Culture lens matters while thinking urban health inequity

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'Culture' Lens Matters while Thinking Urban Health Inequity

*- Anuj Ghanekar**

Introduction

"Sir, zopda (slum) will be ultimately a zopda ... certainly much different from well-off society... the cattle would be roaming everywhere, the children would be playing in dumped garbage, the uneducated residents would be often quarrelling in a raised voice and using abusive language..."

An auto rickshaw driver shared a view while driving me to the field location. He narrated nothing but a perceived culture of a typical urban basti (slum). An urban basti shows more complexity due to possible factors like high population density, less socio-economic resources and higher heterogeneity in terms of ethnicities, religions, backgrounds, migration patterns, occupations and political backgrounds[5]. An urban basti may stand out based on its cultural diversity. '-Basti culture' can be characterized by a great number of "strangers" staying together in a limited place, unlike largely homogenous rural culture.

One eighth of urban population of India lives in slums[1]. The urban poor constitute a sizeable percentage of population in any city, and are socio-economically and geographically marginalized[2]. The National Urban Health Mission (NUHM) calls urban poor as "crowded out" while talking about their health situation[3]. Several causes are enlisted by researchers and practitioners behind the health inequity in cities including inappropriate funding, rising private sector, weak governance, weak public healthcare systems, disproportionate exposure to hazards and urban infrastructure[3, 4]. However, there is dearth of information around cultural factors that influence the health determinants in urban basti (slum).

In this context, the key analytical framing question posed here, was: What different cultural factors within urban basti influence its health determinants?. This paper deals with influence in terms of physical and social determinants of health, perceptions of illness, health seeking behaviour and approaches to health promotion. The scope of present paper was limited to culture of basti itself rather than culture of entire city or that of clinical settings.

Defining Culture and its Relationship with Health

Culture in simple terms, is the "way of life". Characteristics of culture reflect from its several definitions. Anthropologist Edward Tylor defines culture as "a set of practices and behaviours defined by customs, habits, language, and geography those groups of individuals share"[6]. Some definitions emphasizes on group element where culture is a knowledge that is "shared" by a group of people[7]. This knowledge is transferred from generation to generation[8]. Culture sets boundaries, shows what an individual can do and is allowed to do. Culture is integrated into all aspects of an individual's life.

For the sake of working definition of culture, this paper considers commonly shared ideas and symbols within basti, and their translation into everyday behaviour and practices. Literature speaks about how culture of community as well as clinical settings influence health[5].

Research Setting

This paper examined the role of culture in urban health inequity by drawing a case of a basti in Surat (City in Gujarat, India). Like many other Indian cities, Surat is vulnerable in terms of population growth, rapid area expansion and urban poverty. But, what makes Surat appropriate for studying cultural influence on health is highest in-migrant population across India[9], heavy industrialization, climate and natural hazard vulnerability[10] and health challenges like infectious diseases or new resurgent infections[11].

This paper is based on fieldwork conducted in "Azadnagar-Rasulabad" basti from Bhatar ward of Surat. This basti was established on the legal Surat Municipal Corporation (SMC) land 30 years ago. As per local Anganwadi centre records (2014), the total population of Azadnagar- Rasulabad counted 8537 and average family size was 5. There were 841 female per 1000 males. Urban health centre and Vector borne disease control unit was located 1.5 km away while some private clinics operated within and nearby basti area.

Methods and Approach

Culture of Azadnagar-Rasulabad was studied from both the point of view of external observer (an etic perspective) and of local people (an emic perspective). The study was conducted under a project of Urban Health and Climate Resilience Centre, during March-September 2015. A variety of methods were followed in studied cultural context – Participant observations of day-to-day behaviours and practices, open-ended interviews, group discussions, photography and participatory mapping exercises were conducted. Data were manually analysed in inductive manner where themes and subthemes emerged during and after the process of data collection.

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Findings

The findings present a descriptive account of cultural factors: explicit ones like practices based on religious and migration backgrounds, neighbourhood structure, language and communication, material culture; and implicit ones such as attitudes and behaviours towards healthcare facilities and access, gender roles, past experience of disasters and work culture. The linkage of each factor with health inequity is presented ahead with quotes and observations from fieldwork.

Explicit Cultural Factors

Explicit factors were the visible ones and their thrust was upon shared "symbols" rather than mental ideas.

