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Original Research Article

Health-seeking behaviour and empowerment dimensions among married women with special reference to Kudumbashree units

Athira Venugopal[1]*, Sibin Mathew Medayil[2]

[1]Department of Sociology, CMS College Kottayam (Autonomous), Kottayam, Kerala, India
[2]Department of Sociology & Research Centre, CMS College Kottayam (Autonomous), Kottayam, Kerala, India

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***Correspondence:**
Dr. Sibin Mathew Medayil,
E-mail: sibin@cmscollege.ac.in

ABSTRACT

Background: The background of this study was about the health seeking behaviours of married women who are the active members of Kudumbashree units. Health seeking behaviour of an individual refers to the actions taken by them to prevent, cure or reduce the risk of a disease to maintain good health. The measures through which they seek medical care for better health outcomes are refereed as health care services.
Methods: A cross-sectional quantitative study was conducted using a structured questionnaire administered to assess the health seeking behaviours of married women in Kudumbashree units in Ernakulam District. Simple random procedure was employed to recruit the participants for the study.
Results: Health-seeking behaviour was largely positive, with a majority of women that is over 60% of women seeking treatment promptly and primarily depending on government hospitals due to affordability, proximity and trust. Kudumbashree participation significantly strengthened health awareness and autonomy, with more than two-thirds of the respondents reporting improved health knowledge and confidence in taking health-related decisions and regular meeting attendance showing a strong association with health care utilisation.
Conclusions: Financial constraints were the most prominent barrier, reported by over half of the respondents, often combined with transport difficulties and lack of awareness, while around one-third of women avoided healthcare for certain conditions due to stigma. Kudumbashree functioned as an effective empowerment platform, with a large majority indicating greater confidence in discussing health issues and increased participation in household health-related decision-making.

Keywords: Gender roles, Health-seeking behavior, Women's empowerment

INTRODUCTION

Kerala is a state especially well known for the strong health and educational records. But many married women face real obstacles in seeking appropriate healthcare facilities. The rigid gender roles expect them to put family as the first priority. Heavy household responsibilities and duties reduce time available for other activities. And often, they lack power to decide on their own health needs. This leads to delay in seeking care, poor health outcomes and wider health gaps. Community programs designed to address these challenges and to fix this. Kudumbasree leads the way as the biggest network run by women to end poverty. It initiates change through self-help groups focused on health, jobs and rights. Kudumbashree is an initiative in Kerala that helps women build better living conditions. It opens various opportunities to earn money and learn new skills. Some men feel uneasy when women start to speak for themselves and others and their voices become more heard, but women's roles in public life are growing and

people respect them for it. The program unlocks chances for women to learn, lead and push for equal rights like fair pay and owning property. It's not only about money, it's about making women visible and powerful, shifting how families and communities view them. It is an important step towards fairness and opportunity for all.[1]

Kudumbasree was Launched by Kerala's government in 1998, now reaches over 4.5 million women. It starts with small groups called the neighbourhood groups (NHGs). These combined up into area development societies (ADS) and finally into community development societies (CDS). The kudumbasree members acquires skills, save money and act collectively. In health, kudumbasree organize camps, awareness programmes and support for mothers and girls. But the question is does it truly empower women to act on their health?

Kudumbashree make drastic changes in the socio-economic life of women in Kerala, the project of Kudumbashree helped the women to achieve empowerment. The Success of Kudumbashree was not only evident from the individual level but also it can be seen in their family, community etc. Kudumbashree has enhanced entrepreneurship and leadership and the capacity of women to work and earn together. The status of women in family has improved. So kudumbasree empower women and improving their social and economic status and these essential factors are very much helpful for realizing the full potential of women.[2]

Micro-finance has been considered as a way to empower women and many studies have explored its effects. The Kudumbasree initiative links women to local political institutions, giving them economic self-sufficiency and a voice in development. However, empowerment is often confined, consider women more as consumers rather than fully empowered citizens. Feminist perspectives highlight the need for SHGs to promote collective awareness and political engagement, ensuring that gains in income and participation directly transformed to challenge the patriarchal power.[3]

Modern medicine was the most common choice. Factors such as age, education, income, marital status and cultural background played an important role in shaping their healthcare decisions, with less-educated individuals more likely to visit healthcare facilities and the younger people and older ones tend to be more cautious about the self-medication practices.[4]

