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GENDERED HEALTH DISPARITIES IN INDIA: A COMPARATIVE STUDY OF UTTAR PRADESH AND KERALA

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Abstract

Access to quality healthcare is a fundamental human right, but in India, gender-based disparities in healthcare access persist. This study examines these disparities in the states of Uttar Pradesh (UP) and Kerala, shedding light on the complex interplay of social, economic, and political factors that shape women's access to healthcare. ***Objective:*** *Our primary objective is to identify and understand the determinants of gender-based disparities in healthcare access for women in UP and Kerala. Specifically, we aim to: Investigate the factors contributing to the poor health access of women in these states. Examine the demographic and socio-political elements responsible for differential health access between women in UP and Kerala. Explore how regional development disparities, civil societal activism, and women's social positions impact healthcare access.* ***Research Method:*** *This study employs a mixed-method approach. Extensive literature reviews and secondary data analysis of national and international reports provide insights into the structural differences, demographic variations, and historical contexts of UP and Kerala. Primary data collection is carried out through surveys with flexible questionnaires, using stratified and cluster sampling methods to gather data from women in different regions of both states.* ***Results and Discussion:*** *Preliminary findings indicate stark disparities in women's access to healthcare between UP and Kerala. While Kerala demonstrates notable progress in health outcomes, UP lags behind. Factors such as regional development, civil societal activism, and women's social positions play significant roles in shaping these disparities.* ***Conclusion:*** *Gender-based healthcare disparities in India persist, adversely affecting women's health. This research underscores the need for targeted policy interventions to address these inequalities and move toward universal health coverage. Bridging these gaps is essential to uphold the principle of health as a fundamental right for all.*

Keywords: *Gendered health disparities, healthcare access, gender inequality, India, Uttar Pradesh, Kerala.*

INTRODUCTION

The World Health Organization defines health as complete physical, mental, and social well-being. Every individual has the right to optimal health, irrespective of factors like ethnicity, religion, politics, economic or social status. Societal health is influenced by various factors including income, awareness, food and water availability, housing, sanitation, and access to healthcare. (Constitution of World Health Organisation, n.d.) Universal health coverage, as outlined in Sustainable Development Goal 3.8, aims for financial protection and access to quality healthcare for all. Universal health care ensures everyone has access to needed services without financial obstacles. (United Nation Development Programme - Sustainable Development Goals, n.d.) Access depends on factors like transportation, education, and financial infrastructure, as well as provider attitudes and service quality. Cultural considerations and diverse health requirements should be addressed. An example in Delhi highlights issues such as long waiting times, lack of privacy, and logistical challenges, reflecting broader problems in India's healthcare system.

Healthcare access in India faces challenges like government indifference, reliance on an unregulated private sector, and high costs, particularly affecting the 16.4% living below the poverty line. (Multidimensional Poverty Index (MPI) Report:Unstacking global poverty, 2023) Distance is a significant barrier, impacting rural populations' access to healthcare, leading to exclusion and higher mortality rates, especially in epidemics and for pregnant women. Addressing physical, financial, and socio-cultural variables is crucial for improving healthcare access and quality. The relationship between women's agency and access to healthcare is complex. Women's

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agency, reflecting their ability to make decisions, significantly influences their healthcare choices. Higher agency correlates with better knowledge, increased self-care, and greater healthcare utilization. Economic autonomy plays a crucial role, enabling women to afford healthcare services. Societal norms and cultural practices can either empower or constrain women's agency in healthcare decisions. Education positively impacts women's agency, health outcomes, and family planning decisions. Legal frameworks supporting women's rights and reproductive healthcare enhance access to services.

