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CHANGING PERCEPTIONS OF HEALTH AND HEALTH BEHAVIOUR: A SOCIOLOGICAL STUDY AMONG ADULTS IN KERALA

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RESEARCH ARTICLE

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Abstract

Health perceptions are often understood through the biomedical lens. Sociological studies have challenged that concept, arguing that health should be understood as a collective experience, socially constructed and negotiated. This paper examines changes in health perceptions and behaviour among people in Kerala. By situating this study in a state known for its public health advancements and high literacy, this paper aims to understand how the perceptions of health are constructed, negotiated and practised among adults. This study further analyses the nature of health behaviours people consider important and the influence of determinants on them. Based on primary data collected from the state, this study has sought to understand the interconnections among health perceptions, social networks, and everyday life experiences. Understanding the priorities people consider in health matters is essential to ensuring the implementation of sustainable public health initiatives.

Keywords: *Social Construction, Health, Health Behaviour, Lived Experiences*

Introduction

Health plays an essential role in everyday life and remains a primary concern for individuals and communities. A comprehensive understanding of health has recognised that it goes beyond the mere absence of disease, incorporating the physical, emotional, psychological, and social dimensions of well-being. Nonetheless, health is often reduced to its physical aspects in everyday practices, where emotional and psychological aspects receive comparatively little attention. Individuals differ considerably in how they perceive health, seek care, build lifestyles, and evaluate risks and prevention methods, indicating the various ways people experience and negotiate health in society. That defines what we understood as health behaviour.

Health Behaviour is commonly defined as the choices people make regarding their health habits, lifestyle, treatments and prevention. Such behaviours are not simple outcomes of individual choices. Rather, it emerges from the interactions among personal preferences, material circumstances, and wider social leverage. Sociological research has consistently indicated that factors such as education, social class, religion, family dynamics, and occupation are significant social determinants of health behaviour and practice. (Yeracaris, 1961).

However, the changing social setting raises an important question in this context: do these identified determinants continue to exert the same influence, or are there new patterns of engagement emerging regarding people's health behaviour?

The concepts of health and health behaviours can vary considerably across societies, as they are deeply embedded in particular social and cultural contexts. What people consider healthy, acceptable, risky or responsible is heavily influenced by the health culture of each society in which they live. Health culture encompasses the understanding and attitudes through which a society interprets and negotiates health, illness and well-being. Without conscious forethought, people often internalise such collective perceptions and incorporate them into their everyday practices. (Bourdieu, 1977). Research indicates that individuals within any society commonly feel a moral duty towards their community. (Nanjunda, 2014). Consequently, their health behaviours often align with the values, expectations or demands emphasised by that society.

Kerala is a particularly important setting for analysing these processes. The state is globally recognised for its advancements in health indicators, its high literacy rate, and its public health infrastructure (Sankar D et al., 2025). Such a successful image often leads to the assumption that high literacy and a better public health system naturally translate into uniform, positive health behaviours and orientations among people. In this context, this study examines the social construction of health and its integration into people's health behaviour in Kerala. This study aims to understand how people perceive health and health behaviour in their everyday lives and how these perceptions are shaped by changing social settings. By invoking concepts such as social

constructivism, habitus, and material conditions, this study explores the logic people use when prioritising health behaviours and defining wellbeing.

Methodology

This study adopts a mixed-methods approach based on primary data collected in Kerala. Household surveys, focus group discussions, and in-depth interviews were conducted with members of the public, public health professionals, youth, and socio-cultural activists to ensure representation from these groups. 240 households were selected from rural, coastal, and urban regions of Malappuram and Ernakulam districts in Kerala for the survey, using a random sampling method, and 60 spokesperson interviews were conducted across the state to incorporate diverse opinions. The study objectives were informed to the participants, and confidentiality was ensured during analysis and writing of the study. The quantitative analysis was conducted using SPSS software and analysed according to the major themes in the decision.

Negotiation, Conformity and Collective Health Behaviour

Public health discussions often assume that health is basically an individual responsibility and choice. Concepts such as self-care, preventive care, and a healthy lifestyle have put considerable emphasis on health as a personal choice and rational decision-making process. Nevertheless, everyday health practices often emerge from one's social world rather than from an isolated individual action. Decisions on care, treatment, prevention, risk, and food are deeply embedded in the networks of family life, institutional arrangements, social relationships, and material conditions. Therefore, understanding how people perceive their responsibility for health is important for explaining lifestyle choices and for understanding responses to public health initiatives, preventive measures, and collective responsibilities towards society.

