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Navigating the Nexus of Urban Informality and Health - Insights From Surat, India: A Short Communication

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Abstract

Introduction: Urban areas in the Global South are marked by widespread informality stemming from the inability of economic, legal, and institutional systems to accommodate diverse populations. Most urban health research is restricted to assessing determinants of health and population vulnerability, while the intersection of informality and urban health remains underexplored.

Methods: The fieldwork was conducted in two low-income settlements in Surat, a city in western India. Qualitative methods included quasi-participant observation (168 hours), focus groups (12), and in-depth interviews (18), with data analysed through reflexive iteration.

Results: The findings revealed that inadequacies in formal systems - spanning governance, law enforcement, civic amenities, the economy, social systems, and urban planning - were entrenched in health inequities. The study mapped cascading pathways where informalities led to a spectrum of health outcomes, including infectious diseases, non-communicable diseases, climate-induced health impacts, mental health disorders, injuries, and violence. Unregulated healthcare further worsened vulnerabilities by increasing recovery challenges and out-of-pocket costs. Life in both settlements demonstrated a natural integration of formal and informal elements. People actively demanded and sometimes negotiated access to resources while responding to exclusionary state policies. Informal economies and unique subcultures emerged as critical coping mechanisms. People accessed healthcare through "informal traditional" and "informal modern" practices. Situational social networks fostered collective action during health crises.

Conclusion: Informality was not merely a symptom of systemic neglect but a dynamic survival strategy that shaped resilience and recovery. This study underscored the need for context-specific theorisation beyond Western paradigms to comprehend urban health inequities in the Global South.

Keywords: Global south, Health and healthcare, Informality, Surat city, Urban delivery of health care, Health equity, India, Qualitative research, Social determinants of health, Urban health

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Introduction

Urban areas in the Global South are characterised by widespread informality, which influences various aspects of urban life, including health. This paper explores the intersection of urban informality and health, aiming to theorise urban health informality from the perspective of subaltern populations.

The scholarly history of urban informality theories is multifaceted. For instance, De Soto's legalist approach attributes it to failures in economic, legal, and institutional systems,[1] while structuralists link it to broader global economic processes.[2] However, calls for theories grounded in the lived realities of the Global South, pioneered by scholars like Simone[3] and Bhan,[4] continue to advocate moving beyond universal frameworks based on Northern cities to reflect the unique socio-political and economic realities of Southern cities.[5,6] This also resonates with a recent scholarship.[7]

Further, while informality debates are well-established in urban studies, geography, and planning, they remain underexplored in public health. Urban health research often focuses on causal relationships between health outcomes and formal systems of care,[8] while neglecting the adaptive capacities of informal communities. The COVID-19 pandemic further highlighted this gap by exposing the limitations of traditional public health approaches in addressing the resilience of informal communities.[9]

This study bridges existing knowledge gaps by anchoring theoretical discourse in empirical evidence, as emphasised in discussions on informality.[10] This paper conceptualises urban informality as a critical site of inquiry, encompassing not only specific locations, sectors, outcomes, and meanings, but also dimensions that extend beyond these.

Methods

Surat, located in western India, is a rapidly growing urban

centre that exemplifies the urban potential as well as the challenges of the Global South. The mid-sized city also depicts a unique history of health system reforms after the infamous 1994 plague outbreak.

For the fieldwork conducted from April to November 2023, two informal settlements were purposively selected from the most vulnerable zone of the city. These vulnerable administrative zones were mapped by a local research organisation using secondary data. The report was submitted to the urban local body and is unpublished. The local organisation defined vulnerable zones under four domains: socio-demographic indicators (e.g., slum population, sex ratio), health indicators (e.g., disease outcomes from primary health centres), disaster-related indicators (e.g., flood incidents), and urban service indicators (e.g., water supply and drainage coverage).

Selection criteria for specific settlements or study sites included land tenure insecurity, lack of basic services, and non-compliance with planning regulations and were validated through consultations with local authorities. The settlements exhibited socio-cultural diversity, reflected in factors such as settlement duration, patterns of individual migration, and religious composition. Both settlements fell within the catchment of the Health and Wellness Centres (HWCs) program. Participant recruitment employed non-probability sampling to ensure diverse representation across age, gender, caste, religion, occupation, and migration status.

