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# Navigating Health Governance: Public Policies and Everyday Healthcare Practices In Kerala

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## Abstract

Discussion on public policy and governance has become significant in the health sector. Every developmental agenda suggests health policies and initiatives to ensure an inclusive growth in society. Kerala, in this context, has been recognised as a state with an advanced health sector, high literacy and institutionalised care. This paper aims to understand the governance and public health policies in Kerala and to critically examine how people perceive the state's interventions in their everyday health behaviour. The study uses a mixed-methods approach, with primary data collected from two heterogeneous districts in the state. Household surveys, focus group discussions, and stakeholder interviews were conducted in a post-pandemic context. The post-pandemic scenario has changed people's health behaviour drastically.

Drawing on the concepts of risk, social constructions, and habitus in a sociological context, this study analyses changing trends in public health policy among people and their potential to challenge the existing system. The study's findings suggest that people face problems with health policies regarding vaccination, welfare schemes, and institutionalised care. The study also highlights the role of health workers in implementing public policies and how the public receives these policies. This study is relevant because it goes beyond numerical datasets to reveal people's lived experiences, which are essential to the sustainability of every policy.

**Keywords:** Public health policy, Welfare schemes, lived experience, Institutionalised care.

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## I. Introduction

Health is an important factor in a state's welfare agenda worldwide. It is not limited to individual choices or actions, but to a social one. Hence, health governance is a highly strategic and crucial function within state systems. Health governance is "the system of rules, structures, and processes used to direct, manage, and hold health sectors and organisations accountable". According to the World Health Organisation, "effective health governance ensures that strategic policy frameworks are combined with oversight, coalition-building, regulation, and accountability to make health services accessible and equitable. Health governance is particularly evident in public health sector activities, as the sector is open to every citizen" (Universal health coverage n.d.)

Kerala, as a welfare state, is globally known for its high literacy and advancements in the health sector. Public health in Kerala has been appreciated for several factors, including how the state handled pandemics such as Nipah and COVID, as well as natural calamities, along with institutionalised care, vaccination coverage, and so on. (Sankar D, et al. 2025). That does not guarantee public conformity to public health policies. The tension existing between people and the public health policies is not new. For example, studies show that India has witnessed severe disagreements throughout the vaccine implementation process from the beginning. ( Bhattacharya 1988). Similarly, in Kerala, people are not simply accepting the health initiatives as policies but analysing them through their own networks.

The problem is that the data on health initiatives may present a success story. Yet the reality may take a different form, consisting of perceptions, social determinants, networks, and interactions. That is a sociological concern, as studies have argued that health is socially constructed. Even the everyday practice of health policies is more of an outcome of social factors than the governance itself. (Berger and Luckmann 1966). People interpret policies and governance through their existing set of beliefs, risk perceptions and habitus. Their local health culture can determine whether to conform or deviate from a specific health initiative despite its seriousness. Internalised dispositions and social determinants vary among people and can explain why they react differently to the same health policy. ( Nanjunda 2015) .

So, the central question that emerges here is how people perceive, negotiate, and incorporate public health policies in their everyday lives in Kerala. Addressing this will also explain how people perceive the overall health governance, as well as specific policies in their health behaviour. Drawing on the concepts of risk (Beck 1992), social constructions (Berger and Luckmann 1966), and habitus (Bourdieu 1977). In a sociological context, this study analyses changing trends in public health policy among people and their potential to challenge the existing system. Health policies regarding vaccination, welfare schemes, and institutionalised care are examined as major areas of health care. Moreover, examining the role of health workers in implementing public policies can reveal how the public receives decentralised health governance.

## II. Methodology

This study relies on primary data collected from Kerala. The fieldwork was conducted in the two most populous and heterogeneous districts in the state, Malappuram and Ernakulam. A total of 240

households were surveyed. Households were selected based on the availability of children, with assistance from local health workers and Anganwadi teachers. Data was collected through Focus Group Discussions (FGDs) and interviews, which helped gain deeper qualitative insights. Additional key informant interviews were conducted with people who work closely with public health initiatives and other representatives. The participants were informed about the study's objectives and gave consent. Data were analysed through thematic analysis. This study is primarily rooted in theoretical frameworks of social constructivism, habitus, and risk to understand how people socially construct health, how they attach meanings to health policies and governance, how they transform them, and how they make reflexive decisions while navigating competing sources of knowledge in their everyday health behaviour. Post-pandemic context