Barriers like geographical proximity, limited transportation, financial constraints, and societal marginalization hinder women's access to healthcare. Gender biases within the healthcare system can lead to under diagnosis or under treatment. Empowering women in healthcare and improving access are interconnected goals. Policymakers and healthcare professionals must address underlying factors, promote women's empowerment, and create inclusive healthcare systems. These actions can enhance health outcomes and foster gender equity. Women's agency can be studied as both an independent and dependent variable based on research context and objectives. The review explores the intricate relationship between women's agency, access to healthcare, and gender disparities in India. It highlights Mary Wollstonecraft's shift towards recognizing women as active agents of change rather than passive recipients of welfare. Women's agency, influenced by factors like education and economic autonomy, significantly impacts their healthcare decisions and overall well-being. The discussion also addresses gender discrimination in accessing healthcare, emphasizing the impact of societal norms, cultural practices, and discriminatory policies. (Wollstonecraft, 2012) This article calls for a comprehensive approach to address gender disparities in healthcare, acknowledging the multifaceted nature of these challenges. It emphasizes the need for policy interventions that promote women's empowerment, education, and economic independence to improve overall health outcomes and reduce inequities in India. This research aims to investigate and understand the multifaceted issues hindering women's access to healthcare, focusing on the contrasting scenarios in Uttar Pradesh and Kerala. The study emphasizes the need to explore the 'why' and 'how' behind these barriers for targeted interventions.

Gender bias, both societal and within healthcare, remains a pervasive issue globally. Despite progress in women's rights, significant inequities persist, especially in developing countries. The COVID-19 pandemic exacerbated challenges, leading to millions of women losing access to contraception. In India, reports reveal stark disparities in women's healthcare access; with only 37% having proper access compared to 67% of men. The research identifies a critical research gap, emphasizing the need for a localized approach to study gender discrimination's impact on women's healthcare access in India. While some small-scale studies exist, a comprehensive understanding of the contrasting health outcomes among Indian states based on access denial is lacking. (National Family Health Survey (NFHS-5), 2021) Access to healthcare is a complex, multidimensional concept crucial for achieving universal health coverage. The study focuses on the influence of gender on healthcare access in Uttar Pradesh and Kerala, considering their significant demographic differences, literacy rates, healthcare indicators, and economic structures. The choice of Uttar Pradesh and Kerala for comparison is justified by their distinct profiles, including population size, literacy rates, education focus, health indicators, economic development, and demographic transitions. Kerala, as a progressive state, serves as a benchmark, while Uttar Pradesh represents challenges faced by a populous state with lower development indicators.

EVOLUTION AND PERSPECTIVES OF CIVIL SOCIETY: FROM ANCIENT ROME TO CONTEMPORARY DEBATES

The concept of civil society has evolved over time, from Cicero's ancient Roman definition to contemporary perspectives. Classical liberal thinkers like Adam Smith viewed it as the economic realm, while Hegel and Marx explored its role in capitalist societies. Antonio Gramsci associated civil society with the hegemonic apparatus of the ruling group. In the 20th century, civil society gained prominence, influenced by thinkers like Gramsci, and became a key focus in development policies. However, contemporary discussions often overlook power structures, exclude political aspects, and raise concerns about NGOs' role in development. The resurgence of civil society is diverse, with post-colonial countries seeing strengthened associations based on religion and ethnicity. In India, civil society faces challenges, including the rise of fundamentalism. The discourse on civil society has its roots in the political upheavals of the 20th century, with implications for individual freedom, voluntarism, and democracy. The declining legitimacy of the state and eroding institutions pose challenges to civil society in India. Different perspectives on civil society highlight the need for a stable, democratic discourse to ensure its effectiveness. (Ehrenberg, 2017) Informed public action in civil society involves individuals and groups addressing societal issues through active engagement and advocacy. Women's empowerment relies on informed civil society action to foster gender equality by increasing public awareness of women's challenges. Informed individuals are more likely to support women's empowerment, contribute to gender equality organizations, and create safe spaces for

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women. This informed public action can influence policymakers, leading to laws and initiatives promoting women's rights. Civil society organizations play a crucial role in initiating, influencing, and driving public action, shaping policies, and holding governments accountable. Women's collective action, historically significant, now utilizes social media to address shared issues. Understanding collective action and women's agency is essential for overcoming barriers and improving outcomes. Civil society organizations promote gender equality by advocating for policy changes, providing skill-building programs, improving access to education, creating safe spaces, combating gender-based violence, and increasing women's participation and representation in public life. Studying civil society's role in Kerala and Uttar Pradesh can inform strategies for inclusive development.

