# COMBATING DISPARITIES AND DRIVING HEALTH EQUITY IN URBAN INFORMAL SETTLEMENTS ACROSS BANGLADESH, INDIA, KENYA AND SIERRA LEONE: INTERSECTIONAL ANALYSES FROM THE ARISE CONSORTIUM

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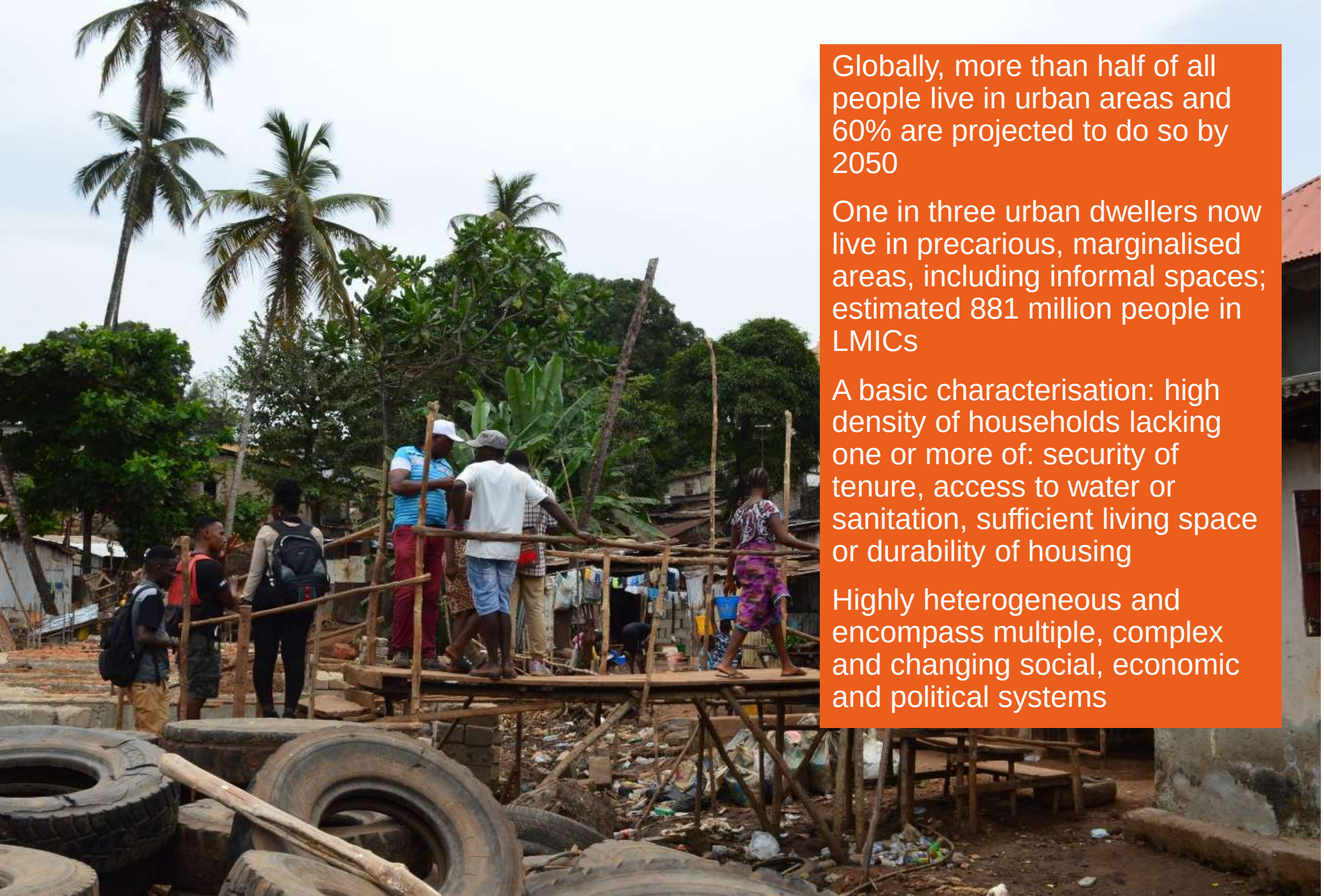

Globally, more than half of all people live in urban areas and 60% are projected to do so by 2050

One in three urban dwellers now live in precarious, marginalised areas, including informal spaces; estimated 881 million people in LMICs