Health behaviour encompasses more than a single choice aimed at enhancing one's well-being. It includes a set of socially negotiated practices produced through interactions among structural conditions, personal experiences, and cultural expectations. The findings of this study indicate that health behaviour in Kerala is more collective than individualised. Respondents often explained that their health decisions are mostly made through consultations, observation, and adaptation in a socially acceptable way rather than through independent deliberation. Nearly two-thirds (65.4%) of respondents reported that they generally tend to "go with the flow" in matters regarding health. Although such orientation may initially appear carefree, sociologically, it reveals the internalisation of social norms of health and routines that have become normalised through shared living experiences. (Bourdieu, 1977).

By drawing on Bourdieu's concept of habitus, this pattern can be understood better. Health practices often become embodied dispositions rather than people's conscious choices, seeming natural and self-evident just because they are socially learned and reinforced often. Hence, what people eat, how they evaluate health risks, whom they seek care from, and whom they trust for advice often emerge from collective experience rather than explicit calculations. Collective conformity was notably evident in the joint family setting, where health behaviours were often mediated and collectively shaped by elders, extended kin, and shared experiences. People report structurally constrained agency in such contexts. This collective decision-making process regarding health can provide emotional and practical support. Still, it may also accelerate the spread of misinformation and reinforce existing patterns of health behaviour, regardless of their effectiveness or validity.

Parallelly, findings suggest significant variation in individuals' exercise of reflexive health agency. Approximately one-quarter of participants reported adopting an alternative approach to health behaviour, following a more structured and deliberate pattern, especially among nuclear families. This group exhibit traits of independent decision-making and active engagement with health matters. This tendency was more commonly reported among people with greater educational attainment, stable occupations and economic security. Their health behaviour emphasised not only personal preferences but also the need for access to resources to question established norms and exercise choice. The remaining respondents between these two occupy transitional positions characterised by uncertainty. This ambivalence indicates the coexistence of competing forms of knowledge, lived experiences and social expectations. People constantly navigate between traditional understandings, practical constraints, biomedical expertise, and community norms in their everyday health behaviour.

The social distribution of such orientations further reveals that reflexivity and conformity in health practices are not simple matters of personality, awareness or preference. It is shaped by unequal access to resources and opportunities in society. Economic insecurity, precarious occupations, and limited education seem to encourage reliance on collective experience and socially available signals. In such contexts, "going with the flow" becomes more of a rational adaptation to constrained choices and uncertainty. Spatial variations further explain this. Respondents from coastal regions were more likely to report a lack of defined health behaviour, whereas those from urban regions reported structured and deliberate health behaviour and practice.
This contrast highlights the broader differences between communities marked by deep-rooted collective traditions and by forms of reflexivity and individualisation. Therefore, health behaviour cannot be discussed or understood independently of the social environments within which people practise it. (Berger & Luckmann, 1966). Despite agreement with "going with the flow" across all social groups, indicating that adaptive health behaviour has become a socially shared disposition, major differences emerged in how that orientation is experienced and enacted. Conformity looked less like a matter of choice and more like a reaction to structural constraints among the scheduled castes and other backward classes.

Limited access to resources and opportunities, and restricted exposure to alternative treatment practices, frequently left them highly dependent on collective experience and socially available choices. These social groups also exhibited greater

disagreements and ambivalence towards collective health practices than others. It can be seen as an indication of the emergence of new forms of autonomy and agency as people negotiate internalised practices and newer opportunities, rather than as inconsistency. This observation suggests that resistance and conformity can coexist within the same social setting shaped by unequal access to resources and opportunities. Conversely, religion exhibits relatively little explanatory power in influencing collective health behaviour. Although Christian respondents showed comparatively higher disagreement (35%) with "go with the flow" orientation, health decisions appeared to emerge less from religious doctrines and more from collective lived experiences, trust and forms of social capital embedded within their religious networks.

The economic position of people emerged as one of the strongest determinants of health outcomes. Although income and health behaviour did not show a uniform pattern, they highlighted contrasting capacities for reflexive decision-making. Lower- and middle-income households reported the highest levels of agreement with collective health practices. This behaviour indicates structural vulnerability, uncertainty, and limited access to alternatives for lower-income groups.

Hence, relying on social cues and collective decisions becomes the only practical and rational strategy, rather than an indication of indifference or ignorance. Middle-income households occupy an intermediate position, exhibiting what may be defined as negotiated agency, as they possess greater resources than economically vulnerable groups yet continue to exist within significant social and material constraints. Higher-income households portrayed considerably higher levels of disagreement towards passive adaptive health behaviour. Economic position and its security appeared to offer the capacity to survive situational pressure, selectively engage with health knowledge and exert greater flexibility in decision-making in the state.