UNDERSTANDING KERALA AND UTTAR PRADESH

Kerala's success is attributed to historical factors, including social movements, cultural openness, and early investments in education and health. It can be argued that Kerala's public action and equitable provision of basic services played a vital role. In contrast, Uttar Pradesh's failures are linked to neglecting similar opportunities, resulting in educational backwardness and gender inequalities. Kerala's informed public actively engaged in politics, driven by mass literacy and emphasis on universal services. (Dreze & Sen, 2002) In Uttar Pradesh, caste divisions persisted, shaping political discourse. The chapter emphasizes the role of public action in breaking or perpetuating historical patterns and influencing private action. The vicious cycle in Uttar Pradesh contrasts with Kerala's virtuous one. Despite economic challenges, Kerala's commitment to education since 1817 has yielded positive human development outcomes. The intent is to challenge the notion that poverty alone explains Uttar Pradesh's poor performance, urging a deeper understanding of the region's unique challenges.

Kerala's exceptional development stands out globally for efficiently translating economic resources into tangible human benefits. Initially considered economically disadvantaged, Kerala's transformation began during the colonial period with tenancy reforms and a focus on basic education. Since the states of Cochin and Travancore joined in 1956, investments in education, health services, and public action propelled Kerala's success in eliminating basic deprivations early in its economic development. Fertility decline was achieved through female education, women's emancipation, reduced infant mortality, and political support. Jean Dreze and Amartya Sen attribute Kerala's success to public action, involving both state interventions and efforts by the public, challenging biases in development policies. Civil society's role in expressing demands and pressuring the government is crucial. (Heller & Tornquist, 2021) Kerala's modernity emerged from grassroots political actions that pressured the state to adopt radical social and political reforms, empowering marginalized sections and promoting equality. Social reform movements since the 1930s, challenging entrenched inequalities, played a pivotal role. The political and social movements in the 1950s, including the Communist Party of India coming to power, led to the People's Plan Campaign in 1996. This mass movement, backed by the State, decentralized the resources and decision-making, embedding democracy in civil society. Kerala's historical struggles for reform and inclusiveness shaped its progressive trajectory, challenging caste-based discrimination. Missionary efforts in the 19th century initiated education for lower castes, weakening the caste system. Social and political reform movements, including the formation of the communist party in 1934, led to land reforms, minimum wages, and progressive policies, making Kerala one of India's most progressive states by the 1950s.Communist mobilization against caste oppression liberated lower strata, linking anti-caste struggles with anti-feudal movements for social justice. Public intellectuals and cultural movements, including the Progressive Writers' Association, Kerala People's Arts Club (KPAC), and Kerala Sasthra Sahitya Parishad (KSSP), played pivotal roles in raising awareness and radicalizing civil society. Libraries and the library movement broke caste hierarchies, disseminating knowledge and instilling nationalist sentiments. Protestant missionaries challenged caste discrimination in education and healthcare. Malayali subnationalism emerged against Brahmin dominance, leading to collective responsibility for the well-being of all Malayalis. Pan-Kerala institutions and the "Aikya Kerala" movement solidified this identity, demanding equal rights for all. (Singh, 2010) The sustained history of mobilization drew the state into a public-centric approach, fostering an educated and aware public. Social reform movements in the early 20th century challenged traditional values, promoting social mobility and state intervention for representation.

