to collaborate with family members in making healthcare decisions.

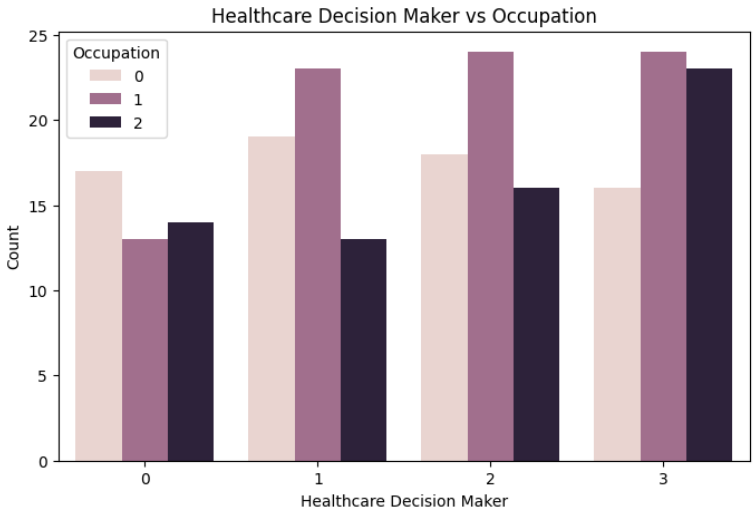

Figure-2

In contrast, housewives were most often the healthcare decision-makers, followed by employed individuals, with self-employed individuals representing the smallest group. This suggests that in households where the husband is the primary payer for healthcare, wives are most often the decision-makers. Housewives are more frequently in charge of healthcare decisions at the household level, with employed individuals coming next and self-employed individuals last. This indicates that wives often take the lead in healthcare decisions within the household. When other family members are the decision-makers, housewives and self-employed individuals are more represented, while employed individuals are least likely to involve other family members in decision-making.

The figure 3 shows the relationship between education levels and healthcare decision-makers. Education levels are categorized as "none," "higher," "primary," and "secondary," while decision-makers include other family members, my husband, myself, or some combination of family members.

When people have no formal education, other family members are the primary decision-makers, followed by a combination of family members, and the individual, and then the husband. This brings to light the fact that, in low-education households, extended family members might make major healthcare decisions. This trend corroborates existing studies that associate lower education levels with reliance on extended family members to help make healthcare decisions (Wolf et al., 2012).

On the other hand, in higher education, family members are still primarily decision-makers, followed by the person, a family member or more than one family member combined with husbands. This indicates that family members still expect many dominant roles in the decision-making processes concerning health even when people have higher education credentials, with educated people likely to contribute in one way or another in matters of health choices. Higher education correlates with advancement in health literacy and autonomy, culminating in independent decision-making concerning healthcare (Marmot et al., 2020).

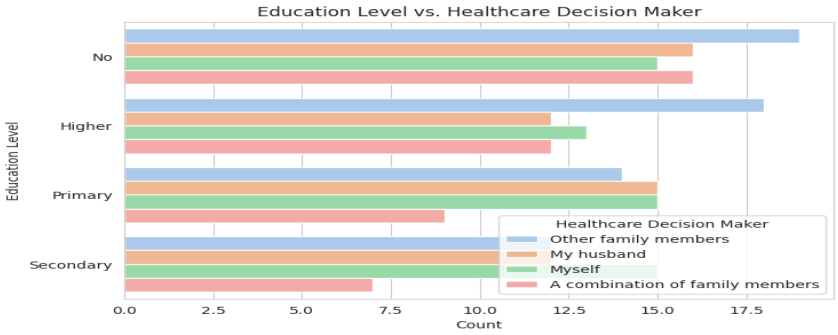

Figure-3

Among those with primary education, other family members are the most common decision-makers, followed by the husband, the individual themselves, and a mix of family members. This indicates that individuals with primary education largely rely on their husband and other family members for healthcare decisions. Lower health literacy often leads those with limited education to depend on family members for health-related choices (Berkman et al., 2011). For those with secondary education, other family members remain the primary decision-makers, followed by the husband, the individual, and combinations of family members. While secondary education shows some impact on health literacy, a high level of family dependence still persists (Nutbeam, 2008).