The association between monthly family income and orientation towards collective health behaviour was statistically significant ($\chi^2 = 40.390$, df = 20, $p = 0.004$), emphasising the importance of material conditions in shaping health behaviour. Similar patterns were observed regarding income regularity, occupational security, and investment patterns. Precarious occupational conditions, irregular income, and insufficient savings seem not to facilitate longer-term preventive orientations and reflexive decision-making in health. People with better financial practices and institutional stability exhibit more reflexivity in health behaviour than in following the crowd.

Economic dependence and household hierarchies further influence health agency. The gendered aspect of health agency indicates that households operating under a shared-earning arrangement between men and women exhibit a high level of reflexive health decision-making. In contrast, households with men as sole earners highly agree with passive and collective health practices. Despite being numerically small, female-only-earning households totally rejected passive conformity in health, reflecting the transformative role of economic autonomy. Men (75%) appeared to normalise health as an episodic concern that requires attention only during illness, whereas women showed greater engagement in everyday health maintenance and preventive care. This active role of women in health is a byproduct of internalised dispositions that position them as caregivers not only to their children but also to their partners, older people, and households. The statistically significant association between gender and health behaviour orientation ($\chi^2 = 15.700$, df = 8, $p < .05$) explains the gendered divisions of care and responsibility. Educational attainment emerged as another important source of health agency.

Collective and adaptive health behaviours were reported among respondents with lower levels of education. At the same time, higher educational attainment was positively associated with greater reflexivity and independence in health behaviour. Therefore, education is not merely the acquisition of information but a form of cultural capital that broadens people's ability to evaluate, negotiate, and practice autonomously in society amid competing claims. Political affiliation does not exert greater influence on health behaviour, suggesting that it is shaped more by everyday material realities than by ideological commitments.

Taken together, these orientations towards passive adaptive health behaviour cannot be interpreted as ignorance, individual failure, or irresponsibility. Rather, this passive-reflective health behaviour reflects the socially produced disposition materialised through different structural stabilities, unequal access to resources and varying capacities for future-oriented practices. The social position of people is highly influential in deciding to what extent they can engage in deliberative, preventive and reflexive health practices. From a political-economic standpoint, economically vulnerable people often experience health as an unaffordable future concern in comparison with immediate survival needs. The relatively weak influence of religion, political affiliation, and region underscores that health rationality in this context is structured primarily by material conditions rather than by ideology or cultural differences alone.

Hierarchy of Health Behaviours

Understanding how health decisions are made leads to examining what counts as health behaviour for people in Kerala. The findings suggest that health behaviour cannot be reduced to a set of actions aimed at maintaining well-being, because people consider some practices central while others remain marginal in Kerala. The assignment of importance to various health practices, based on their standing in that context, thereby creates a hierarchy of health behaviours. This hierarchy is based on what people consider essential, responsible and desirable in health behaviour. According to the study's findings, health behaviour in Kerala is mainly organised around the concepts of collective responsibility, cleanliness, and a perceptible form of prevention.

Hygiene is reported as the most important health behaviour. Across religion, class, social groups and gender, hygiene is considered a key component of self-care and prevention. This salience of hygiene among people indicates that health behaviour is more than an individual preference; it is deeply institutionalised, shaped by family, schools, state campaigns, and social interactions. This bodily discipline becomes internalised as a moral responsibility. By invoking Foucault (1977), this can be

understood as a successful form of biopolitical governance. Hygiene or cleanliness is no longer considered a private concern but a social responsibility, which makes maintaining it in personal and social environments both a health practice and a socially recognised moral behaviour.

Vaccination is the second most important health behaviour among people (22%). Vaccination holds a unique position in this context as both a personal health decision and a collective obligation. Respondents perceived vaccination not only as an individual preventive care but also as a socially expected responsibility associated with defining a responsible citizen and member of society. The social construction of vaccination beyond biomedical intervention has made it a moral and civic duty as well. Schools, healthcare clinics, state programmes and families have normalised vaccination as a routine health behaviour. Therefore, despite possessing the freedom to refuse it, social expectations make vaccination more of an obligation than a choice. Vaccination and hygiene appear as normative health behaviours that specify socially acceptable inclusion in the state.