The most important thing is making the right to health available to everyone, irrespective of their caste, religion, economic status, geographical location and social background. People's health-seeking behaviour depends mainly on their perception of the quality of health care and there is a gradual but upward shift can be seen towards accessing the government hospitals for health care services. This study highlights that further improvements can be achieved by enhancing the quality of care and fostering a caring and sympathetic attitude among healthcare professionals.[5]

Problem statement

Kerala's robust health and educational metrics obscure the persistent barriers married women encounter when seeking appropriate healthcare. Rigid gender norms prioritize family obligations over individual needs, while demanding household responsibilities and restricted decision-making authority often delay care-seeking, thereby exacerbating health disparities. Although Kudumbashree, Kerala's extensive women-led community network, aims to foster socio-economic empowerment through self-help groups, skill-building and income generation, its extension of these efforts into health via camps and awareness programs remains under-examined in terms of efficacy. Existing literature predominantly focuses on Kudumbashree's economic impact, neglecting whether such participation genuinely enables women to address their own health requirements. Consequently, it is unclear if involvement in Kudumbashree improves health-seeking behavior or if structural and gender-based impediments to healthcare access endure despite these community-level initiatives. This study investigates the health-seeking behavior and empowerment dimensions of married women in Thiruvamkulam CDS, Ernakulam district, to determine Kudumbashree's actual influence on healthcare decisions and to identify the specific barriers limiting access to quality care.

Geographical isolation and weak transport infrastructure, making women difficult to travel to reach health care facilities, Economic constraints such as poverty, which limit the ability to afford healthcare or related costs like travel and medicines.[6]

Purpose of the study

The study that was undertaken had the primary objective of assessing the health-seeking behaviour of these married women and the role Kudumbashree played in their ability to take care of their health needs on their own. Besides looking at the established economic aspect of these women's emancipation, it is equally important to understand their health-related empowerment, as well as the challenges they still have to deal with when accessing healthcare services. Hence, the current research will aim to identify the core factors related to the latter issue. The study will focus on the population of married women residing in the Thiruvamkulam CDS in the Ernakulam district.

Objectives of the study

The study gives an account of the socio-demographic profile of married women, their health-seeking behaviour, assesses the extent to which Kudumbashree empowered them with regard to health and finally, looks at the factors

that hinder women from accessing appropriate health care services.

METHODS

Study design

The present study adopted a quantitative cross-sectional research design to examine the health-seeking behaviour and empowerment of married women who are active members of Kudumbashree units in the Thiruvamkulam Community Development Society (CDS) under Tripunithura Municipality, Ernakulam district. The study area comprises 13 wards with 135 Kudumbashree units and a total membership of 1,718 women. Thiruvamkulam CDS was purposively selected due to its well-functioning organisational structure and active participation of members, making it suitable for fieldwork. The study population included women aged 18 years and above who were registered and actively participating in Kudumbashree activities for at least two years, while inactive members, non-members, women below 18 years and recent migrants were excluded. A sample of 130 respondents was selected using simple random sampling from the CDS membership list obtained from the office, ensuring equal chance of selection and minimising bias.

Location of the study

This research was conducted in Thiruvamkulam CDS in Ernakulam district. Thiruvamkulam CDS has 13 wards, 135 Kudumbashree units and 1,718 registered women. This area is a mix of rural and urban life and strong group activity makes it ideal for the study. In this study simple quantitative cross-sectional method is used. Earlier works or studies concentrated on Kudumbasree's role in economic empowerment. But very few dig into health-seeking behavior or empowerment aspects. This study fills the gap. It describes women's socio demographic profiles, analyze their health seeking patterns, measures Kudumbasree's empowerment role in health-related matters and find out healthcare barriers that restricting women from achieving better and quality health care services. By doing so, it offers more practical ideas for better programs to guides leaders to strengthen women's health choices and equity in places like Kerala.

Target population

The target population of my study is married women who are members of the Kudumbashree units in Thiruvamkulam CDS, Ernakulam district, Kerala.

Inclusion and exclusion criteria

The sample size was selected among women who were married, registered members of Kudumbashree units in Thiruvamkulam CDS, permanent residents of the above-mentioned area and who gave informed consent to participate in the study. On the contrary, women who were not members of Kudumbashree units, who were not permanent residents of the said area, were excluded from the study. Moreover, those who did not give informed consent to participate in the study or those who were not willing to answer the questions were also excluded. In addition, those who were too ill to answer the questions at the time of the survey were excluded from participation in the study.