The study employed an ethnographic approach, beginning with immersion, and a suite of methods was used with an ethnographic lens. This included quasi-participant observation (168 hours), informal interactions, focused group discussions (FGDs) (12 sessions), and in-depth interviews (18 sessions). In Quasi-participant observation, the researcher observes a group while participating in some activities, maintaining a distinct, detached role rather than fully integrating into the community. Sampling continued until data saturation was achieved. A total of 108 individuals participated in the FGDs (61% women, 39% men), predominantly aged 31–50 years (60%). Most participants (80%) were migrants, with the vast majority residing in Surat for over a decade. The sample was religiously and educationally diverse. Livelihoods were deeply embedded in the informal economy: men typically worked in textiles, construction, and transport, while women combined domestic duties with home-based piecework. Living arrangements varied from nuclear to joint families. Interview participants were purposively selected to capture experiences with key chronic and occupational health conditions. Along with routine ethical protocols, to address gendered ethical sensitivities, a female co-facilitator led discussions with women participants. For tabooed topics, interactions were conducted in private settings to ensure confidentiality, build rapport, and create a safe space for sharing personal health narratives.

Data were analysed using reflexive iteration, where collection and analysis occurred concurrently to inform subsequent interviews. An inductive, open-coding approach was employed without predetermined themes. Credibility was ensured through prolonged engagement and data triangulation, allowing for the systematic structuring of verified themes.

Results

This study revealed a natural integration of formal and informal elements in both settlements. This "selective informality" extended beyond traditionally informal sectors, permeating even ostensibly formal public healthcare systems. For example, some cases of such selective informality included unofficial referrals to private practitioners, informal coordination between health centres to optimise patient coverage, staff relying on informal means for capacity building, and ad hoc community collaborations for preventive health activities. While these examples demonstrated the pervasiveness of informality in healthcare delivery, this paper primarily focused on informality in health outcomes and behaviours at the community level.

Cascading Pathways of Informality and Health Outcomes

In both settlements, informality had multiple effects on shaping health outcomes. For instance, as a *setting*, eviction-prone areas within settlements often lacked essential amenities such as water supply, toilets, and drainage systems, creating conditions conducive to waterborne diseases. As a *sector,* the informal economy-such as textile mills operating without adequate safety measures or social security- exposed workers to occupational hazards and injuries. As an *outcome*, the economic hardships exacerbated by the COVID-19 lockdown had pushed some families into extreme poverty, compelling women to engage in commercial sex work as a means of survival, thereby increasing their risk of sexually transmitted diseases. However, beyond such isolated categories of setting, sector, or outcome, informality was reflected as a critical, complex pathway. Two top health priorities within these communities emerged: substance misuse as a pervasive social health issue and widespread musculoskeletal problems among women.

Substance misuse arose from an interplay of factors rooted in informality: overcrowded living conditions in unregulated settlements, the absence of formal governance and oversight through police and security systems, the unregulated production and trade of substances, mental stress caused by unemployment and precarious informal work, and the breakdown of social networks. Together, these factors positioned substance misuse as a primary health issue, which in turn led to secondary problems such

as accidents, injuries, crimes and gender-based violence, mental health disorders, and culminated in chronic non-communicable diseases (NCDs).

Similarly, musculoskeletal problems were a common feature for the women engaged in home-based informal work activities, such as saree thread cutting, tailoring, attaching stones and diamonds to sarees, soldering, lace tying, and rubber cutting. Pressures of contributing to the family income, combined with the gendered responsibilities of managing households, led to women's long-term involvement in informal work activities. Additional stressors included rising inflation, income uncertainty, experiences of financial fraud by middlemen, and a lack of safety equipment. The static posture for long periods, bending over a work surface for extended periods in awkward positions, and the repetitive movements often resulted in overuse injuries, which were further compounded by old age and excess body weight in some cases.

Apart from these "*burning health concerns*" voiced by people, the informal pathways found extend across a spectrum of health outcomes like infectious diseases, NCDs, climate-induced health impacts, mental health issues, road traffic accidents, injuries, and violence.

