Culture of Health Care in Urban Slums

VALORISATION

The purpose of the valorisation addendum is to describe the scientific and societal impact of this thesis. This chapter presents a summary of the societal significance of the thesis's presented work. This societal value will be expressed in terms of the practical relevance of the study's findings, the stakeholders for whom these findings are significant, and practical implications of the findings.

RELEVANCE

Slum residents are extremely vulnerable to health and environmental dangers. They tend to settle around waste management facilities like landfills, sewage treatment plants, and industrial operations. Slums are also characterized by a hostile built environment, including poorly designed and unsafe living conditions; shared shelters, access to quality water and piped water supply; safe and clean sanitation, proper waste disposal, and restricted access to healthcare. All of these lead to high rates of illness and injury among the urban poor. Overcrowding, filth, air pollution, and contaminated water and food allow infectious diseases to spread in these locations. Drugs, alcohol, abuse, crime, social isolation, residential instability, and violence worsen slum inhabitants' mental health. At the community level, the health burden and disease morbidity factors among slum dwellers require immediate and concerted attention.

Over 93 million people live in slums (Census, 2011). Most families affected by urban development in India live in slums being resettled or rehabilitated. Examining slums and their inhabitants' lifestyles could help identify the most critical regions in need of assistance. Urban slum poverty, starvation, infectious diseases, and lack of clean water and sanitation contribute to India's high infant mortality rate. The challenges that plague India's whole slum population have thus far eluded the Indian government's control. To improve the health and well-being of the urban poor, urban health development programmes must surmount various obstacles. Some of these factors include the inadequacy of the physical environment and the lack of government assistance for health in slums, as well as a lack of identification, which inhibits the urban poor from having a legal voice. Efforts to enhance the health and well-being of the urban poor are hampered by a number of institutional and sociocultural impediments, such as cultural challenges to improved health for everyone and dysfunctional and uneven governance structures. Population increase, environmental deterioration, and global warming all contribute to the problem and work against a solution, so aggravating the current circumstance. Without gains in urban health, particularly for the urban poor, the Millennium Development Goals cannot be achieved.

Efforts should be undertaken to support and strengthen a comprehensive and need-based urban healthcare system. Volunteers and community health workers can help urban poor engage in self-care and environmental stewardship. The foundation of urban health programmes should be preventative and promotive care. The urban poor have an urgent need for primary care services that are both affordable and of good quality. It is necessary to develop public sector primary care facilities, but it is also crucial to support private providers, non-governmental organisations (NGOs), and community-based organisations (CBOs) that provide healthcare. In this context, governments should consider public-private partnerships. Expanding access to public healthcare for the urban poor requires a focus on both primary care and community-based referrals to secondary and tertiary facilities. Social health insurance and other inventive health care funding could reduce patients' out-of-pocket and catastrophic expenditures. Finding locally-tailored solutions to enhance urban poor access to healthcare involves operational research to establish effective community-level healthcare service models.

Strengthening social capital is vital for promoting health. Social capital can only be fully comprehended in its context for obvious reasons. The increased mobility and transient nature of urban poor habitations pose a danger to the sense of community, which is often strong in economically stable urban neighbourhoods and to a lesser extent in rural ones. Due to their proximity, urban dwellers may have quicker access to institutional help networks, but informal networks may be strained. Due to their economic and social disadvantage, individuals are more prone to become victims or criminals (stealing, trafficking etc.). This causes residents to feel insecure, which harms their emotional and psychological health. Food insecurity is just one of the numerous ways that poverty affects people's lives negatively, and it can lead to riots and even civil conflict. People's well-being often suffers as a result of migration and poverty due to the loss of culture, language, medical systems, and social structures. Since slum dwellers can't stand up for themselves, it's necessary to invest in the area's social capital so more people can get part in health efforts. Through social networks, people can obtain access to opportunities and resources. Resources are in social network architecture, not the person. Race, religion, nationality, or language-based relationships are essential to many people's social expectations. Possibilities for upward mobility and good health can be boosted by acquiring access to various forms of capital, such as education (human capital), wealth and assets (financial capital), and social networks (social capital). Both social capital and cohesiveness are based on the idea that networks are useful and that network norms establish expectations of behaviour that benefit individual and communal goals. Collective social capital may indirectly improve health by boosting communities' ability to collaborate on health concerns (Kawachi et al., 2008). However, social capital alone is not enough to positively influence health and health behaviours. Poor communities can't be helped without additional government funding and public services. Instead,

it can be an indispensable instrument for maximising the value of existing resources and increasing the availability of new ones.

TO WHOM ARE THE RESEARCH RESULTS OF INTEREST?