Sampling technique and sample size

The study adopted a simple random sampling strategy with a sample size of 130 respondents. The questionnaire covered socio-demographic details, Kudumbashree participation, empowerment attributes (decision-making, confidence, informal family support, independence) and health-seeking behaviour (Health care awareness, frequency of visits, promptness in seeking health care, perceived satisfaction with health care services, barriers and use of traditional remedies). The independent variables of this study include age, education, employment, income, marital status, caste, residence type and number of children, while dependent variables focused on the health-seeking behaviour and empowerment indicators.

Data collection techniques and data analysis

The data were collected through a structured questionnaire administered through face-to-face interviews between November 13 and December 15, 2025, after obtaining informed consent and necessary permission from the CDS chairperson.

The Collected data were coded, entered and analysed using the software SPSS. Descriptive statistics were used to summarise the data and chi-square tests were carried to examine associations between socio-demographic factors and health-seeking behaviour and empowerment, as most variables were categorical. This strategy helped in understanding how social and structural factors influence women's health seeking behaviour and empowerment within the Kudumbashree framework.

Conceptual framework

In this study the conceptual framework is based on the Andersen's behavioural model of Health service utilization model. This model is widely used in areas of public health and social sciences to explain about the healthcare utilization pattern and also about how individuals use healthcare services and why they use them.

According to the Andersen Behavioural Model, says that health care utilization is depended on three major factors they are Predisposing factors, enabling factors and Need factors. These three factors interact together and influence

the decision of individual about how to seek and utilize healthcare services. The predisposing factors means the background elements, socio demographic characteristics and the social structure. The background elements include the persons character, behaviour and traits. The demographic characteristics include age, sex, marital status etc. Next one is social structure it includes education, occupation, religion, values, health beliefs, awareness about the health care system etc. These all factors shape individuals' attitude and perception towards health care system.

Enabling factors are the factors that makes them enable or obstruct the access to healthcare services these include availability and accessibility of health care services, the level of income, insurance coverage etc. These can significantly increase the rate of utilizing healthcare services. Need factors include perceived and evaluated health needs. Perceived health needs of an individual mean their own assessment of their health status, the degree of severity etc, while evaluated health needs means the professional medical attention by healthcare professionals. These factors play a major role in influencing the decision of individual to seek medical care and frequency of healthcare visits and its utilization.

Based on this model, health service utilization in the present study is examined in terms of type of care used (such as clinic/hospital services, home care or traditional medicine), purpose of visit (curative or preventive) and frequency of use.

The Andersen behavioural model is most appropriate for this study because it provides a comprehensive framework to understand how the social characteristics, availability of resources and perceived health needs collectively influence health-seeking behavior of individuals. It is also very much useful for analyzing the degree of variations in healthcare utilization patterns among women and community groups such as Kudumbashree members, where socio-economic factors and healthcare factors play an important role.

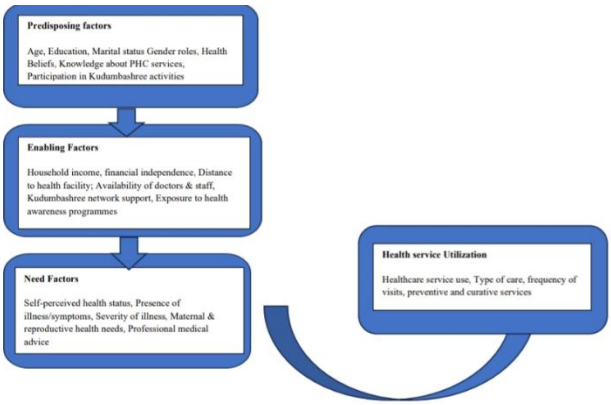

Figure 1: A conceptual framework on health services utilization based on Anderson's behavioral model.

RESULTS

Of the 130 respondents, the largest age group was above 46 years (40.00%, n=52), followed by 36-45 years (30.00%, n=39), 26-35 years (20.77%, n=27) and 18-25 years (9.23%, n=12); the sample was thus predominantly middle-aged and older.