The World Bank's 2004 World Development Report once had painted India as a paradigm case of development failure. Locked in a vicious cycle of public apathy and poor governance, it is at the bottom among Indian states on virtually every indicator of human development. In terms of early child health, nutrition and schooling, it performs significantly worse than much poorer countries of sub-Saharan Africa. A historical legacy of exploitative economic relations, an oppressive caste hierarchy and restrictive gender norms are among the reasons given for these developmental woes. There are several factors that may contribute to the relatively low number of social movements in Uttar Pradesh. Uttar Pradesh faces a long history of caste-based discrimination and oppression, hindering grassroots social movements. Despite some successes among lower-caste groups, the overall number of movements may be limited due to barriers like political populism, state-mobilized movements, and electoral

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politics focused on caste lines. The state's low commitment to broad development and social equity, coupled with a lack of civil society challenge, has resulted in a comprehensive failure of public services. Lessons from recent development experiences emphasize the potent role of public action in promoting the quality of life, yet Uttar Pradesh lags behind in crucial well-being indicators. The need for perpetual innovation in social movements and the impact of government disruption pose additional challenges, contributing to a potential lack of momentum for change in the state.

The concept of women's agency revolves around their ability to identify and pursue their own objectives, particularly concerning access to and utilization of healthcare services. Within this context, women's agency encompasses three essential dimensions. One of the critical factors contributing to women's empowerment in healthcare access is their ability to participate in decision-making processes. This empowerment allows women to make choices regarding their healthcare, household matters, and financial affairs. Such autonomy enables them to efficiently utilize available resources to achieve their objectives, including accessing maternal health services. Unrestricted freedom of movement is another pivotal aspect that facilitates women's access to necessary maternal health services. In many traditional societies, women's limited and dependent mobility poses a significant barrier to healthcare access. Often, women are required to be accompanied by another adult, typically their husband/partner or family-in-law, when traveling to access healthcare services. Overcoming this constraint is crucial for enhancing their access to healthcare. The vocalization and promotion of gender-equitable attitudes play a pivotal role in improving women's control over financial resources allocated for their health. This, in turn, enhances their access to healthcare services and their ability to negotiate reproductive choices with their partners. The importance of personal control over one's life for individual and societal well-being is increasingly recognized in public health and development literature. Nobel Prize winner Amartya Sen believes that a society's prosperity depends on its citizens' quality of life and liberty. Sen stresses living a fulfilling life and having control over one's life. It is agreed to, that individual control affects health, well-being, and lifespan. (Marmot, 2005) The 2008 Global Commission on Social Determinants of Health (CSDH) study emphasizes that control and participation gaps contribute to health inequities. (Global Commission on Social Determinants of Health :Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health, 2008) According to several theoretical frameworks, empirical data is needed to investigate how limited control affects health outcomes and health disparities. In the workplace, empirical observations in affluent nations have focused on reliable indicators of "job demand," which refers to workload stresses, and "job control," which refers to workload autonomy.

DEMOCRACY, GENDER, AND SOCIOECONOMIC FACTORS IN HEALTH EQUITY

The social and political settings of populations affect health beyond biological and behavioral considerations. Political regimes affect public health directly through human rights and indirectly through socioeconomic systems. Due to gender vulnerabilities, women globally bear a disproportionate disease burden. Due to sexual exploitation and violence, reproductive health hazards, child-rearing and domestic labor, discriminatory traditional and cultural practices, and poverty and inequality, these vulnerabilities exist. These health risks originate from women's human rights violations. A democratic government that cares for its citizens, especially the marginalized, can help end inequities and create a more equitable society. Therefore, the relationship of Democracy-women's health analysis is vital. Democratic institutions can improve women's health by preserving human rights and promoting gender equality. Due to improving socioeconomic conditions and women's rights, democratically developed countries have improved women's health and eliminated inequities.