This study aimed to explore how people in urban slums evaluate their own health, the factors that drive these perceptions, and how these beliefs affect their health-related behaviours and access to treatment. These findings are significant to public health researchers, clinical physicians, community health workers, informal health care providers, civic groups, faith-based organisations, and social workers. Non-specialists may find the findings useful. These results may provide light on the etiological pathways that should be considered when designing place-based public health interventions in a variety of complicated slum environments by think tanks and policymakers.

Our research showed that many of the urban poor choose to get health care from informal healthcare providers (IHPs) like spiritual and religious healers, shamans, and unlicensed medicine dealers. Among the urban poor, reliance on the more accessible and affordable informal providers is on the rise (Onwujekwe et al., 2011). This is due to a number of factors, including the limited availability of health insurance (Okoli et al., 2019) the necessity of making out-of-pocket payments for healthcare (Aregbeshola & Khan, 2021), and the uneven distribution of healthcare facilities and services in urban slums (UN Habitat, 2012). Our research indicated (Chapter 5) that traditional healers are culturally sensitive and have similar views on illness as their patients (Simwaka et al., 2007). They use a holistic approach, taking a patient's social life, relationships, external surroundings, and spiritual health into account (Simwaka et al., 2007). Drug dealers and unlicensed practitioners are popular for similar reasons; they are easy to go to, don't need extensive travel, and are often less expensive than conventional medical care (Courtright, 2000; Munthali et al., 2014). Since traditional healers are better familiar with culture-specific health challenges and traditions, their relationships with patients and their families qualify them to act as an alternative to conventional health care specialists. Given that traditional healers act as physician, counsellor, psychiatrist, and priest, it will be challenging to alter their traditional role in society (Soodyall & Kromberg, 2016).

At this point, the thesis provides health care practitioners and policymakers with a valuable perspective on what is relevant in health systems. What is more crucial is instilling in slum dwellers the habit of seeking medical care when they are ill. For this flexibility in providing healthcare experts, whether for clinical or informal care, they must be made available. We discovered that slum dwellers readily substitute health and well-being in the first place or deny its existence when they are forced to do with fewer resources. To encourage individuals to seek preventative or primary care, it is

necessary to provide them with inexpensive and culturally appropriate healthcare. Formalizing informal practitioners (IPs) is a strongly contested concept. While many organisations, particularly those representing formal providers, are wary of IPs, the reality is that IPs represent a substantial share of providers and that efforts to eradicate or ignore them have failed. Regardless of a nation's approach to IPs, it is essential to comprehend both the rewards and risks of their care in order to make prudent choices. In nations without comprehensive health care coverage, such as India, patients are sometimes restricted to attending providers whose rates they can pay. Because IPs are generally inexpensive, they are frequently the provider of choice for non-life-threatening conditions.

Our research shows that self-care is common at both the micro and macro levels (Chapter 4). On a smaller scale, people follow cultural norms and practises, such as taking concoctions and herbal remedies and praying to gods and spirits, as a way to stay healthy and get better. At the macro level, these include the larger socioeconomic and cultural contexts of a person at the family, community, and societal levels, as well as the demand and supply sides of the health service delivery system. Families are responsible for thorough self-care for mild ailments, decision-making on illness disclosure and health-seeking behaviour, and social and emotional support during illness and when seeking care. At the community level, social and moral support, lay referral mechanisms, and physical and psychological care support comprehensive self-care. At the micro level, people's health behaviour is negatively influenced by their belief in sickness aetiology; for example, those who believe cancer is caused by karma do not seek treatment; those who believe jaundice or leprosy is caused by luck do not practise proper cleanliness or limit alcohol use. Low levels of illness acceptance and treatment adherence are linked to high levels of fatalism. Family can negatively impact self-care by deferring self-care, procrastinating seeking care, receiving lower-quality care, failing to keep medical appointments, failing to comply with medical recommendations, and prematurely discontinuing long-term therapy. The best community-based self-care initiatives are those that draw from both beneficial lay and traditional self-care practises for a revitalised approach to individual health and wellness.

The thesis also indirectly argues that community health workers should promote and strengthen the informal network (Chapter 4) to address the unplanned and unscheduled needs of the poor, reduce the economic shock caused by health expenditures, and maintain the balance of other basic needs. Formal network expertise can be used to provide scheduled and structured care services (Wacker & Roberto, 2013). Self-care can boost community engagement and social cohesion, which can help a low-resource neighbourhood through a crisis. Our findings reveal that collective action and solidarity are considered desirable but only within the context of small, trusted circles (Chapters 3 and 4). But, how can this solidarity and

collective effort be strengthened for the adoption of self-care in an ethnically diverse slum? The Learning Network for Health and Human Rights shows that small-scale individual acts, such as shared health and human rights education, can contribute to the common good (Douwes et al., 2018). Given the increased demand for care among community-dwelling individuals, the model suggests more people may engage in informal caregiving in the coming years, leading to the creation of vast and diverse care networks encircling the ill and dependent. Informal caregivers, such as family, relatives, friends, and neighbours, should be encouraged to indirectly implement self-care in the home of a person who requires support with activities of daily living and instrumental activities of daily living. This could be in the form of transportation to and from medical appointments and social events; companionship; emotional support; or help setting up professional medical treatment (Triantafillou et al., 2010).