A Chi-Square test was conducted to assess the relationship between education level and healthcare decision-making. The p-value of 0.9298 suggests no significant association between education and who makes healthcare decisions in the family. This finding supports the bar chart's conclusion that education levels do not significantly influence the division of healthcare decision-making responsibilities within households. In conclusion, the data and statistical analysis highlight the continued influence of family members in healthcare decisions across all educational levels. However, those with higher education may be more likely to take charge of their own healthcare.

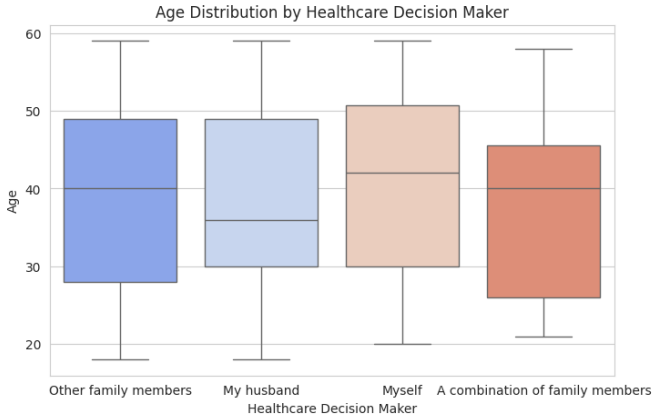

Figure-4

A one-way Analysis of Variance (ANOVA) was performed to assess whether age differs significantly across the healthcare decision-maker categories (Myself, My Husband, Other Family Members, Combination of Family Members). The results showed no significant difference in mean age across these categories, $F(3, N) = 0.264$, $p = 0.8516$. With a p-value greater than 0.05, it meant that age does not have a significant impact on healthcare decision-making roles within households. This implies other factors-having income levels, educational background, or cultural contexts-might play a more established role in accessing healthcare decision-making responsibility. Research could study these alternative factors in future to achieve a better understanding of household health settings.

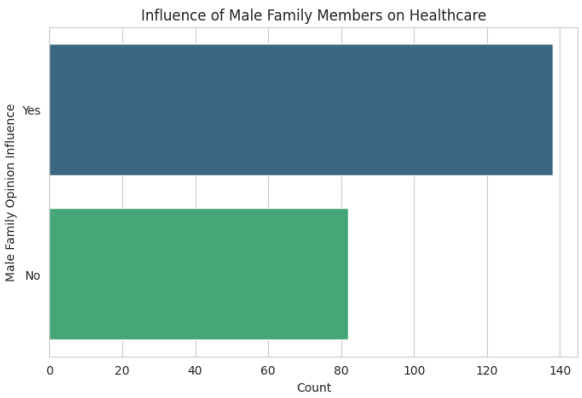

Figure-5

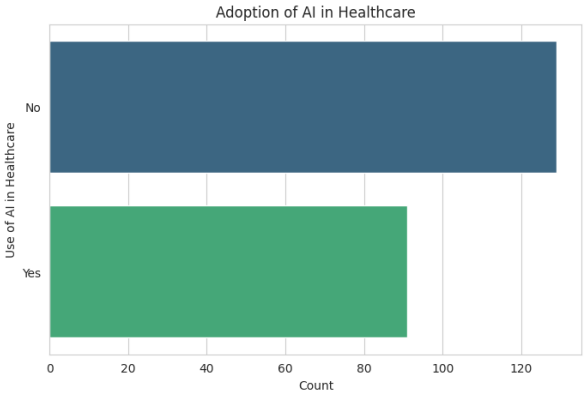

Figure-6

Findings on how well male family members influence healthcare decisions are summarized in Figure 5. Of the 220 respondents, 138 (62.7 percent) indicated that male family members have an influence with regard to healthcare decisions, while 82 (37.3 percent) said that they don't. This clearly brings out that patriarchal norms still restrict women's autonomy in healthcare decision-making, where, in many families, male figureheads are in control. This matches literature on gendered dynamics in South Asia, wherein sometimes patriarchal figureheads curtail women's freedom in making decisions (Jejeebhoy, 2000; Nainar, 2013).

On the other hand, the increasing number of women who reported they were not influenced by their male family members is a clear indication of women's growing autonomous voice and empowerment in healthcare decision-making, which is an important dynamic for improving health outcomes in women and making agency-based decisions. Tackling the problems arising from patriarchal norms and suggestions for women-oriented health management will help improve the autonomy of women in healthcare (Sen & Batliwala, 2000).