Practices Based on Religious and Migration Backgrounds

The Basti dwellers were settled migrants from five different states - Maharashtra, Bihar, Rajasthan, Karnataka and Andhra Pradesh. Religion-wise mixed population of Hindu-Muslim-Neo Buddhist was present. This heterogeneity on the basis of ethnicity and migration backgrounds indirectly would interfere in health matters –Interestingly respondents reported few unique practices.

• While reporting "festival" as a major source of expenditure, basti dwellers explained their "expenditure burden" in monsoon season when most festivals are celebrated, daily wage income sources are uncertain and disease proneness is high.

• Certain religion specific customs were found linked with health status, for example, Burkha dress pattern causing skin infections in summer or lack of health insurance due to religious prohibition were reported by Muslim residents.

• Journeys to native place and return, via long, congested rail travel, were often associated with health problems.

Neighbourhood (basti) Structure

Different social groups intermingle with each other but they seemed to retain unique identity through settlement pattern within basti, for instance, neo-buddhist population in Rasulabad had formed separate Ambedkar nagar. Additionally, separate worship places and community gathering sites were visible. Religious harmony was evident in day-to-day life; however, the basti was perceived as one of the "dangerous" ones when communal riots take place anywhere else in country.

Nuclear family structure also seemed motivating people to gather on ethno-religious and migration status basis. Basti functions with too many informal leaders and political affiliations. Routine conflicts resulted out of garbage dumping or quarrels of children had tendency to bring social group based identities on surface for example, through abusive language.

Basti Structure was found Influencing

• Mobilization efforts of local Non-Governmental Organizations for community health (e.g. cleanliness campaigns or promotion of medical camp at urban health centre),

• Formation of Mahila Arogya Samitis as proposed nationally (NUHM, 2008)

• Cooperation of basti dwellers with community health workers

There is further scope to inquire possible mental health issues in basti arising out of complex neighbourhood structure.

Language and Communication

Established since long, the local Gujarati language of Surat and National language Hindi were widely used in public sphere. Usage of native languages, on the other hand, dominated private sphere (families and extended relatives) even after migration. The native languages included Marathi, Urdu, Kannada, Telugu and local vernaculars of Bihar & Rajasthan, which were often mixed with Gujarati or Hindi. Marathi and Urdu medium municipal schools were located within basti. However, Gujarati language was a subject and its education was given importance by parents for their children.

The working Hindi-Gujarati knowledge had certainly minimized the role of language as a "barrier" in healthcare access and health education. The Guajarati speaking urban health centre staff and a private practitioner from Bihar were able to manage with their patients in Hindi unless the patients were Kannada or Telugu speaking. However, there were some concerns expressed. A medical officer from nearby urban health centre stated,

"Our services must get communicated to illiterate basti-dwellers in a dialect and manner which they easily understand and can comprehend".

The local understanding of diseases was also expressed in popular language which must be understood by healthcare professionals. The malaria, for instance, was classified, according to community members, as "sada malaria/ (simply) malaria" (P. vivax) and "jeheri malaria" (P. falciparum). Sada malaria can be recognized with fever in night, chills etc. Jeheri malaria is dangerous and it cannot be recognized by us... it can be only told by doctors once patient is admitted. Jeheri malaria also has symptoms like stomach upsets, vomiting etc. Jeheri malaria can lead to the death."

Health communication material, say, posters displayed in health centre, medical camp publicity

pamphlets and mosquito larvae identification exercises for schools were in Gujarati language. Their utilization was reported minimal by basti-dwellers. Noteworthy actions from other parts of Surat like printing Malaria action pamphlets in Oriya language for Orissa migrants could not be found here.

Material Culture

Material culture included physical objects and artefacts affecting health directly or indirectly. It was reflected through plastic bags, garbage dumps, street food stalls, lack of playground for children, commonality of televisions and smart phone usage in youth.

Implicit Cultural Factors

In contracts with the explicit factors, the implicit factors were more underlying in nature and psychological.

Attitude and Behaviour Towards Healthcare Facilities and Access

Attitude and behaviour of basti dwellers seemed to be forming roots of health practices. A 42 year old woman from Rasulabad, showing inclination towards private healthcare utilization, told:

"In private clinics, doctors and nurses talk very politely to you... they listen to you... They allow you to talk. We don't feel like going urban health centre cum maternity home for child delivery. Women over there shout at us or refer to civil hospital".

In another instance, a 55 year old informal leader whose opinion indicated a religious take on how might he not opt to take precautions for preventing cardiac diseases, since he believed that nothing could be done to stop such 'plans' of the god.