Democracy must be combined with a moral viewpoint that prioritizes everyone's health to overcome health inequalities and injustices, especially those harming women. Social and political issues affect health outcomes, and democracies can improve women's health by improving their socioeconomic conditions and protecting their human rights. Developing countries must democratize to empower all sectors of the population, especially poor women and children. India, despite of being a democracy , shows inconsistencies in human rights preservation due to a variety of factors. The caste and class stratification must be examined in depth. Hereditary, local, and occupational castes create a hierarchical framework. Scheduled castes and indigenous tribes have historically been excluded and exploited by higher castes. Positive discrimination was implemented by the government to redress historical oppression but do not ensure elimination of caste based atrocities. Although caste discrimination has reduced since the 19th century, it still affects practices, beliefs, and social norms, including women's independence and employment. Economic and social caste discrepancies suggest lower-caste women may have more health issues. Epidemiologists and public health professionals agree that socioeconomic status affects health where, better socioeconomic status is associated with better mortality, morbidity, and self-assessed health.

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POLICY, FEMINIST PERSPECTIVES, AND SOCIAL PROGRESS

Male dominance and women's submission have affected the health scenario for millennia. Despite improvements in health and living circumstances, gender equality remains an issue. Women need political empowerment to obtain resources, skills, and gender equality policies. Traditional and male-created social standards can hamper women's political liberation, property, and economic rights. National, local, and public service organizations must promote women's empowerment and gender equality. Liberal feminists promote gender equality in higher education and the workplace. It was promoted that knowing caste, socioeconomic status, and gender dynamics is necessary to alleviate health inequities and gender inequality in India. For actual gender equality, policymakers and organizations must aggressively promote women's empowerment, political representation, and resource access. The only focus on mortality and reproductive health as metrics of women's health has been criticized in both rich and poor nations. Health views and non-reproductive demands must be considered to assess women's health. Morbidity is a key indicator of inequality since chronic sickness and disability affect women more as life expectancy rises. Economically disadvantaged women, especially those from marginalized ethnic or racial groups, generally have poor self-assessed health. While social health disparities have been studied in numerous contexts, India and other low-income nations have received less attention. Women and girls make up about half of India's population, hence their participation in its development is crucial.(Census,2011). Kerala will be used as a reference for Uttar Pradesh to clarify the contrast. The South Indian region was chosen to demonstrate the stark contrast between the states and the rest of India. So a relatively sophisticated section of India and the previous state Kerala were picked.

Limited autonomy in many development-related areas hinders women's empowerment. Their institutionalized incapacity due to low literacy, limited mass media, money, and mobility limits their competence and control (such as cooking). The family is their main focus. Even at home, women's engagement is gendered. Nationally, 51.6% of women make healthcare decisions. Women's health is harmed by widespread ignorance. In 60% of births without prenatal care, women believed it was 'not necessary', according to the NFHS-5. In a country where AIDS is considered an epidemic, 60% of married women had never heard of it. Women's inferior standing harms their health and hinders their healthcare access. Social literature acknowledges that families care for the sick and help in emergencies. Care and family resources can favor men. Feminists often call the family 'the primary site of oppression' since it plays out healthcare disparities. Using ethnographic evidence it has been often show how son preference affects feeding, medical care, and (presumably) 'love and warmth' in north Indian families. Girls are more likely than boys to develop weaning diarrhea, which is caused by weaning and worsened by poor nutrition and medical care. North Indian boys may get more food and savories. (Karney, 2000)However, such differentials are less prominent in south India and may favor women during menstruation. Most data suggests girls receive delayed and cheaper medical care. Boys may be more willing to see a doctor. Other researches have found gender-based healthcare discrimination in the home. Indian marriages are patrilocal, with the bride moving in with her husband. A shortened education often leads to early marriage, which disadvantages girls. The new bride, unaware of health protocols, may have trouble seeking healthcare. In their study on married teenage girls in Maharashtra, Barua and Kurz found that 'girls had neither decision making authority nor influence' in seeking healthcare. These ailments that prevented girls from doing housework were cured rapidly. (Barua.A. & Kurz.K, 2001) Sexual health treatment was discouraged by silence. Some reproductive health issues were ignored as 'normal'. In the Nasik study by Madhiwalla, 45% of women's illnesses went untreated. Most women avoided therapy due to budgetary constraints. Interestingly, nearly 25% of women believed the sickness did not require medical attention. Inaccessibility and inadequate health facilities prevented treatment. A Mumbai and Bangalore study examined HIV/AIDS patients' discrimination, stigmatization, and denial (DSD) in healthcare, home, community, job, and schools. Discrimination is a 'gendered phenomenon', say the authors. Gender-based discrimination is most common in marriage. The son and daughter-in-law may have had HIV/AIDS, but the woman was most likely to be discriminated against, including refusal of shelter, denial of household property, denial of access to the children, and being blamed for the husband's HIV positive status (that she could not keep him 'under control'). "Discrimination against daughters-in-law was blatant even when sons received good familial care," the authors write. Denying therapy and the family's refusal to pay for the daughter-in-law's treatment were common themes in such discrimination. A part of the scholarship calls it 'shared fate: gendered experiences'. Old age usually means reliance for most women (and men). The period is lonely (the spouse usually predeceased the wife) and reduced domestic and external power. The woman may be discriminated against, neglected, or abused. It was found in Uttar Pradesh that old women's nutritional needs were often overlooked, though food consumption discrimination may not occur. Family members may care about sudden and acute illness, but chronic illness is generally ignored since aging people are considered as a burden. Nationally representative surveys like the NFHS and NSS show pan-Indian gender healthcare disparities. Discrimination against females in the home can hinder community health programs in public spaces. Child vaccination has gender differences. Boys are more likely to be fully vaccinated than girls, except for the birth polio vaccine, according to NFHS-1 statistics. The poll also