There is growing importance attached to exercise as a health behaviour, reflecting a different social process. This growing interest is driven by concerns about body image, self-presentation, and social comparison, not by a sense of collective responsibility. Younger respondents often associated going to the gym with exercise and physical appearance for social acceptance rather than for health benefits (Shilling, 2012). Comments on body size, peer comparisons and expectations triggered their decisions. Within contemporary sociological discussions, this behavioural pattern aligns with the view of the body as a social project (Turner, 2008).

Particularly for young people exposed to social media narratives and cultures, the body often becomes a site of identity construction and social evaluation. Hence, people who consider exercise under such pressure treat it as a social performance rather than a health activity. Even then, respondents often acknowledged that the absence of time, a support system and discipline makes it difficult to maintain a regular exercise routine. This indicates Bourdieu's reasoning that health practices are shaped not only by preferences but also by lifestyles, resources, and class positions.

Surprisingly, regular check-ups have an ambiguous position among people as a considerable health behaviour. It is not considered a preventive practice by many. Most of the respondents perceived that health check-ups are unnecessary without visible symptoms, reflecting a largely reactive orientation towards health. Illness is still interpreted through bodily experiences rather than the calculation of biomedical risks. Some respondents intentionally avoid health check-ups because they fear screening may reveal hidden illnesses. People justify not having health check-ups to avoid unnecessary anxieties for themselves and their families. This mindset also suggests that avoiding preventive care is not necessarily ignorance or irresponsibility, but may be a rational response to economic risk and uncertainty.

These findings also resonate with health behaviour theories that explain how perceived susceptibility and costs can influence health decisions. Avoidance becomes a reasonable strategy for managing uncertainty when there is no immediate benefit. Regular check-ups remain uneven across social groups, with higher-income and socially privileged respondents (58%) exhibiting stronger engagement with regular preventive practices.

Unexpectedly, diet does not have a significant position within understandings of health behaviour. Despite the contemporary public health trend focused on lifestyle modification, protein and nutrition, only a minority (9%) considered diet as part of health behaviour. Even among them, dietary practices are limited to reducing portion sizes and sugar intake, rather than following a scientifically based plan under professional guidance. Household experiences of chronic illness and social media or peer influence primarily shape diet control. Families with diabetic patients automatically reduce their sugar intake. Healthy eating in such a context is a response to existing sickness rather than a proactive preventive plan.

Safe sex turned out to be the least considered component of health behaviour despite the rising public health concerns regarding sexually transmitted diseases in Kerala. The limited importance of practising safe sex across all social groups indicates the internalised influence of cultural conservatism, stigma and moral sensitivity associated with discussing it in public and family settings. Foucault's understanding explains that sexuality holds a particular position where silence itself becomes a form of social regulation. (1978). In the Kerala context, the low prioritisation reflects the dominance of cultural mechanisms that restrict open discussion of safe sex over awareness. That invisibility consequently limits its integration into people's everyday health practices. Regional differences in preferences for important health behaviours indicate that health behaviours remain embedded in local and moral cultures and community expectations. Ernakulam emphasises vaccination, hygiene, regular check-ups, and safe sex, while Malappuram emphasises exercise. Similarly, family structure influences the hierarchy of health behaviour. Nuclear families appear to prioritise individualised health practices such as diet, hygiene, and exercise, while joint families emphasise collective welfare through vaccination, check-ups, hygiene, etc. Family, as an important socialisation agent, influences and transmits health responsibility, self-care and preventive understandings.

Religious communities operate as social spaces to mediate health behaviour rather than determine it for people. Variations in practising vaccination, regular checkups, and safe sex can be understood through community narratives, institutional trust, and communication rather than religious doctrines. For example, awareness regarding safe sex practices is higher among Christian respondents owing to the activities they organise inside their church. Economic conditions and educational attainment significantly determine health behaviours.

Higher-income households exhibiting greater engagement with vaccination, regular check-ups, diet control, safe sex practices, etc., reflect that economic security expands the capacity to consider health prospectively, not only reactively. Economically vulnerable people appear to prioritise immediate and visible health behaviours and concerns. Medical sociologists define this

pattern as the social production of future orientations. Resources, stability, and farsightedness in the practice of preventive health behaviour are unevenly distributed across social groups.

Exercise is an interesting exception in this context. A higher inclination towards exercise among lower-income, single-earner households (61%) reflects a greater focus on physical health than a lifestyle choice. Based on the class positions, the same practice carries different meanings. People's social positioning strongly shapes their preference for organised, institutionalised health behaviour that prioritises preventive practices.