Informality Deciding the Narratives of Health

In the previous section, informality was discussed in relation to specific health outcomes. However, its influence was much broader, shaping people's perceptions and responses to health issues. The interplay between formal and informal health knowledge was found to manifest in diverse ways. On one hand, individuals often adopted formal medical terminology, such as "caesarean delivery", "viral infections", or "blood sugar check-up," incorporating these clinical terms into their everyday discourse. On the other hand, community-specific language persisted, utilising terms and concepts absent from formal medical dictionaries. For instance, people described health conditions using culturally rooted expressions, such as "*kharab khun jam jaana*" (accumulation of bad blood in the body) or "*Sukha aur gila thyroid*" (Hyper/hypo thyroid), and referred to specific diseases with localised names, such as "*jeheri* malaria" for Plasmodium falciparum infection.

People's definition of health, their rationale for seeking (or even not seeking) healthcare, and the narrative of wellness were deeply intertwined with the pressures of informality. The work informality pressures dictated priorities for survival over wellness actions such as a healthy diet, physical exercise, screening for NCDs stress management, etc.

One of the most reported markers for '*being healthy*' was *'the one capable of working, earning and performing any kind of work activities, including tasks that demand physical strength'*. Further, people had their own "Cut-off points" for describing ill health and seeking healthcare. These cut-offs were guided by personal judgements, opinions of people around and also the perceived accessibility of healthcare.

Illness Management and Treatment Seeking Behaviours

Some migrant families in settlements informally practised traditional Indigenous strategies of illness management; however, those were integrated into new formal urban contexts. In this hybrid system, people accessed healthcare through a mix of "informal traditional" methods, such as herbal remedies, traditional birth attendance or ritualistic mystical healing, and "informal modern" practices, including self-medication, accessing unregistered clinics, preserving past medical prescriptions for accessing medications without consultation in future episodes and over-the-counter medicines. In pluralistic treatment-seeking behaviours, people often shifted back and forth between formal and informal care. Even multiple illness conditions within the same individual were dealt with by different care systems. In one case, based on word-of-mouth recommendations, a woman travelled hundreds of kilometres away from the city, despite the financial burden, in search of informal care.

The intricate relationship between informal economies, healthcare expenses, and broader socioeconomic factors emerged as a significant theme when discussing healthcare expenditures. Informal economic activities, such as street vending, have surfaced as crucial coping mechanisms for some families to manage the recurring burden of healthcare expenses. Some people even drew connections to broader macroeconomic systems and global events, such as the rise of online shopping as a threat to local street vending, or international wars and economic recessions, which resulted in a strained local textile sector. Unregulated practices, particularly within private healthcare systems, exacerbated the vulnerabilities of already marginalised populations. The high out-of-pocket costs, misleading diagnoses, and unnecessary treatment procedures increased the financial burden on individuals and families already struggling with limited resources.

Informality Guiding Health Resilience and Demands for Rights

Furthermore, informality was not just found to be a symptom of systemic neglect but also a dynamic survival strategy that shaped resilience and recovery. In both settlements, self-motivated individuals without any '*formal leadership tag*' played a pivotal role in organizing informal networks that facilitated healthcare access or mitigated risks. Their contributions were evident in routine activities such as vaccinating the children or organizing collective action to resolve drainage issues in the narrow alleys of the settlements. There were examples

when people self-organized and creatively addressed crises by leveraging local knowledge, social networks, and collective action. For instance, they coordinated responses to individual hospitalization episodes, helped the neighborhood navigate flash floods during monsoons, and distributed nutrition supplements during the COVID-19 lockdown.

In response to exclusionary state policies, people were constantly demanding and negotiating access to formal healthcare. Some of the key demands raised by people about healthcare facilities can be categorized as per 4A's: availability (services proximal to the neighborhood, expansion of services at existing facilities), accessibility (the idea of having "all facilities under one roof" similar to private hospitals, responsive timings to match people's work schedules, enhancement in the quality of care resulting to positive outcomes, supervision and punishments when services fail to take reliable actions, user-friendly approaches in health facility management like linear patient flow mechanisms or token system, support to navigate healthcare facilities, minimized waiting time, efficient outreach services), affordability (information provision for cost-effective and free options, regulation of private doctors), acceptability (formal promotion of existing healthcare services, use of multilingual communication strategies, improvement in staff behaviour, grievance redressal mechanisms, equitable treatment to all patients).