## III. Major Results

### 3.1 Public Perceptions of State Health Institutions

When it comes to public perceptions of health governance, the first factor people notice is its material aspects. Here, this includes the state's health infrastructure, how the state health system is operated and implemented, and how the public evaluates and accepts it. The state infrastructure also includes government hospitals and primary healthcare centres, as well as the wider public and private healthcare facilities through which the general public receives healthcare. How people evaluate such institutions can reveal whether they are satisfied with the services provided. Whether they consider different institutions equally accessible or useful, or whether they develop preferences among such institutions based on their perceptions. These perceptions can also reflect in their everyday health practices. Understanding public perceptions of state health institutions is very important to examine the connection between people and the state health system. (Anbu and Sheeba 2020)

The study's findings show that respondents maintained a continuing connection with government health institutions despite having very limited routine engagement with primary health care facilities. Among the 240 households, 19.6% reported visiting PHCs (Primary Healthcare Centre) monthly, while a majority (around 76%) reported visiting PHCs very rarely. Only a very small proportion reported not visiting the PHCs at all. Such responses indicate that PHCs remain a part of respondents' health care experiences, but regular utilisation of these institutions was not so common in Kerala. When it comes to public health care centres, proximity or physical accessibility is often considered the most important factor in utilisation. However, the findings suggest that physical accessibility alone does not necessarily encourage greater utilisation. Only about 19% of respondents said they would use PHCs if they were located closer to them, while 81% said they would not, even if they were closer. This suggests that respondents' decisions about using public primary healthcare facilities are not determined solely by geographic availability or accessibility. Other factors also influence such decisions regarding the use of these institutions.

The evaluation of government hospitals provides a somewhat different picture. In Kerala, people generally view government hospitals positively, but this positive assessment coexists with a strong demand for improvement in the same sector. Out of the 240 households surveyed, 147 households described government hospitals as good, while only 17% households described them as the best. Mean-

while, 26 households described the government hospital facilities in Kerala as bad, and 49 households were unable to rate them. Although positive assessments were more common than negative, around 68% of respondents also demanded that government healthcare services undergo thorough improvement. The findings thus show a combination of positive perceptions of government hospitals and expressed expectations for further improvement in the provision of services, health care work, people's encounters and experiences, and their experiences with state health institutions.

The findings also reveal that people prefer private healthcare centres, small clinics, and larger hospitals in several situations rather than relying on government or primary healthcare facilities. Private healthcare was particularly preferred for major treatments and emergencies, with many people describing such facilities as more convenient and accessible there. Some people stated that they were unable to receive the same level of care or accessibility at government facilities when seeking treatment. The unavailability of specialised doctors, insufficient staff, and limited infrastructure were also identified as major problems contributing to the perception that public health institutions are not always able to meet people's immediate healthcare needs.

Overall, the findings do not suggest a uniformly positive or negative perception of the state in institutions in Kerala; people continue to engage with government healthcare institutions and generally evaluate government hospitals positively. At the same time, identifying limitations is also important. It is very important to understand preferences for public and private health care in particular situations, to show further how people's experiences of the health system involve choices among various institutions and forms of healthcare.

### 3.2 Public Health Interventions and Everyday Health Behaviour.

When it comes to public health policies and everyday health behaviour, how people respond to state interventions is crucial to understanding health governance. There are several public health policies through which people exercise some degree of choice, while others appear more directly as state interventions. Vaccination, in that case, particularly as a preventive health behaviour, is a form of state intervention. Health insurance and welfare schemes are also important areas where people encounter the state in their everyday lives. Understanding how people respond to state interventions in the healthcare sector, how they make choices, and how health information about such interventions is communicated and received can help explain how they actually perceive and navigate health governance in their everyday lives.

Vaccination is considered an important aspect of people's understanding of preventive health behaviour. (Attwell, Meyer and Ward 2018). Around 84% of people recognised vaccination as their key aspect of health, indicating a very high level of recognition of its importance. The importance of vaccination was also considered necessary, with around 91% of respondents stating that both children and adults should be vaccinated. A very small proportion, around ten per cent, do not share this perspective, even though specific vaccination practices also showed high uptake. Regarding tetanus vaccination, around 92% of respondents said they would receive it whenever required. Such findings indicate that vaccination, as a state-supported preventive health intervention, was generally recognised and incorporated into their health practices in Kerala.