Figures 6, 7, and 8 show possible features and constraining factors to the influence of married women's responses to digital healthcare in Ahmedabad. Figure 6 presents views on AI in healthcare having mixed responses: 62.7 percent of respondents view that AI, in its contribution to women's empowerment, has long-term benefits while 37.3 percent disagree. By this, the role of AI in empowering women for decision-making in healthcare is met with a conflicting public perception.

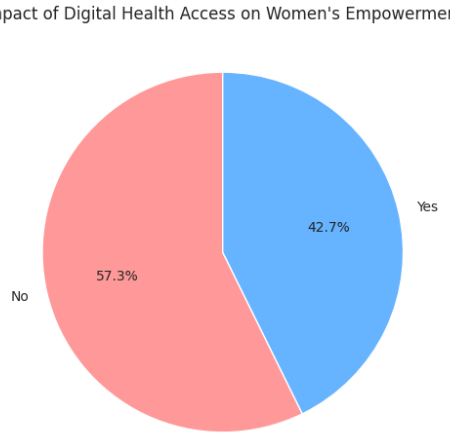

Figure-7

Figure 7 depicts the responses regarding the effect of digital health access on women's empowerment. The pie-chart analysis revealed that 57.3% of the respondents believed that digital health access does not affect women's empowerment while 42.7% believed that it does. This

pushback indicates that there are barriers that make it difficult for digital health to empower women effectively. Figure 8 makes a comparison between the adoption of digital health tools according to education levels. The no-formal-education group consists of the highest number of non-adopters.Since the education developmental stride is observed to correlate with ready acceptance of what will enable women to engage freely in choosing health concepts, education apparently plays an essential role in fostering digital health acceptance as it drew the relationship between higher education and digital literacy.

Even with the broad access to mobile telephony and internet connectivity among 213 respondents, women still face significant obstacles to the adoption of digital health solutions. These include male influence on healthcare decisions, a lack of trust in digital health for fear of scams or of privacy being compromised, and a lack of awareness of available digital health tools. These findings are in line with Finlay's earlier study, Sinha and Schryer-Roy (2018), which highlights the patriarchal norms and gender roles in women's access to digital health as the bottlenecks to women's digital health access. It calls for target strategies to mitigate the gaps outlined in women's digital health literacy.

Digital healthcare would fulfill several empowerment functions for women through informed health decision-making on easy paths toward medical care and by working to attain gender equity. Utilizing digital devices, women can access health information, engage in virtual consultations, and become more proactive in their own health care. Besides, through digital health, education and empowerment could equally mean making better-informed decisions concerning women's health (Srinivasan et al., 2024).

Discussion:

The findings underscore the pervasive influence of patriarchal norms on women's healthcare decision-making in Ahmedabad. Despite some degree of autonomy among educated women, family influence remains a significant barrier. The study aligns with existing literature that highlights the role of patriarchal structures in limiting women's autonomy (Jejeebhoy, 2000; Nainar, 2013). Digital health solutions, while promising, face significant barriers in patriarchal societies. Mistrust in digital platforms, privacy concerns, and limited digital literacy hinder their adoption, particularly among women with lower education levels. These findings echo previous studies that identify socio-cultural barriers as key obstacles to digital health adoption (Sinha & Schryer-Roy, 2018).

The study also highlights the need for intersectional approaches to address the multiple layers of disadvantage faced by women. Factors such as caste, class, and religion intersect with gender to shape women's healthcare experiences, and future research should explore these dynamics in greater depth.

Policy Recommendations:

1. Implement gender-sensitive healthcare policies that prioritize women's autonomy.
2. Launch community education programs to improve health and digital literacy among women.
3. Develop secure and user-friendly digital health platforms to build trust and encourage adoption.
4. Engage local NGOs and community health workers to empower women and challenge patriarchal norms.

Conclusion:

This study reveals that patriarchal norms and male family influence significantly restrict married women's autonomy in healthcare decision-making in Ahmedabad. While digital health solutions offer potential for empowerment, socio-cultural barriers limit their adoption. The study calls for gender-sensitive healthcare policies, community education programs, and secure digital health platforms to promote women's autonomy and health equity.

Future Research:

Future studies should explore the intersectionality of gender, caste, and class in shaping healthcare decision-making. Longitudinal studies could track changes in women's autonomy over time, while comparative studies could examine regional variations in patriarchal influences.

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