Our findings remind policymakers that obtaining lay knowledge by giving slum dwellers a voice can provide an alternative way to understand social pattern of health and illness (Chapter 2). How some groups or classes of people get sick while others stay well requires the creative application of multiple disciplinary perspectives and methodologies in close collaboration with laypeople. This thesis argues that social science research largely excludes lay information from etiological discussions. Instead of trying to figure out what causes bad health, research focuses on lay explanations to figure out why different kinds of explanations are given. Blaxter (1992) also says that there haven't been many systematic attempts to combine epidemiological studies on social differences in health and research with lay people's biographical views on health and illness. This is strange because these two types of research have a lot to offer each other in terms of making study results more generalizable and valid and answering questions that one or the other leaves unanswered (Ferrarotti, 1983). There is more and more evidence that public health researchers, no matter what their specialty is, need to take into account the etiological views of lay experts.

WHAT CAN RESULT FROM THE RESEARCH FINDINGS?

As stated previously, the purpose of the research presented in this thesis was to get a better knowledge of lay perceptions of health and illness from the perspective of urban slum residents. There were no projected physical products, services, processes, operations, or commercial activities. It is difficult to discover direct applications for this type of research. As our thesis demonstrates, the potential contributions of lay knowledge to our understanding of health and disease patterns are broad and varied. On the basis of common knowledge, our research seeks to develop more rigorous and exhaustive explanations for patterns of health and illness in modern urban poor neighbourhoods. The basic argument of this thesis is that laypeople develop 'expert' knowledge distinct from but comparable to that of public health professionals through a more or less systematic process in which experience is compared to life

events, circumstances, and history. We are not arguing that "professional expertise" should be devalued. However, we propose that a much more reflective understanding of the formation of professional and amateur knowledge is required. Equally crucial is a broader awareness of how varied forms of knowledge can increase our understanding and guide policy. The "borderland" between "science" and "opinion", where many public health challenges exist, is a crucial venue for assessing the validity of this type of democratic or public research.

REFERENCES:

Aregbeshola, B. S., & Khan, S. M. (2021). Out-of-pocket health-care spending and its determinants among households in Nigeria: a national study. Journal of Public Health, 29, 931-942.

Blaxter, M. (1992). Inequality in health and the problem of time. Medical Sociology News, 18(1), 12-24.

Census of India 2011. https://censusindia.gov.in Accessed.

Courtright, P. (2000). Collaboration with African traditional healers for the prevention of blindness. World Scientific.

Douwes, R., Stuttaford, M., & London, L. (2018). Social solidarity, human rights, and collective action: considerations in the implementation of the National health insurance in South Africa. Health and human rights, 20(2), 185.

Ferrarotti, F. (1983). Biography and the social sciences. Social Research, 57-80.

Kawachi, I., Subramanian, S. V., & Kim, D. (2008). Social capital and health. In Social capital and health (pp. 1-26). Springer, New York, NY.

Munthali, A. C., Mannan, H., MacLachlan, M., Swartz, L., Makupe, C. M., & Chilimampunga, C. (2014). Non-use of formal health Services in Malawi: perceptions from non-users. Malawi medical journal, 26(4), 126-132.

Okoli, C., Obikeze, E., Ezenduka, C., Arodiwe, E., Ochonma, O., & Onwujekwe, O. (2019). Investigating the level of awareness and extent of financial risk protection among the population in Enugu State, Southeast Nigeria. Int J Med Health Dev, 24(2), 70-77.

Onwujekwe, O., Hanson, K., & Uzochukwu, B. (2011). Do poor people use poor quality providers? Evidence from the treatment of presumptive malaria in Nigeria. Tropical Medicine & International Health, 16(9), 1087-1098.

riantafillou, J., Naiditch, M., Repkova, K., Stiehr, K., Carretero, S., Emilsson, T., ... & Vlantoni, D. (2010) Informal care in the long-term care system. European Overview paper. Athens/Vienna: Interlinks. http://interlinks.euro.centre.org

Simwaka, A., Peltzer, K., & Maluwa-Banda, D. (2007). Indigenous healing practices in Malawi. Journal of Psychology in Africa, 17(1-2), 155-161.

Soodyall, H., & Kromberg, J. G. (2016). Human Genetics and Genomics and Sociocultural Beliefs and Practices in South Africa. In Genomics and Society (pp. 309-319). Academic Press.

UN Habitat: Nigeria: Onitsha Urban Profile. In. Nairobi; 2012.

Wacker, R. R., & Roberto, K. A. (2013). Community resources for older adults: Programs and services in an era of change. Sage Publications.