However, recognition of vaccination does not automatically mean uniform compliance with compulsory vaccination. Although people generally prefer to decide whether to vaccinate themselves or their children, around 55% of respondents supported making all vaccinations mandatory. While around 26% of people opposed mandatory vaccination, 19% expressed uncertainty, suggesting that whether vaccination should be mandatory could depend on the situation and the people involved.

The most notable finding was that around 56% of households reported being unaware of their own or their children's vaccination status, including which vaccines had been received and which doses had been given. When it comes to COVID-19 vaccination, the data similarly shows a variation in vaccine uptake. A majority of respondents had received the COVID-19 vaccination, particularly the first and second doses, while uptake of booster doses has decreased. At the same time, a substantial number of people had not received the COVID-19 vaccine. The sources of vaccination also reflect the role of government and health facilities in preventive healthcare. For children, most people reported using government healthcare facilities, while a smaller proportion used private facilities. A similar pattern is also observed for COVID vaccination. Government health facilities, therefore, remain an important source of both childhood and adult vaccination in the study.

The preference for government facilities for any vaccination is also connected to considerations of accountability. Some people stated that if something went wrong with the vaccination, it would be easier to seek accountability from a government facility than from a private hospital. For some, vaccination was also understood as a social responsibility, but did not mean complete trust in the system. The choice of government facilities was associated with both the availability of free services and the expectations that the government could be held accountable in the event of a problem. Similarly, respondents also identified limitations in the availability of certain vaccines in government facilities. Some parents reported that vaccines, including vitamin A and other vaccines required for children, were not always available in the government facilities. So, parents who want to provide all necessary vaccinations for their children sometimes use private facilities, especially when specific medical requirements are involved.

Convenience was another factor shaping the vaccination behaviour. People considered vaccination a social responsibility and, in some cases, associated it with children's schools, admissions, or travel documentation. (Korn, et al. 2020). So, parents would generally be willing to vaccinate their children, but the convenience and availability of the service also influence this. Private hospitals described as convenient in such situations were those that provided vaccination as part of the delivery package itself. So, parents did not have to make a separate visit to obtain the vaccination, and the vaccination schedule could be maintained and communicated through the hospital.

Health welfare schemes are another important area through which people also encounter state health governance. Kerala has implemented various health-related welfare schemes that provide free healthcare services, health insurance, and other support related to childbirth. But respondents reported difficulties accessing and using some of these schemes, even though many households are eligible for health insurance. Those who registered under the programs reported that they often did not know which hospitals could be used under this claim or which diseases and treatments were covered. There was very limited awareness regarding when and how such insurance cards had to be renewed.

The findings also reveal that registration under a welfare health scheme does not necessarily mean that households were able to make full use of its benefits. This issue becomes especially important in the post-pandemic context, when the need for healthcare is high. The inclusion of family members within these welfare schemes is another issue reported by people. In some families, not all members can be included in the available insurance arrangements. So, respondents reported situations in which women, including mothers or wives, were excluded from insurance coverage, while the father and the children were included as primary beneficiaries. Similar restrictions are also reported for welfare schemes for non-resident Indian families. Additional payments could be required to include certain family members under health schemes. Such restrictions actually affect the extent to which households could benefit from welfare schemes. The findings show differences in how people experience and respond to various forms of public health intervention in their everyday lives.

### 3.3 Health Workers, Social Relations and Policy Negotiations

Policies and health governance do not reach individuals in isolation; they are mediated by various actors, including health workers, families, and social communities, as well as by existing cultural beliefs and practices. When the government implements a particular health policy, it is often decentralised through local self-governments. Therefore, it is very important to understand how health workers and social relations operate in the negotiation of such policies. Understanding how people perceive the role of such health personnel, and how health workers perceive and perform their roles, can provide a clear picture of how policies reach people, how they are implemented, and why some policies receive greater acceptance than others. (Gilson 2003).

ASHA (Accredited Social Health Activist) workers, Anganwadi teachers, child health development program officers, local social workers, and politicians are among those involved in spreading awareness of existing policies and helping people understand and navigate them at the local level. Health communication occurs daily through various interactions that convey information about government programs and health initiatives to people. So, from a people's perspective, most recognise the role of ASHA workers and other healthcare workers in the local healthcare sector.