Although, it falls outside the direct purview of present paper, attitude and behaviour patterns of healthcare staff were worth considering too. One of the health department staffs, for example, identified Azadnagar-Rasulabad residents as a *"naffat praja"* (people who don't listen and act)".

Past Experience of Disasters

Like other parts of Surat, Plague (1994) and massive flood (2006) were reported as major events by basti-dwellers while recollecting their history. Memories of Tetracycline drug distribution as a remedy of Plague, rescue activities during flood, tremendous helping spirit shown by community irrespective of religion boundaries, lessons learnt from 2013 Swine Flu episode were proudly narrated. Such kind of community wisdom would be helpful, especially, for maintaining health post disasters.

Gender Roles and Habits

Men worked as casual wage labourers in unorganized sector (in construction, textile industries, carpentry etc.) or were engaged in self-employment (like auto rickshaw driving, street vending, meet selling etc). Women often played the role of earning member in many families. However, traditional gender roles of cooking, rearing children and household chores persisted for women along with new role of earning. They worked as housemaids, cleaners, rag pickers or were into "earn from home" textile jobs. Adolescents girls were helping hands for parents. Gender roles in basti were influential in several ways, for example: Most rag pickers in basti were women. Centre for Social Studies, Surat has documented how rag pickers in Surat are subjected to skin infections and physical injuries due to dog-bites, dead animals, spoiled food etc. Tobacco addiction to get "high" while doing laborious job was "natural" for men and women. Alcohol and gambling spots within basti were popular and used to be crowded by casual wage male labourers. Interviewed group of women perceived substance abuse as a priority health area which needs attention.

Work Culture

The "work culture" i.e. beliefs and practices associated with work and workplace also mattered. Most of the basti residents were daily wage labourers. They preferred private clinic utilization. Their timings were suitable for labourer men and women rather than public health facility. Preferred access to private facilities was also driven by the thought that the medicines from private facilities provided instant relief.

"Lack of time" was reported as the main barrier for community participation activities in health, for example, difficulties in Mahila Arogya Samiti formation in Rasulabad or demand of " ready to eat" food to Anganwadi workers by community rather than raw food material.

Certain occupation specific habits were also harmful to local environmental health, for example, throwing empty tobacco packets by auto drivers in Rasulabad at auto junction point or families into cattle rearing having low acceptability for mosquito reduction insecticide in stored drinking water due to its perceived risk for animals.

Cultural Competence: a Brief Discussion

The study brings forth useful knowledge about cultural factors that tend to influence the health determinants in urban slums. However, the study is not free of limitations. In terms of theoretical limitations what counts as a cultural influence, is at times somewhat open to debate as there are several views on culture as a concept. The proposed categorization of "explicit" and "implicit" factors can also be deepened further at theoretical level. On methodological grounds, the

possible subjectivity of researcher can be reduced with further validation of responses and ensuring maximum representation of social groups. Using quantitative research methods will substantiate qualitative insights. Several questions raised in this paper provide ample scope for in-depth inquiry.

Culturally competent care has been proposed as a means to reduce health disparity. Cultural competence is defined as awareness of the cultural factors that influence another's views and attitudes, and an assimilation of that awareness into professional practice[5]. Considering the limit of present paper, few world-wide experiments are mentioned here as an idea.

In case of language and communication, for example, the programs to recruit bilingual and bicultural health care providers, development of interpreter services and language-appropriate patient education materials, the use of lay health advisors, and cultural competency training for health care providers are being implemented[12]. The case studies of interventions in Indian urban context are, however, can be the way forward.

Another example could be, The Diagnostic and Statistical Manual of Mental Disorders DSM (2000) of the American Psychiatric Association introduced a method what is now called the Cultural formulation [13] where the patient is asked to develop a life story i.e. a culturally embedded biographical narrative[14].

Other cultural factors proposed here can be seen as opportunity, for example, trend of using smart phones in youth provides the scope for m-health interventions or past experience of disasters can be documented for advocacy of epidemic management in future.

Summary and Conclusion

In this paper, an attempt has been made to illustrate how the "urban" culture of bastis influences health. The cultural factors were thematically categorized as explicit and implicit.

Each factor seemed fostering urban health inequity by limiting the opportunity to become healthy but it also offered scope to minimize health inequity. The policy makers, trainers and medical practitioners are suggested to provide culturally competence in health and healthcare delivery. The paper simultaneously provides direction for future in-depth inquiry, such as whether migrant basti dwellers were having struggle with being 'between cultures' – balancing the 'native' and the 'new urban'.

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