A basic characterisation: high density of households lacking one or more of: security of tenure, access to water or sanitation, sufficient living space or durability of housing

Highly heterogeneous and encompass multiple, complex and changing social, economic and political systems

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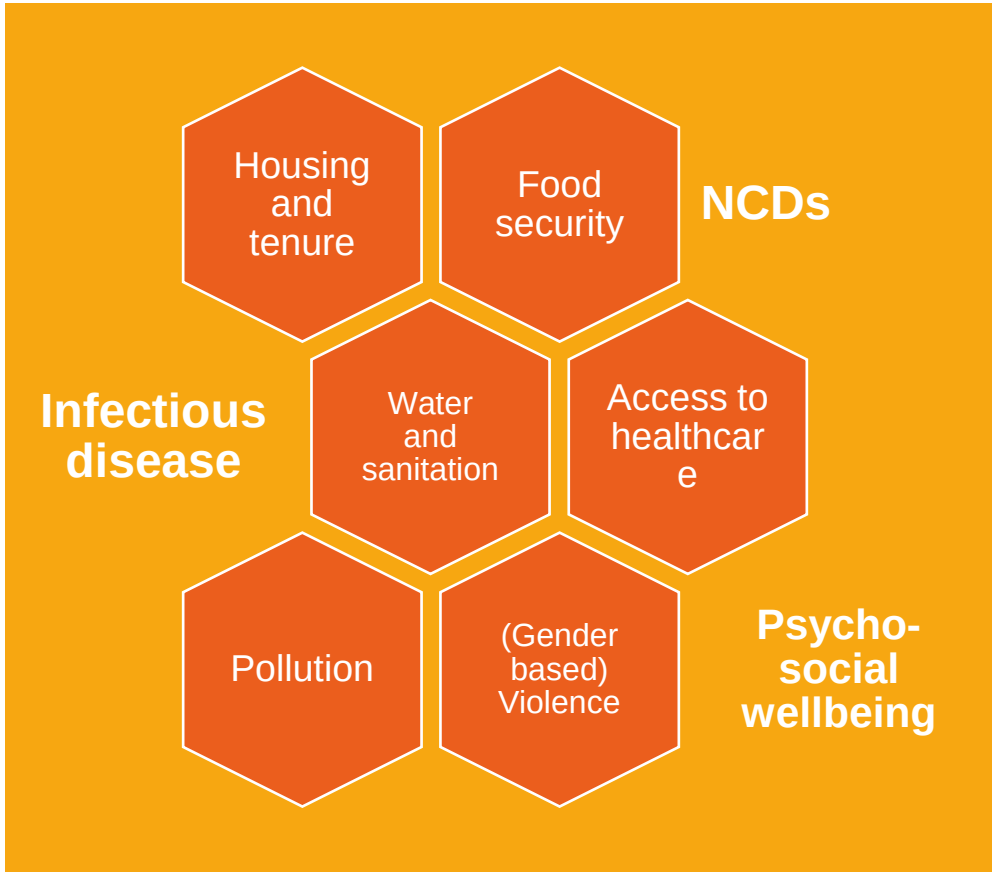
# CHALLENGES OF DAILY LIFE, WORK, HEALTH AND WELL-BEING IN INFORMAL SPACES