The findings of the study suggest that respondents encountered government health policies not only through government institutions but also through local health workers and their existing social relationships. Trust in such friendly health workers is relatively high among people, whereas around 31% reported not trusting ASHA workers when it comes to health-related matters. This does not necessarily indicate that ASHA workers were perceived as completely untrustworthy. But it also shows that trust in the role of health care personnel at the local level was not shared by everyone, despite their position remaining an important point of connection between them. People also report paying attention to advice from ASHA workers, particularly regarding factors outside the body, such as the environment and everyday conditions, that may affect health. Respondents also expressed greater hesitation regarding medicines provided or recommended by such local healthcare workers, particularly for general infections and similar conditions. According to several people, ASHA workers are not sufficiently trained to provide health-related awareness and advice on certain matters.

The experiences reported by local healthcare workers, especially ASHA workers, provide a different

perspective on the implementation of several health policies at the local level. They described having to work largely on their own, visiting households in their assigned locality and informing everyone about health-related initiatives and policies. Though the areas are familiar to them, moving from house to house and communicating the health messages as described is very demanding; they also report difficulty entering several households and conveying these messages effectively due to restrictions. Insufficient and inadequate training was considered a difficulty in carrying out their responsibilities across all aspects.

The local healthcare workers also said that limited involvement of ward members and representatives in health-related activities has a negative impact. They suggest that greater involvement by local representatives can help people navigate health policies more effectively, as they tend to trust their elected representatives more than government-appointed officers. Child health program officers and other officials responsible for health-related matters reported facing difficulties, as many of their official responsibilities are beyond their health-sector roles, limiting the time available for their specific health-related tasks. That creates further difficulties in properly operating and communicating such initiatives and policies, resulting in a negative perception of these policies among people.

When it comes to social relationships, especially family relationships, it is considered very important that around 59% of households believe family members have a right or responsibility to intervene in any family member's health-related decisions. Meanwhile, approximately 18% of households felt that health decisions should remain personal, while some expressed ambivalence. Such responses show the variation in how people perceive the role of family members in individual health decisions. Respondents' attitudes towards government health programs also reflected a distinction between political identity and participation in public health initiatives. The majority of respondents said they do not consider the ruling government's political identity a reason to support or reject any health programs.

The findings suggest that health policies and health-related decisions are situated within everyday social relationships, and people's experiences reveal that healthy decisions were considered in relation to family members, health workers, and broader social contexts, rather than as an exclusive individual choice or a direct response to state intervention. So, experiences and social interactions with people around them regarding preventive healthcare practices or major public health initiatives contribute more than the system can provide. So, the findings indicate that when discussions within the social relationship help to legitimise health policy or practice, acceptance will be higher. In contrast, acceptance is lower when such legitimacy is not established. Participation in public health initiatives coexists with expectations regarding the state's role and performance in the healthcare sector.

## IV. Discussion

The findings show that having a developed public health infrastructure does not automatically result in regular engagement with it. Public health institutions in Kerala have a long-established network of government hospitals, PHCs, and other state health institutions, and people continue to recognise their importance in providing health care. But there is a relationship between people and these institutions that is based not only on their physical availability but also on other factors. Even when

people positively recognise or perceive a state health institution, there is a huge demand for greater involvement. Here, the issue is not simply whether people support or oppose public health care, but also whether they can recognise the value of such institutions while identifying their limitations and the services they provide.

The relationship between the state health system and the public seems to be shaped more by experiences with the institutions than by the institutions' existence or infrastructure alone. And selective engagement is further evident when the preference for private healthcare is mentioned. So, this does not mean that people have completely rejected the public health system. But it means that people actually move between public and private healthcare institutions and facilities based on the kind of healthcare they require and what they expect from the institution at that particular context, which is influenced by the social network.

These findings are very important for understanding health governance because public healthcare divisions and factors are often discussed solely in terms of the availability of institutions or services. Still, the everyday experiences of government, the experiences of health governance, take place when people actually interact with these institutions. So, a PHC can be geographically available to a household but may still choose not to use it because they consider it insufficient for their particular healthcare needs, even though they perceive that option as available to them. People's experiences are becoming a very important part of how the public health system operates in everyday life.

And when it comes to the role of frontline healthcare workers, it also shows that the relationship between the state and the people is not limited to formal institutions but also extends to informal social communication and networks. So, they trust people towards any healthcare worker or any system, but that trust is built through interactions and their experiences, and hence it forms an important part of the way public health governance is received through them. The findings point to a difference between the availability of healthcare and its engagement. So, Kerala's public health system actually has an established institutional structure, but people continue to decide when and in what form they will use it. So, health governance in this aspect is experienced through everyday choices rather than only through the existence of any state health facilities.