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found that boys are more likely than girls to be sent to a doctor for acute respiratory infections, fever, and diarrhea. Several micro studies have found families unwilling to pay for female healthcare. NSS data confirms this nationwide. Males spend more on non-hospitalized and hospitalized treatment in rural and urban India than females. (S.Ghosh, 2014)

SOCIAL INERTIA IN UTTAR PRADESH

Women in Uttar Pradesh have limited healthcare access for numerous reasons. Lack of regional healthcare infrastructure and facilities is a major factor. Uttar Pradesh lacks hospitals, clinics, and healthcare specialists, making it hard for women to get proper care. Socio-cultural variables also hinder women's healthcare access. Traditional gender conventions limit women's movement and decision-making authority, making it hard for them to seek treatment freely. Medical care may be delayed or prevented if women need consent from male family members. Gender disparity in Uttar Pradesh has far-reaching effects on women's well-being. Uneven gender dynamics in this region include systematic marginalization of women's agency. This hurts women's welfare and economic and social progress. Several demographic studies show that Uttar Pradesh has extremely restricted gender relations. Women's agency transcends demographics and affects political and social change. Women's movement and autonomy are limited in Uttar Pradesh's society, keeping them at home. Various means of confinement limit their ability to participate in and out of their houses. Low female schooling involvement and limited external interaction are evident. Uttar Pradesh has less than half of deserving women exposed to mass media, while Tamil Nadu and Kerala have 80%. Insulation from information sources hinders women's ability to make educated family and social decisions. (Bhat, 2022) Women in Uttar Pradesh have restricted labor force participation, which limits their agency. This underlines two important gender relations aspects. First, there is strong evidence that family-level gender equality decreases when women get more jobs. Second, gainful employment shows women's involvement outside of housework. Kerala has 23% rural wage and salaried women workers, while Uttar Pradesh has 3%, according to 2011 census statistics. Kerala has 46.6% salaried women workers in metropolitan areas, while Uttar Pradesh has 21.7%. In Uttar Pradesh, women's talents and efforts are mostly focused on home matters, limiting their potential contributions. Kerala's discrepancies with Uttar Pradesh highlight three major societal failures: low education, women's marginalization, and poor public service infrastructure. This contrast shows the complex causes of Uttar Pradesh's underdevelopment.

