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Contestation and negotiation of urban health in India: A situated political approach

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ABSTRACT

This article examines health as a political struggle, where individuals contest and negotiate to secure health in a situated context. In this context, individuals who are socially embedded and exposed to the existing biosocial arena integrate macro-institutional determinants with everyday micro-institutional settings during the life course. Drawing together institutional analysis and a life course approach, the article examines the interplay of institutions in the exposure, action and outcomes behind individuals health in two case study wards in urban India-one planned settlement, and the other a 'slum-like' settlement. It applies longitudinal methods of household survey and life course analyses of individuals reporting diseases to understand the interplay of institutions. The analysis reveals statutory rules creating boundary conditions for exposure to infection. The individuals exploit these using the socially embedded norms to contest and negotiate through coalitions and networks. The statutory rules defines the scope and outcomes of the health-seeking decisions. The study in two case study reveals that seemingly 'planned settlement' is conducive over the spread of infections than in slum-like settlement. It calls for strategic focus on improving the boundary conditions – the environmental hygiene and public health infrastructure – which might be more effective than contemporary neo-liberal techno-centric and individualized interventions. Failure to promote these actions will provide an environment conducive to the future spread of infectious and non-infectious diseases. Theoretically, it pushes for greater understanding of the socio-political struggle of individuals, rather than focusing on risk factors and dualistic nature of macro- and micro-institutions. The approach leaves room for applying situated political approach in understanding mobility and seasonality of exposure to diseases in urban regions.

1. Introduction

The urban environment in the developing world is increasingly offering suitable conditions for triggering infectious diseases (Alirol, Getaz, Stoll, Chappuis, & Loutan, 2011). The continued colonial legacy of urban planning, limited investment in infrastructure, rapid economic growth, increasing rural-urban migration, and governance failure have created the foundations for contemporary urban problems (Bakker, Kooy, Shofiani, & Martijn, 2008; Chaplin, 2011). Moreover, the unjust distribution of power and control over resources has significantly affected the spatial and temporal struggle of actors looking to secure their health. This article takes an institutional perspective to explore the contestation and negotiation by individuals of their health in a situated political context.

Health, traditionally, was the domain of biomedical science, which treated any illness or disease as having a single underlying cause, with the removal or attenuation of the disease helping an individual attain healthy living (Wade & Halligan, 2004). The social and preventive medicine approach extended this application from the individual to the family and to the immediate environment (Turshen, 1977). In the last few decades, interest in the social and environmental dimensions of health has expanded, with epidemiologists and geographers particularly taking a critical perspective. Epidemiologists have focused on the individual and identified a variety of risk factors influencing health (WHO., 2016). Through their individualized focus they examined the distribution and determinants of disease. However, they disregarded the social structures and dynamics underlying the causes of diseases and their spread (Shy, 1997; Susser, 1998). Social epidemiology sought to give social weightage by focusing on the effects of social-structural factors on the state of health, assuming that the distribution of advantages and disadvantages in a society reflects equally the distribution of health and disease (Honjo, 2004). Through experimental and quasi-experimental methods, such as randomized control trials, authors have attempted to understand

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the causes behind the dissemination of health inequalities and how they remain useful for policy-making (Wemrell, Merlo, Mulinari, & Hornborg, 2016). However, the limitation of these comparative designs have been well recognized (Victora, Black, Boerma, & Bryce, 2011). Without understanding the policy paradigm and macro-level structures, social epidemiologists provide solutions to policy-making by stigmatizing and blaming the victims of disease. A reductionist approach by epidemiologist, ignored the macro-level determinants of health (Krieger, 2011:4).

Health and medical geography originally generated critical perspectives of biomedical sciences through political ecology of health (Mayer, 1996; Rosenberg, 1988; Turshen, 1977). This perspective took a collectivities approach by focusing on the macro-institutional environment (Turshen, 1977). Their interest remains on policy dimensions (Kotsila, 2017), patterns of discourses (Huff, 2014), contestation of institutions (Saravanan, 2013) and narratives and perceptions (Connolly, 2017), i.e. the collectivities shaping health inequalities. King (2017), for example, gave political voice to spatial inequalities in health from a socio-ecological perspective, in an attempt to explain why certain people are more vulnerable in one place than in another location. By focusing on the political environmental context, he juxtaposed the social and ecological domains of health. He demonstrated how the political environmental context shapes the ways in which health is embodied, experienced, and managed. Political ecologist interest on macro-institutional environment could complement the individualistic and reductionist focus of the epidemiologist. Nonetheless, both these fields maintain their interest in identifying the diverse risk factors and dualistic nature of macro and micro institutional environment shaping health inequalities.

