State vs. Culture or State 'and' Culture vs. the Individual Body: A review analysis

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Abstract

This paper reflects on the dichotomy of state and culture through 'certain groups of people', impacting their behaviour and wants towards their own health. Analysis commences with a brief commentary on pre-independence India, whereby the rhetoric of nationalism was imprinted on individual bodies through the call for maintaining the health of a nation. This argument is then extended to include the present day-scenario of the state, whereby, the state sees itself as something beyond the individual; where it is the hub of 'know-how' of maintaining its population, yet at the same time distant from it. Second section presents the control of culture through community on the bodies of individual members (women). The two arguments are based on the review of an in-depth study by Jeffery and Jeffery (2010) in a village in Uttar Pradesh on the perceptions of the village population on national health policies. The article is concluded, with the necessity to understand and discover discourses of not state vs. culture (or community), but also of state and culture vs. agency vis-à-vis health and health care provisions.

Keywords: state; culture; bodies (women); structural violence; systemic control

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I.   Introduction: Juxtaposition of the State and the Community

Investments in the field of health, monetary or otherwise in India have been on the decline. Evidence can be established by the facts and figures as provided by the World Health Organisation and World Bank.[1] However, there have been some improvements across certain health indicators over the last two decades such as life expectancy.[2] This said, the corroding picture of public healthcare is a tangible reality and, in spite of state efforts in the field of health, we still observe the decline and operational deficiencies of national health programmes. It is often under the umbrella of national health programmes that the subtle subtexts of health (local, political, economic and cultural) which are highly influential processes in themselves are often acknowledged but not weighed. The combined or individual impacts of inherent political, economic, environmental, cultural mores consequently can be seen to either bolster, maar or boost the entirety of national health programmes.

Role and control of the state

National health programmes in India have their genesis in the health programmes of colonial India. Building on this argument, Amrith states that: "when national health began to emerge as a singular problem (and one which necessitated a singular response ─ national health policy), this happened in a way that was informed by distinct yet overlapping concerns. The concerns of the Indian elite […,] the concern of social reformers, and the concern of the modernists […] melded in sometimes contradictory ways to shape the political culture of health in India" Amrith (2007). Thus, even in colonial times the multiplicity of health cultures composing national reality was not acknowledged.

In colonial India, the rhetoric of health was intertwined with the concept and identity of nationalism. Health of the body was eulogised as health of the nation. In terms of our current study, I wish to explicate this argument through the writings of Gandhi, whose iconography on nationalism is widely accepted. Gandhi through Key to health, Young India and Harijan often called upon the people of India, especially the youth, to practice abstinence in terms of control of food and sexual habits for achieving 'absolute' purity, both inner and outer, for a healthy mind, body and soul free of illness in order to progress on the path of ahimsa and brahmcharya. His call to the people of India for maintaining a certain kind of lifestyle was, moreover, individually focused: the cause of ill health was to be

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[1] Though there facts and figures could not be cited as sacrosanct, nonetheless some wider perspective is reflected through them. According to WHO, in India the government expenditure on health as percentage of GDP is low (1 per cent). According to World Bank the Government spending as percentage of GDP in 1995 was 4.0 and 3.9 in 2011,

[2] Life expectancy increased from 55 years in 1980 to 66 years in 2011 in India (World Bank indicators).

found within the individual but where gain was of the nation through the collective healthy bodies of individuals. Writing in Young India (1925), Gandhi explained:

> My hope lies in the youth of the country. Some of them are prey to vice and not vicious by nature. They are helplessly and thoughtlessly drawn to it. They must realise the harm that it has done to them and society. They must understand too that nothing but a rigorously disciplined life will save them and the country from utter ruin.[3]

In Harijan (1946), Gandhi built upon this individual-state interdependence in asserting that:

> A person who has tried nature beyond endurance, must either suffer the punishment inflicted by nature or in order to avoid it, seek the assistance of the physician or the surgeon as the case may be. Every submission to the merited punishment strengthen the mind of men, every avoidance saps it.[4]

The latter statement not only implies individual responsibility but also reflects Gandhi's aversion towards Western biomedical discourse, because doctors and physicians provide a chance for "every avoidance", weakening the mind in return. In Hind Swaraj, this contrast is more effectively played out: "[T]he fact remains that the doctors induce us to indulge, and the result is that we have become deprived of self-control and have become effeminate.[5]"

Thus, as Alter (1996) conveys, in the context of colonialism there was a more direct relationship between individual self-control and the political culture of that time rather than that of "subconscious symbols or some other set of cultural meanings" for invoking and establishing nationalism through health.