With regard to education, 43.85% (n=57) had completed secondary school and 30.77% (n=40) had primary-level education only, while smaller proportions had graduate-level (19.23%, n=25) or higher-secondary (6.15%, n=8) education, indicating that most respondents had relatively low formal educational attainment. The majority of respondents were married (80.00%, n=104); smaller proportions were widowed (10.77%, n=14), separated/divorced (4.62%, n=6) or unmarried (4.62%, n=6). In terms of employment, 42.31% (n=55) were unemployed or homemakers, 27.69% (n=36) were in full-time employment, 19.23% (n=25) in part-time employment and 10.77% (n=14) were self-employed. Regarding monthly family income, 41.54% (n=54) reported income below ₹10,000 and 29.23% (n=38) reported ₹10,001-20,000, so 70.77% of families had a monthly income of ₹20,000 or less; only 12.31% (n=16) reported income above ₹30,000.

By caste category, SC/ST respondents formed the largest group (38.46%, n=50), followed by OBC (28.46%, n=37), General (20.77%, n=27) and other categories (12.31%, n=16); SC/ST and OBC respondents together accounted for two-thirds of the sample. Slightly more respondents resided in urban areas (54.62%, n=71) than rural areas (45.38%, n=59). More than half of the respondents had two children (53.08%, n=69), followed by one child (24.62%, n=32), no children (14.62%, n=19) and three or more children (7.69%, n=10).

A chi-square test of association was performed to examine the relationship between attendance at health awareness programmes and confidence to seek healthcare independently among the study participants. All 130 respondents had complete data for these variables and thus were included in the analysis.

The crosstabulation showed that among those who did not attend health awareness programmes, 36.4% (8 out of 22) reported not having confidence to seek healthcare independently, while 63.6% (14 out of 22) reported being confident. In comparison, among those who attended health awareness programmes, 16.7% (18 out of 108) were not confident, whereas 83.3% (90 out of 108) reported confidence to seek healthcare independently. Overall, 20.0% (26 out of 130) of participants lacked confidence, while 80.0% (104 out of 130) reported being confident.

The Pearson chi-square test indicated a statistically significant association between attendance at health awareness programmes and confidence to seek healthcare

independently (χ^2=4.432, df=1, p=0.035). Although the continuity-corrected chi-square value for this 2×2 table was only marginally significant (χ^2=3.29, df=1, p=0.070), the likelihood ratio (χ^2=3.94, df=1, p=0.047) and Fisher's exact test (two-sided p=0.044) both supported a statistically significant association at the 5% level. One cell had an expected count slightly below 5 (minimum expected count=4.40), which justifies the parallel reporting of Fisher's exact test. Effect size, assessed using Phi and Cramer's V, was 0.185, indicating a small to modest strength of association between programme attendance and confidence to seek healthcare independently. This suggests that while the association is statistically significant, the practical magnitude of the relationship is not very strong. The crosstabulation indicated that among participants who did not have decision-making power in the family, 22.2% (4 out of 18) had not avoided healthcare due to stigma, whereas 77.8% (14 out of 18) reported having avoided healthcare because of stigma. In contrast, among those who reported having decision-making power in the family, 74.1% (83 out of 112) had not avoided healthcare due to stigma, while 25.9% (29 out of 112) reported avoidance of healthcare due to stigma. Overall, 66.9% (87 out of 130) had not avoided healthcare due to stigma and 33.1% (43 out of 130) had done so. The Pearson chi-square test showed a statistically significant association between decision-making power in the family and avoidance of healthcare due to stigma (χ^2=18.859, df=1, p<0.001). The continuity-corrected chi-square value for this 2×2 table was also highly significant (χ^2=16.588, df=1, p<0.001), as were the likelihood ratio (χ^2=17.845, df=1, p<0.001) and Fisher's exact test (two-sided p<0.001). None of the cells had an expected count below 5 (minimum expected count=5.95), indicating that the chi-square test assumptions were satisfied. Effect size statistics showed a Phi coefficient of −0.381 and a Cramer's V of 0.381, which corresponds to a moderate strength of association between decision-making power and avoidance of healthcare due to stigma. The negative sign of Phi reflects the direction of the relationship, with decision-making power being associated with lower likelihood of avoiding healthcare due to stigma.

Table 1: Socio-demographic factors of the respondents.