Health is not a conglomeration of factors for scholars to identify or explore; rather, these are embodied in human health and understood as 'biological expressions of social relations' (Krieger, 2001, 2005) and represents a interplay between exposure, resistance and susceptibility (Krieger, 2001). In this interplay, health is not static; instead, as people move around, they are exposed to diverse social environments in their everyday struggles during their life course, which take place on multiple levels (individuals, neighborhoods, regional to supra-national) and in multiple domains (home, workplace, social space and public settings) in relation to relevant ecological niches (Krieger, 2001). Institutions play a prominent role and constitute a cross-cutting factor in a wide range of human/environment interactions (such as human health) occurring at most levels of social organization (Young, 1999). They are cross-cutting as their operations explains a significant variations in the socio-economic and biophysical environment. The challenge before us is to assess the proportion of variance that is attributable to the effects of the institutions, rather than identifying different risk factors in the health inequalities.

Health is embedded in the past and present experiences shaped by wider social, economic, and cultural contexts of where and how people spend their time whilst are engaged in daily activities. Socially and institutionally patterned exposure, especially during the life course of an individual, such as childhood, transition towards adolescence, leaving the parental home, entry into employment, establishing one's own residence, old age and the onset of unforeseen health outcomes, significantly affects one's health (Bartley, Blane, & Montgomery, 1997; Kuh, 2003). A situated political approach to health analyzes the contestation and negotiations of individuals with other individuals and organizations in a relevant ecological niche to secure their health. In this situated political context, individuals who are socially embedded and exposed to the existing social and political environment integrate macro-institutional determinants with everyday micro-institutional settings during the life course. Such a struggle takes place in diverse decision-making arenas, which sets the backdrop for boundary conditions (exposures), actions (resistance), and outcomes (susceptibility) for individuals in securing health. Boundary conditions for exposure depend on the socio-environmental and historical settings and the position of the individual. The action of individuals to seek health care strategies is influenced by their socio-cultural background, social network and mobilized coalitions, as well as available information. Individual's health outcomes are defined by the opportunities and benefits available in a situated political context. Against these backdrops influencing human health, the article identifies the role of statutory organizations, socially embedded groups, and contextual factors behind exposure to diseases, as well as reasons for growing health inequities.

Institutions represent a system of established and prevalent social rules that structure social interactions (Hodgson, 2006:2), including social norms of behavior, social conventions as well as statutory rules (Hodgson, 2006:3). In this paper, they are considered as statutory-rules, socially embedded norms and social behavior. Institutions are drawn by actors, who are individuals and organizations, in different decision-making arenas. These arenas are social settings that are accessed, activated, and created in a situated context by actors, in order to contest, negotiate, and exchange goods and services, and to solve problems (such as health security) (Dorcey, 1986; Long, 1989b; Ostrom, 1998). These arenas can be formal or informal, location-specific or generic, created or evolved, whereby different forms of governance arrangements interact incrementally and cumulatively (Saravanan, 2008). Here, the integration of institutions takes place through linkages between pre-existing and existing activities, and across the life course of an individual. The scale of integration conceals the discrete distinction between local, national, and global, between state, market, and community, and between various sectors or factors involved in human health and healthcare practices. The challenge before us, therefore, is to understand how individuals integrate diverse institutions across multiple platforms when securing their health. Ostrom (1998) elaborates on some of the broad sets of rules involved in decision-making (Table 1). Heuristically applying these broad sets of rules affecting individual helps us understand the role of institutions in shaping human health and generating inequities in urban regions. Boundary and positional rules define the context of exposure, while choice, aggregation and information define the action, and scope and pay-offs define the outcome in a decision-making arena (Ostrom, 2005:32–68).

Boundary rules expose an individual to various public health effects, defining who is inside and outside the exposure arena and what qualities propel them into the boundary. The boundary is not an administrative jurisdiction but is rather bounded by the effects of pathogens and chemical compounds. These may be concentrated in one particular location or region (such as radiation exposure) or occur in different places through pathogen exposure (such as malaria and E. coli), or they might even occur over a period of time, depending on their pathology and behavior (such as HIV/AIDS).

In these bounded arenas, the position of the actor matters significantly. Positions for individuals are endowed by statutory organizations (such as emergency and healthcare workers), social embeddedness (positions as wife, mother, employer, etc.), historical factors (such as settlement near to exposure points), and demographic-related positions (such as women, children and the elderly community). During the Fukushima nuclear accident, for instance, several thousands of workers—mostly contractors—were employed by statutory authorities for on-site, high-risk emergency purposes, who were most affected (Hasegawa et al., 2015). Similarly, people living in the vicinity of the accident have a high chance of exposure.

The choice rules specifying what an actor must, must not, or may not do in a particular situation influence their exposure to infections and pathogens. For instance, statutory choice rules place