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# INTERSECTING INEQUITIES IN HEALTH AND WELL-BEING

**Wider social forces: patriarchy, racism, caste discrimination, heterosexism**

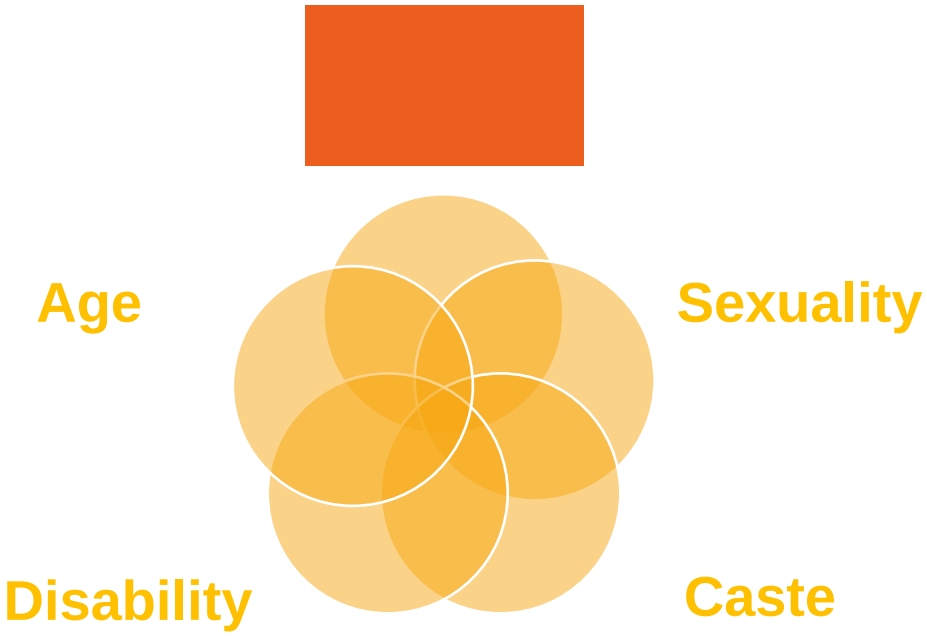


**Photo credits: Shrutika Murthy and TGI communications team, APHRC communications team**

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# AN INTRA-CATEGORICAL EXPLORATION OF HEALTH AND WELLBEING IN BANGLADESH, INDIA, SIERRA LEONE AND KENYA.

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# STRUCTURAL AND SOCIAL INEQUITY: When did you last notice?


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# INFORMALITY AND THE NEED TO CONSIDER VIOLENCE


- “A kind of settlement or economic activity that is outside the realm of legal, formal institutions and processes of the state” (Porter, 2011) – not necessarily illegal
- Lack of entitlements and denial of human rights to realise health potential
- Not a binary -formal relies on informal yet denies it legitimacy and visibility – e.g., in state information systems and planning
- Fundamentally a problem of unequal power relations
- Absence of formal government institutions creates multiple, interlinking systems of informal governance, including community-based arrangements, non-governmental initiatives, private sector and criminal organisations

Photo credit Shrutika Murthy and TGI communications team

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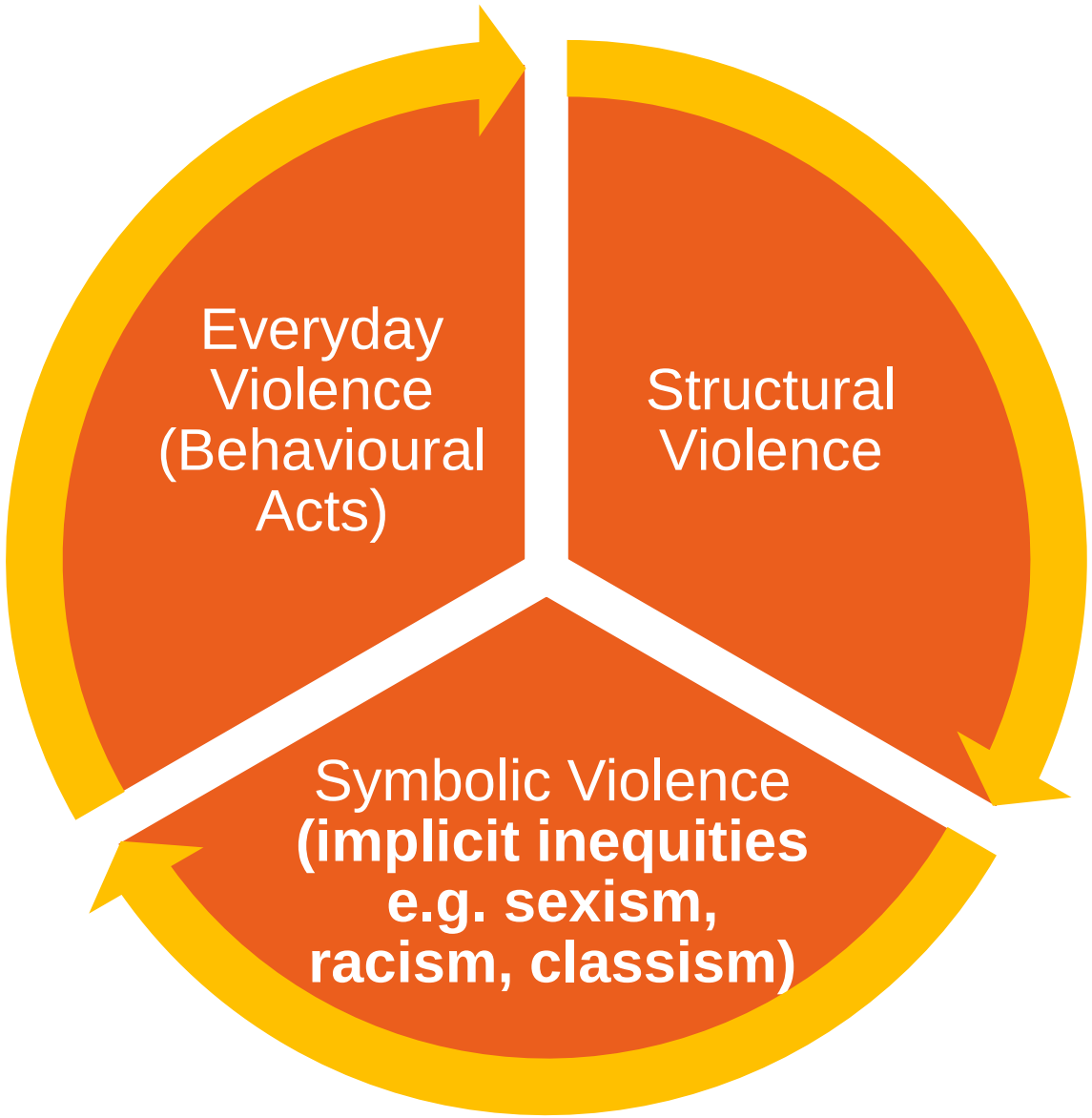
# MERGING MULTIPLE SOCIAL AND ANTHROPOLOGICAL THEORIES TO CREATE ARISE'S EQUITY ANALYSIS FRAMEWORK