Discussion

This study discourages reducing informality to narrow categories, such as setting, sector, or outcome. Such a categorisation limits the ability to capture its broader influence, as literature suggests.[10] Informality in the studied settlements operated rather as a complex system of political, social, cultural, and economic processes creating cascading pathways toward health inequities - a finding that resonates with recent conceptualisations of informal urbanism as a producer of acute health vulnerabilities[11]. The inadequacies of formal systems- including governance failures, weak law enforcement, insufficient civic amenities, economic precarity, fragmented social systems, and exclusionary urban planning clearly entrenched health inequities.[12,13]

The overall findings challenge the reductionist view of informality as merely a legal or tenurial status. Instead, these align with Roy's conceptualisation of urban informality as a "mode of urbanisation," where the state itself possesses the power to determine legitimacy.[14] The perspective is reinforced by recent analyses of the political economy of urban space.[10, 15, 16]

In alignment with the critique of Western views of informality as a disorderly or illegal and isolated category,[14, 17, 18] this study revealed a natural integration of formal and informal elements in both settlements- the "grey spaces" as conceptualised by Yiftachel.[19] The "selective informality" within public providers often emerged as adaptive but sometimes unethical responses to systemic inefficiencies and resource constraints, resonating with other scholarly arguments.[15]

Also, unlike the static view of the poor as passive victims, the observed "Illness Management" behaviours reveal a sophisticated, albeit precarious, agency.[20,21] The findings offered a critical counter-narrative to de Soto's formalised asset-based theories.[1] They suggest that for people experiencing urban informality, resilience is not rooted in legal titles but in the fluidity of social networks and adaptive informal systems. [22] This also resonates with Priya's analysis of local health traditions and community coping strategies that persist outside the biomedical mainstream.[23] Yet, this resilience has limits. The community's demands for rights indicate that while informal mechanisms provide a safety net, they are not a substitute for structural equity. The persistence of health inequities despite high resilience validates structuralist critiques: without addressing the underlying political economy that produces informality, merely "formalising" the poor or relying on their resilience risks legitimising the state's withdrawal from its public health responsibilities. [24,25]

Conclusion

Theories of urban informality offer vital insights into urban health inequalities.[26] Informality blurs formal-informal divides, challenging binary notions like legality versus illegality, and serves as a dynamic site of negotiation, survival, and innovation. Its ontology, defined by hybridity, resilience, and embeddedness, directly shapes health access, often filling the gaps left by exclusionary formal systems. However, resilience alone is insufficient. Bridging these divides is key to equitable urban futures that promote health equity and social justice. This calls for integrated policy responses that break silos between health professionals and urban practitioners while addressing structural barriers and leveraging the adaptive capacities of informal systems.[27]

First, addressing "Cascading Pathways" requires improving governance of urban services to break the cycle of environmental vulnerability. Second, countering the "Narratives of Health" that internalize stigma, public health communication must explicitly validate the citizenship status of people, reframing them as integral urban contributors rather than "encroachers." Third, to improve "Illness Management," the observed "selective informality" should be constructively adapted, informal patient coordination mechanisms can be institutionalized into official "patient navigator" programs, and the role of informal practitioners must be regulated yet integrated into the primary care referral chain. Finally, leveraging "Health Resilience and Demands for Rights" requires that

people and health workers must be empowered not just as beneficiaries or implementers, but as planners. Such an approach can ultimately advance the global Sustainable Development Goals (SDGs), specifically SDG 3 (health) and SDG 11 (sustainable cities and communities).[28]

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Authors' Contribution

Conceptualisation: Anuj Ghanekar.
Data Curation Anuj Ghanekar.
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Competing Interests

The authors declared that they have no competing interests.

Ethical Approval

The study was conducted in accordance with the Declaration of Helsinki, and was ethically approved by the Institutional Review Board for the doctoral program at the Tata Institute of Social Sciences, Mumbai (Ethics Code:2022-23-40). The Committee provided some suggestions that were incorporated by the researcher during the implementation of the methods. The administrative clearance was obtained from the health department of the urban local body to conduct the study in selected healthcare facilities and other relevant institutions. All ethical principles were followed throughout the research process. The written informed consent and Participant Information Sheet (PIS) were prepared in accordance with the standard comprehensive format used for research projects. Before data collection, the PIS was first handed over to the participants, and then it was explained to them orally. The participants were briefed about the study and were given the opportunity to ask questions of the researcher. The informed consent was explained orally. For participants with limited reading and writing capacity, the local witness to the consent was involved, and this provision was made in the formats. The act of consent was recorded in a format such as a signature or thumbprint, whichever was applicable. Maintaining the anonymity of insiders was done at all stages of research appropriately to avoid easy identification.

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