Vaccination provides a clear example of the relationship between state intervention and everyday health behaviour. There is no uniform, complete conformity with every form of state intervention among people. So, the difference between recognising the vaccine as a necessary choice and supporting it as a mandatory procedure is particularly important. And so, the differences between the opinions mentioned above suggest that people may accept the health practice itself. While still having reservations about the extent to which they enforce their everyday health behaviour. Vaccination is actually a point where public health responsibility and individual choices meet and work together.

This is all connected to how one socially constructs their everyday health behaviour and, based on availability, the associated idea of risk. What people actually consider necessary, responsible, safe, or appropriate is very important alongside the official details. For example, in such a context, vaccination is never considered as only a medical intervention delivered by the state. People consider it an everyday health practice because of how they understand its importance. To respond to the information they get, they assess the risks and benefits and decide how to take it and to what extent they

should receive it. The findings also take the idea of agency into discussion. People are not simply passive recipients of health policies; they recognise them, participate in them, and often consider them a social activity. They also make choices based on their understanding of it and the source of the social situations in which they understand that. So, people's responses suggest that state intervention and individual choice operate together rather than as completely separate processes.

The findings show that health governance can be explained as follows: when it comes to reaching people, health policies reach them through social relationships. The social relationship provides the everyday setting in which people receive various information, discuss health, and decide on a particular health policy and practice. The people providing the information are acceptable. The problem expressed by healthcare personnel reveals a gap between the policy as designed and the conditions under which it must be implemented. So, the local health personnel may be responsible for this health communication, but their ability to do so depends on the training resources, time, and institutional support available to them. The work they are doing is not simply a mechanical implementation of any government health decisions. They have to communicate with people through households, be actively responsive to queries, and work within the actually existing household system as well.

From a people's perspective, trust in them and their advice is not necessarily general or absolute. That can vary based on the type of health information or intervention being discussed, and that is where the concept of risk applies, because people assess risk based on how they use their social network. The qualitative findings particularly show that social interactions can strengthen or weaken the acceptance of any state health policies. This acceptance or rejection is not simply opposition between people or the government. People tend to be evaluative of state interventions, participate in every government program that uses public institutions, recognise their responsibility towards such healthcare initiatives, and are assertive, questioning the adequacy of existing services and making their own choices about how to engage with each.

The concept of habitus is useful for understanding such processes as everyday health practices. They do not actually emerge from individual decisions made outside social life, but rather from people's health behaviour, which is formed through repeated social experiences, relationships, expectations, and interactions with institutions. So, these experiences actually influence what kind of health behaviour becomes acceptable, expected or practised daily. Also, it is very important to understand that these are not fixed practices. People navigate between the public and private realms, respond differently to various policies and may reconsider their choices based on the situation.

Health governance in Kerala, hence, can be understood as a process that unfolds across several interconnected levels. The state actually forms and provides policies and services through institutions, implements them, and health workers communicate and mediate them. People interpret and incorporate them into their health behaviour on an everyday basis. So, families, social networks, and the communication around them further shape how such state interventions are understood, based on internalised habitus dispositions, risk analysis, and the social construction of health in relation to that policy.

The governance of health is, consequently, not completed when a policy reaches the household; it further continues through the interactions and decisions that follow. In short, the study's findings suggest that the effectiveness of a state's health governance depends not only on the existence of

policies and institutions but also on the number of people registered under various health schemes. But it also depends on the relationship between these policies and the social context in which people live. The Kerala experience here shows a population that continues to recognise the role of the state in healthcare, but one that also questions, evaluates, negotiates, and selectively engages with such interventions. Hence, understanding these everyday processes is crucial to understanding how health governance actually works beyond policy formulation and institutional conditions.

## V. Conclusion & Suggestions

The study reveals that health governance in Kerala is experienced not only through available public health institutions and government policies, but also through people's daily interactions with these institutions, healthcare personnel, and social relationships. Though people tend to understand the importance of government healthcare facilities and support them, most healthcare decisions are shaped by availability, trust, convenience, risk assessments, and personal experience. Particularly since the health policies do not reach them uniformly or directly. People's greater support for government initiatives in the health sector is accompanied by a greater demand for and expectation of better healthcare services in the state. Therefore, this study suggests that health governance should consider how policies are understood and experienced by people in their everyday lives. Communication through frontline healthcare workers should be strengthened by ensuring that implemented policies are easier to use and more widely available. Such changes can help reach state health initiatives much closer to people's reality, through which they experience the healthcare services in the state.

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