Embodiment

**Health and Wellbeing Outcomes**

* Dis/ability, age, gender, geography, wealth, ethnicity, education, caste

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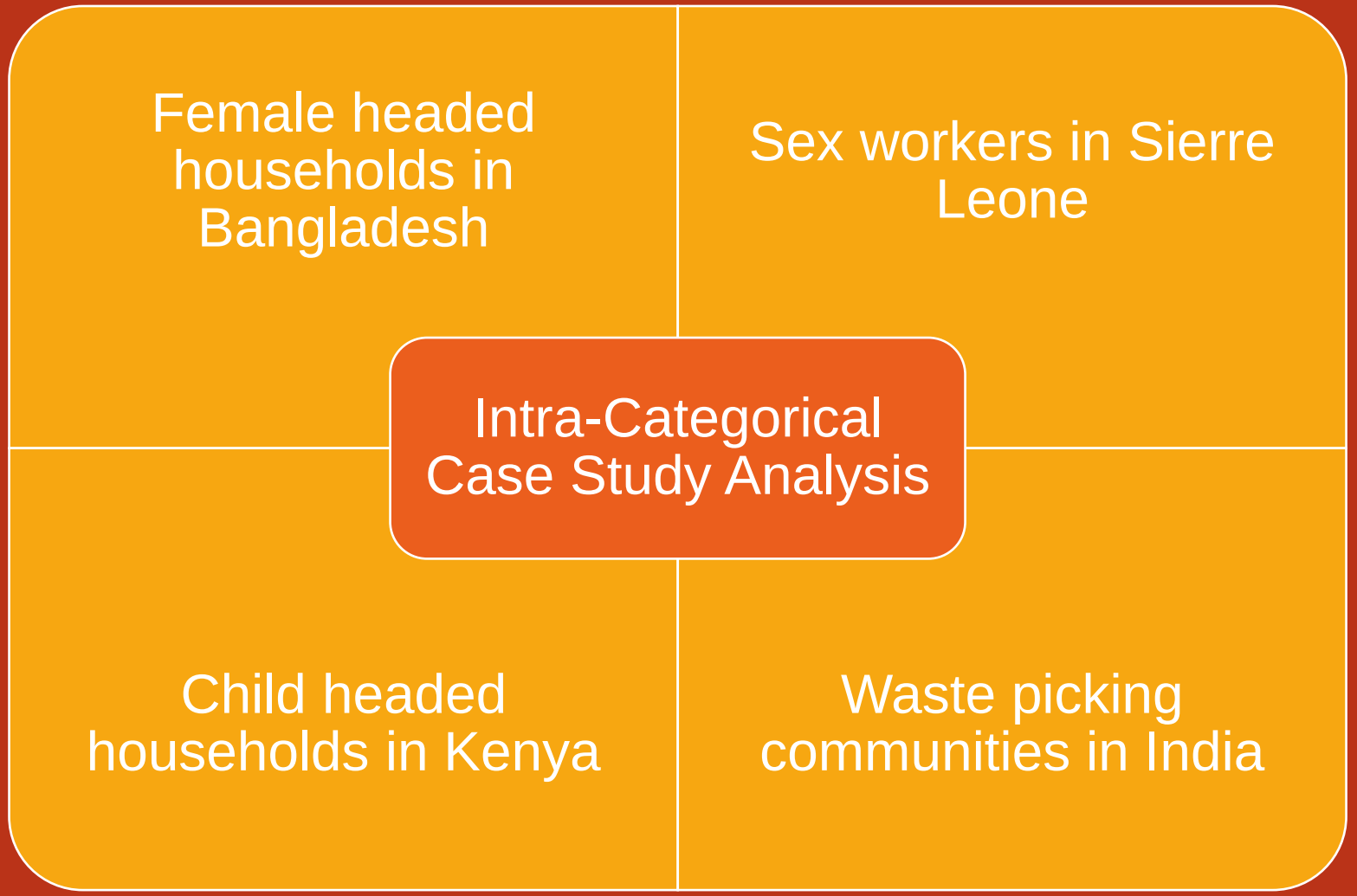
# CASE STUDY FRAMING