In "Development as Freedom," Amartya Sen warns against equating economic progress with real development. Democracy and human rights foster progress, according to Sen. Press, speech, and assembly rights promote openness and reduce corruption, making governance accountable. Sen believes "functioning democracies" have prevented famines because they are accountable to public opinion and elections. He believes progress expands human liberties by improving capacity to live meaningful lives. Poverty, political oppression, restricted economic prospects, systematic social suffering, and inadequate public services must be addressed from this perspective. Sen lists five interconnected freedoms—political, economic, social, transparency, and security—that the state must protect. Public education, healthcare, social safety nets, macroeconomic policy, productivity enhancement, and environmental protection are needed. Sen defines freedom as the ability to carry out actions. Economic possibilities, political liberties, social empowerment, excellent health, basic education, and initiative support determine capabilities. Sen estimates that parity in healthcare and attention for Asian and North African women might add 100 million women worldwide. He claims that "capability deprivation" defines poverty more than poor income. GDP usually improves quality of life, although outliers exist. Lower GDP/capita regions like Sri Lanka, China, and Kerala have greater life expectancies and literacy rates than Brazil, South Africa, and Namibia. Despite higher average real incomes, Afro-American men live shorter lives than Chinese and Indian men. These situations show that poverty isn't only about income; it means limited political, economic, social, and cultural prospects. The Population Crisis Committee (PCC), recognized by the World Bank and UN, created a composite index that measures women's health, education, work, marriage, childbearing, and social equality. (Sen, 1999)

Kinship patterns, household structure, and domestic violence have examined how family setting affects women's agency. Family relationship quality may also affect women's agency, according to this chapter. The Madhya Pradesh Women's Reproductive Histories Survey was used to determine if family connection quality affects women's agency. Better husband-wife and parent-in-law relationships provide women more agencies. International development has focused on women's empowerment as a means and aim. Family relationship quality is equally as important as education and jobs. Women are encouraged as development beneficiaries through education, micro-credit, and land rights. Moreover, these policies and programs aim to empower women as development agents. Empowered women seem better able to protect themselves and their family. The importance of women's empowerment to development is widely recognized, but its drivers and effects are still poorly understood. Quality of family interactions has not been effectively addressed. Love, affection, and support are companionate qualities in relationships. Highly supportive family ties may empower women. Higher-quality partnerships may encourage women to assert themselves and family members above them to consider her

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decisions. Husbands, mother-in-laws, and other elder family members may be more aware of her wishes and take young women's preferences more seriously. Family members desiring to keep a loving or pleasant relationship may also encourage them to offer women more decision-making power. Thus, we examine whether high-quality family ties help women. Before continuing, we need define terminology. Women's empowerment has many names yet is often ambiguous. According to Kabeer and an authoritative assessment by Malhotra and Schuler, empowerment is the ability of women to make life and environmental choices. This concept emphasizes women's agency—their ability to make choices—and states that empowerment is a process of transformation that gives women power over time. Cross-sectional data typically refers to women's autonomy as the same agency as women's empowerment without change. The term autonomy is criticized since it emphasizes acting alone and ignores family life and women's inclinations to make choices with others. (Malhotra & Schuler, 2005)

CONCLUSION

The patriarchal system has harmed women's resources, healthcare, education, and political representation. Patriarchal systems organize resources and privileges by gender. Thus, even modest disparities, such as women giving men more food, can generate a chain reaction and promote inequality. Genders have differing material and social resources due to patriarchal society. Male and female resource demands have rarely been addressed in Indian plans. The majority of inequality reduction efforts have used quantitative approaches to level the playing field and assume gender equality. Society's gender disparity is ignored. Due to their family role, most policies examine women, their identity, and their needs in relation to males. Due to their diverse vocations, men and women need distinct resources. Accessibility improvements ignore this. Families typically hesitant to spend in women's healthcare, even though gender norms organize labor to make women sicker. According to previous arguments, women use convenient and affordable services. Facilities near home or inexpensive are used. The National Sample Survey Office (NSSO) observed in 2016 that urban and rural Indian women spend less per hospitalization in public and private hospitals. Many separate elements affect women's agency. Multiple elements contribute to women's agency in this setting. Social, economic, cultural, and political problems influence women's decisions and actions. By using women's agency as a dependent variable, this chapter investigates complex interactions between factors and their effects on empowerment and decision-making. It shows the intricacy of women's agency and empowers women. The method challenges simple or monolithic portrayals of women's lives, especially in the global South, such Chandra Mohanty's work on women's agency. Western feminist narratives simplify women's agency in diverse cultural and socioeconomic contexts, she says. Cultural, historical, and socio-political contexts are vital to understanding women's agency. Women negotiate their agency based on lived experiences and restrictions.