Gender roles, occupational differences, educational level, etc., help define that position by providing the required forms of capital. Political affiliation has a very limited influence on the hierarchy of healthy behaviour. Combined, certain practices become normal and markers of responsible health behaviour, while a few remain marginal in the hierarchy despite their biomedical importance. The hierarchy of health behaviour reflects the social processes at work among economic security, moral expectations, institutional trust, and cultural legitimacy. Everyday meanings are more important to people in health behaviours, and constraints, opportunities, and social expectations define them.

The Idea of Well-being

The hierarchy of health behaviour appears to align with the public's concept of well-being. Well-being is commonly understood as a universal welfare concept encompassing physical, emotional, social and psychological aspects of life. Nevertheless, what people define as “living well” is neither universal nor permanent. Perceptions of well-being can emerge through social experiences, material conditions and cultural expectations. Hence, understanding how people perceive well-being can reveal vulnerabilities, social conditions, and priorities beyond individual intentions. The study's findings indicate that well-being in Kerala is essentially organised around the notions of security, stability, and safety from uncertainty.

Individual fulfilment or actualisation is secondary. Respondents mostly chose two or three components of well-being based on their preferences, but there is a clear hierarchy among them. Physical health and financial security are the dominating components in almost all responses, while lifestyle dimensions and psychological health are comparatively least preferred. Physical health is undoubtedly the most preferred component of well-being across all social groups. Physical health is considered a foundation upon which all other components of life depend. A recurring sentiment during field interactions was that maintaining physical health makes other challenges easier to manage. Hence, bodily well-being is central to overall well-being.

Closely connected to physical health was the overwhelming (80%) importance given to financial security. Economic stability is considered a fundamental condition of well-being. Financial security is perceived as an important aspect towards access, autonomy and survival in healthcare for individuals and families. Marxian readings can emphasise that broader experiences of well-being are constructed upon the material conditions. (Acton & Baur, 2017). Understanding of well-being among people is directly linked with their social position, labour, resources and economic stability. So, when health becomes expensive, financial security becomes inevitable.

People strongly believe that financial stability can alleviate numerous challenges and dependency in life. Field narratives further reinforce this interpretation. Young people often associate their inability to follow a healthier lifestyle with their economic dependence and limited resources. Older respondents shared their efforts to reduce illness to avoid becoming a financial burden on their families. People also consider well-being to be maintaining autonomy and independence alongside personal growth. The prioritisation of the absence of emergencies (34%) highlights this orientation towards security. This reflects the collective memory of recent crisis experiences with floods, the pandemic, and climate disasters, and the economic and social uncertainty they brought. Such experiences shaped people's everyday perceptions of risk in Kerala.

This prioritisation cannot be reduced to pessimism but is a reflection of vulnerability. Households are well aware of the capacity of unexpected crises to simultaneously disrupt economic stability, health, and social security. By invoking Beck (1992), this preference can be understood as an organisation of contemporary life that anticipates, manages, and limits future risks rather than prioritising immediate needs alone. Social Security's preference (30%) among people further underscores the centrality of safety and stability in people’s conception of well-being. Living better is not always about abundance but the absence of insecurities.

Mental health is noticeably the least preferred component of well-being in Kerala, despite the ongoing discussions on emotional well-being. Maslow’s hierarchy of needs can explain this pattern of preferences. People prioritise components that can provide immediate solutions to their everyday problems, while psychological components seem personal and secondary. Psychological distress is often associated with physical symptoms, financial concerns, social issues and so on. Few people have explained other components of their well-being, such as housing and infrastructure. However, every explanation of aspects of well-being is interlinked with their socio-economic and material position in society.

Conclusion & Suggestions

Understanding health behaviour necessitates going beyond individual choices to collective social narratives. Health behaviour in Kerala is changing in response to the social interactions people have in their day-to-day lives. The high tendency to follow the crowd in health behaviour shows how health is experienced and practised socially. Similarly, whether people perceive health behaviours as important or not, defining well-being is inextricably linked to their socio-economic positions. Education, Income, Gender, and Family arrangements currently emerged as the most influential determinants of health behaviour in the state. Factors

like religion, politics, and so on appear to be significant in relation to material conditions. Health behaviour is therefore a socially constructed practice, and people negotiate it through their everyday practices. However, the health agency's adherence to the practices seems to be influenced by collective health networks rather than by individual rational choices.

Public health authorities need to understand the changing patterns and concerns of health and health behaviour among people, as it can also be influenced by negative experiences or misinformation from various sources. The authorities should try to implement programs that align with the new health perception, are context-specific, and are inclusive, ensuring that every voice is heard and the programs are sustainable.

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