# VULNERABLE AND MARGINALISED CHILDREN DURING COVID-19 IN NAIROBI, KENYA

**Vulnerabilities**

- **Overcrowding and orphanhood:** Greater risk in homes, unemployed parents, difficulties in home schooling, devastating effects on children with mental health needs, orphaned children had to drop out so that they could provide support to younger siblings
- **Living conditions, built environment, health challenges and disaster vulnerabilities:** Houses built from improvised and combustible scrap material like polythene, plywood, metal sheets; prevalence of accidental burn injuries in overcrowded homes, unsafe water, unsanitary condition, poor housing, and hazardous location for play
- Mental health and psychosocial vulnerabilities: Poor quality of housing (overcrowded), living environment (noise, lack of sanitation, garbage collection) and non-environmental factors (inadequate income, insecurity, the constant threat of eviction) create stress which is the underlying cause of many psychosocial disorders

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# VULNERABLE AND MARGINALISED CHILDREN DURING COVID-19 IN NAIROBI, KENYA contd.

- **Increased isolation of children living with disabilities:** Children with disabilities faced increased isolation from their able-bodied peers and were often excluded in activities like play
- **Food insecurity and malnutrition:** Dwellers of informal settlements, especially children left on their own, are only able to purchase food from street vendors with inadequate nutritional availability affecting child psychomotor and cognitive abilities

**Capabilities:**

- **Enable schools and wider public services:** Teachers can play vital roles in supporting children in deaths, abuse or mental stress, but inadequate training restricts them

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# EMBODIED, SYMBOLIC AND EVERYDAY VIOLENCE IN FEMALE HEADED HOUSEHOLDS IN DHAKA

**Structural Violence:**

- Precarious livelihood of women exacerbated during COVID-19 shutdowns leading to violence & poverty.

**Symbolic and Everyday Violence**

- Gendered norms of financial control leads to women experiencing physical and verbal abuse from their husbands. Many women report husbands gambling away the money which was to be used for rent, groceries, medicines and savings.
- Added stress and worry due to COVID-19 induced insecurities around money - women experience greater burden on mental health as they feel alone and vulnerable.