Variables	Frequency (n=130)	%
Age (in years)		
18-25	12	9.23
26-35	27	20.77
36-45	39	30.00
>46	52	40.00
Education		
Primary school	40	30.77
Secondary School	57	43.85
Higher Secondary	8	6.15
Graduate and above	25	19.23
Marital status		
Married	104	80.00
Separated/Divorced	6	4.62
Unmarried	6	4.62
Widowed	14	10.77
Employment status		
Full-time employed	36	27.69
Part-time employed	25	19.23
Self-employed	14	10.77
Unemployed/Housewife	55	42.31
Monthly family income		
Below 10,000	54	41.54
10,001–20,000	38	29.23
20,001–30,000	22	16.92
Above 30,000	16	12.31
Caste category		
General	27	20.77
OBC	37	28.46
Other	16	12.31
SC/ST	50	38.46
Residence type		
Rural	59	45.38

Variables	Frequency (n=130)	%
Urban	71	54.62
Number of children		
None	19	14.62
One	32	24.62
Two	69	53.08
Three or more	10	7.69

Table 2: Association between attendance at health awareness programmes and confidence to seek healthcare independently.

Observed counts			
Attended health awareness programmes	**Confidence to seek healthcare independently**		**Grand total**
	No	**Yes**	
No	8	14	22
Yes	18	90	108
Grand total	**26**	**104**	**130**
Expected counts			
Attended health awareness programmes			
No	4.4	17.6	22
Yes	21.6	86.4	108
Grand total	26	104	130

Table 3: Association between decision-making power in the family and avoidance of healthcare due to stigma.

Observed counts			
Decision making power in family	**Avoidance of healthcare due to stigma**		**Grand total**
	No	**Yes**	
No	4	14	18
Yes	83	29	112
Grand total	87	43	130
Expected counts			
Decision making power in family	**Avoidance of healthcare due to stigma**		**Grand total**
	No	**Yes**	
No	12	6	18
Yes	75	37	112
Grand total	87	43	130

DISCUSSION

Attendance at health awareness programmes and confidence to seek healthcare

In the present study, women who had attended health awareness programmes reported markedly higher confidence in seeking healthcare independently (83.3%) than those who had not attended (63.6%) and this association was statistically significant (χ^2=4.432, p=0.035), although the effect size was small to modest (Cramer's V=0.185). This finding is consistent with an earlier study reporting that women are often uninformed about available government health programmes and that raising awareness through community health workers-together with rebuilding trust in public health facilities-is central to improving women's engagement with the healthcare system.[7] The present result also aligns with evidence that participation in Kudumbashree's group and individual economic activities builds confidence and social interaction among women, even though gains in awareness do not automatically translate into full empowerment, since political participation and legal awareness often remain constrained by external influences and lack of knowledge.[8] Taken together, these comparisons suggest that structured awareness interventions delivered through community platforms such as Kudumbashree can meaningfully strengthen women's self-efficacy in health-seeking, even where their overall empowerment remains only moderate.

Decision-making power in the family and avoidance of healthcare due to stigma

The present study found that women with decision-making power in the family were considerably less likely to avoid healthcare due to stigma (25.9%) than those without such power (77.8%), with a moderate effect size

(χ^2=18.859, p<0.001; Cramer's V=0.381). This is in line with earlier findings that, following participation in Kudumbashree, members experienced a marked advance in decision-making power, self-efficacy and personal skills, alongside greater awareness of nutrition and health-related hazards, although corresponding gains in formal health knowledge were comparatively limited.[9] The present finding is further supported by evidence that Kudumbashree's income-generating and community-based activities help women who previously felt powerless to recognise their own agency and take greater control over decisions affecting their lives, including healthcare decisions. While that body of work also cautions that full empowerment has not yet been achieved for most members, it concludes that continued strengthening of Kudumbashree units has the potential to further reduce stigma-related barriers to healthcare-seeking, consistent with the significant association observed in the present study.[10] Overall, the comparison with previous studies indicates that both programme-based awareness and family-level decision-making power are consistently associated with improved health-seeking behaviour among women in Kudumbashree-affiliated communities, reinforcing the case for interventions that combine health education with broader empowerment strategies.

CONCLUSION

The current research aims to ascertain if the health awareness through Kudumbashree has helped the selected married women to adopt an attitude towards taking an opportunity to access health services and how Kudumbashree health awareness programmes have augmented information for the women to know when and where to seek the intervention. This study's results showed that those who attended Kudumbashree health awareness programmes were found to have a better perspective regarding health-related services. However, those who did not attend such programmes relied on the information provided by informal sources and thus, there were cases of misconception and subsequent dangerous health problems. Though the health awareness provided by Kudumbashree has helped women to know where and when to seek healthcare, financial limitations and the domestic burden hinder women from taking time to avail of the services. The current study throws light on the additional role of Kudumbashree apart from their economic empowerment and provides evidence for developing strategies to address women's health issues in Kerala, India, by conducting more health awareness campaigns among married women.

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