Women's agency is the ability to modify or take a difficult action in social and political situations, according to the chapter. Agency implies ambiguity because it is context-specific and has contradictory components that cannot be separated. Women operate within rules and customs, adding to its complexity and paradoxes. A woman's family often determines her healthcare. Family support may impact medical care, appointment scheduling, and treatment adherence. Diet and family life may affect a woman's health. Lack of family dietary awareness may cause health issues. Family planning, gestation, and delivery decisions and reproductive healthcare availability affect reproductive health. Family and support systems affect women's stress and mental health. Some women suffer physical and emotional health issues from family abuse. Negative families generate stress, while supportive families boost mental health. Female stress and health can be affected by work-family balance. Family support enhances work-life balance. Psychological and social support from family can improve a woman's health. A woman's smoking, drinking, and exercising may depend on her family. A woman's health understanding and decisions may depend on family education and health awareness attitudes. Traditional gender norms may impede women's health agency in some communities. Health and family context are linked, thus promoting healthy family contexts that prioritize women's well-being and agency is vital.

Women's health and subjugation are complex. Subordination can deprive women of proper healthcare, which may harm them. Discrimination, resource inequality, and household decision-making can limit healthcare access. Poor family planning, early and coercive marriages, and limited reproductive healthcare can increase maternal mortality and early pregnancies. Domestic violence and women's abuse escalate with subordination. Events like this can cause trauma, depression, and anxiety. Societies may overlook female family members' dietary demands. Health conditions like malnutrition can damage women. Women may not receive health education due to subordination. Healthcare seeking can be delayed by ignorance. Subordination restricts women's economic potential. Financial dependence and gender subordination can induce stress, anxiety, and depression in women. Unfair power relations and social expectations may affect their mental health. Stress and illness can result from low pay and few advancement opportunities. Subordination inhibits women's autonomy and decision-making, harming their health.Different civilizations have different gender roles and norms. Kerala allows women more freedom and choice than other societies due to its civil society development, although gender conventions may limit their

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agency. Economic empowerment transforms women's agency. Women with financial freedom have more say in education, employment, and healthcare. Financial constraints may limit their choices. Women's empowerment requires education. Women with greater education can make better life, health, and future decisions. Lack of education limits awareness and chances. Healthcare, legal, and information access affect agencies. Women without these resources may struggle to make choices that support their well-being and goals. Legal and political systems can empower or limit women. Women's freedom to choose depends on equal legal rights and anti-discrimination. Family, community, and social networks can empower women. Supportive surroundings can provide her the confidence and resources to make goal-oriented decisions. Media portrayals can influence society's views of women's ability. Positive and diverse depictions empower women, whereas prejudices limit them. Cities and rural areas affect women's agency. Urban locations may have more resources, whereas rural areas may have customs that limit women's choices. Marriage and family can limit women's agency. While dominating or patriarchal partnerships may limit her autonomy, supportive relationships might help her make decisions. Social elements include cultural norms, economic status, education, access to resources, legal and political climate, social support, media portrayal, geographical location, marital dynamics, and reproductive rights affect women's agency. Improving these factors can help women make decisions that match their goals. To understand Kerala's relative success in providing women with better healthcare than Uttar Pradesh, historical, social, and policy aspects must be considered. Kerala's focus on education, gender equality, healthcare infrastructure, awareness, and political engagement has improved women's health services. On the other hand, Uttar Pradesh has several socio-economic issues and patriarchal practices that limit women's progress.

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