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# COMMERCIAL SEX WORKERS LIVING IN INFORMAL SETTLEMENTS, SIERRA LEONE

**Cultural Violence**

- Social exclusion through stigma and criminalisation particularly through supposed protectors like health care workers and police - leading to lack of knowledge/interest/participation in community governance

**Direct Violence**

- High risk and prevalence of rape, extortion and direct violence (even by partners), unwillingness of police to file complaints due to illegitimacy of occupation leading to added vulnerability

**Embodied Experiences**

- Exposure to multiple vulnerabilities deepened by structural and cultural inequalities; sex work often the last resort for vulnerable young women
- Greater risk of illness and infections due to the nature of occupation and access to quality healthcare

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# EVERYDAY, DIRECT, SYMBOLIC AND STRUCTURAL VIOLENCE FACED BY MIGRANT WASTE WORKERS IN BANGLORE, INDIA

**Visible/everyday violence**

- Direct physical violence by state actors like police during waste collection in streets, and within informal settlements, physical violence and harassment by local landlords
- Housing insecurity due to contentions in land ownership, ever present threat of evictions

**Symbolic Violence**

- Intersecting identities (gender, religion, caste, migrant status, occupation) exacerbates precarity. Women from waste working communities face difficulties in finding other jobs - as they are seen as polluting and carriers of diseases
- Viewing migrant (waste, domestic) workers with suspicion - current socio-political discourse makes Bangla speaking migrant workers susceptible to suspicion and targeting by state authorities and the general public

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# EVERYDAY, DIRECT, SYMBOLIC AND STRUCTURAL VIOLENCE FACED BY MIGRANT WASTE WORKERS IN BANGLORE, INDIA contd.

- Stigma associated with shared spaces of waste segregation and living - in informal settlements, waste segregation happens in close vicinity to spaces of living. On the one hand, people living in these settlements are seen as polluting, on the other, for the city's municipal administration, this is seen not as contributing to the city's cleanliness and waste management, but as a source of additional pollution, which bears the threat of eviction
- Inability to seek accountability from state actors as public officials are dismissive of migrant workers due to their non-local status, absence of voting rights and linguistic barriers

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# EVERYDAY, DIRECT, SYMBOLIC AND STRUCTURAL VIOLENCE FACED BY MIGRANT WASTE WORKERS IN BANGLORE, INDIA contd.

**Structural Violence**

- Denial of social security, welfare and health care entitlements due to migrant status
- Increased out-of-pocket expenditures for health care, food provisions
- Absence and denial of sanitary infrastructure through the state - water and vector borne diseases; exacerbated impacts of seasonal health risks

**Embodiment**

- Housing insecurity causes frequent exposure to pollutants, sewerage, weather elements - causing frequent infections, vector borne diseases
- Malnutrition - occupational insecurity makes wholesome meals unaffordable, prominently for women and children
- Precarity and depreciating health are mutually reinforcing - ill health leads to inability to work and earn

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# CONCLUSIONS

- Precarity in living conditions and occupation exacerbates risks like occupational hazards, accidents, infections and diseases.
- Symbolic violence exercised through gender norms, and stigma associated with occupation compound structural inequities like access to entitlements, welfare and health care provisions.
- However, the effects of these forms of compounding violences are contextual.
  - For vulnerable children in Kenya, these factors affect their physical and emotional development and wellbeing.
  - Women in female headed households in Bangladesh experience gendered restrictions on freedom, financial control and physical and verbal harassment within family and society.
  - Sex workers experience direct violence on their bodies, and exclusion from health care systems; which is embodied in higher frequencies of infections and deaths.
  - Migrant waste workers in India face discrimination, harassment and exclusion from health care systems, welfare and entitlements - exacerbating their precarity.

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# CONCLUSIONS

- Health systems need to become cognisant of multiple forms of vulnerabilities, structural and symbolic violences affecting marginalised populations.
- This would enable design of socially sensitive policy making and implementation, as well as fill existing gaps - which can improve the wellbeing of marginalised populations in particular, and everyone in general.

# CONCLUSIONS

- Multiple identity markers embodied by individuals - age, gender, class, caste, occupation - make them vulnerable to various social forces and actors.
- Within these networks of social forces and actors, everyday, symbolic, structural and cultural forms of violence play out - within which vulnerable people and groups are tied.
- The interplay of such violences and vulnerabilities induces disease, exacerbates existing conditions, increased the likelihood of malnutrition, burdens the mind, and traps people into poverty.
- Vulnerable people find themselves trapped in mutually reinforcing poverty and debilitating health and wellbeing.

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# ACKNOWLEDGEMENTS

The UKRI GCRF Accountability for Informal Urban Equity Hub is a multi-country hub with partners in the UK, Sierra Leone, India, Bangladesh and Kenya which we call ARISE. The Hub works with communities in slums and informal settlements to support processes of accountability related to health. It is funded through the UKRI Collective Fund.

UKRI Economic and Social Research Council

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