Almost concurrent to Gandhi's discourse on health and lifestyle practices, the National Planning Committee's report on the sub-committee of National Health released in 1947 also observed that:

> Since the middle of century […] the people of India are of poor physique, low vitality and of short lifespan. This low vitality, debility and diseased epidemics was the result of poverty and 'almost destitution' and the 'lack of adequate wealth' of the people of India, because modern science and medical technique have discovered ways and means effectively to prevent them and also social customs and institutions of the people of India are no less accountable for the low standard of public health in the country.[6]

Thus, again similar to Gandhi's point of view, the responsibility or the cause lay with the individual through the customs and traditions of the Indian people. Promotion of the modernist view in every aspect of the Indian lifestyle including health and healthcare programmes thus became the priority. Along with this was the construction of a nationalist notion through homogenisation of the 'Indian people' where realities of multiple traditions and customs of Indian people were to be placed in the shelf of the past. As Veena Das (1995) observes the state maintained:

> The only legitimate orientation to the traditions of one's own society which is permitted, it seems, is to place these traditions squarely in the past… The only attitude the modern Indian can take to his own traditions is to place them in the past. It seems that in no case can these traditions offer an intellectual recourse to the contemporary societies […] her own past appears as the other.

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[3] See India of my Dreams by M.K.Gandhi

[4] Ibid

[5] Ibid

[6] Also see Amrith (2007)

The tilt of the elites of that time in all spheres of public life was towards Western notions which propounded the binary of 'us' and 'them'. This tilt also created the distinction within the conceptualised idea of 'Indian people', whereby the modern Indian elite had to locate the causes and discover the remedies for the penury and 'almost destitution' of the Indian populous. Thus, the 'we' became the proprietor of suggesting the ways to improve the 'you'. As Arnold (1993) observes:

> […]even Indian nationalists' critical rhetoric of the official neglect of indigenous healthcare ─ Western medicine had already taken off in India, that even before 1914 […] it had already begun to infiltrate in the lives of influential section of Indian population and had become the part of a new cultural hegemony and incipient political culture.

Thus, the ways and methods through which the state separated itself created the dichotomy of a service provider, with the knowledge and ability to group and control the population as service receiver. It was with this inheritance that major state institutions of post-colonial nation state, including health and health care as state functions, were created.The Health Survey and Development Committee (1943-1946) was highly instrumental in the formulation of subsequent Indian health policies with various committees and sub-committees forming over a period of time. Each of these remained highly bureaucratised in their approach which invariably led to the construction of concrete boundaries between the local or regional perceptions and realties, and various state institutions. The state becomes a provider of 'how' and 'what' standards of living are both suitable and possible for its population, declaring and defining mechanisms of governance through checks and controls, with the intension of creating, and meeting, ideals of equality. Given this, the glaring inequities and inequalities defining the condition of healthcare services provided by the state machinery is a contentious fact contradicting the very strategy upon which these services were founded.[7]   This happens to be so because the state sees itself as outside the domain of local norms and from this outside position it seeks to treat all forms of localities as a homogeneous, singular entity. The structures of the present day state health programmes follow similar patterns, notwithstanding the modifications which are taking place. Despite launching numerous health programmes with the intention of improving population health, the assumed 'distant-provider' status of state machinery cannot take into account differences which impact and define health and its cultural framework. What's more there is, what Gupta (2012) terms as "arbitrary outcomes in its provision of care.[8]"

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[7] Dreze and Sen (2013) argue that India's expenditure on health care accounts for less than one-third of the total health care expenditure, which is one of the lowest in the world, apart from war and conflict ridden nation states. They mention that "the unusual reliance on private health care in India results largely from the fact that the country's public health facilities are very limited, and often quite badly run" and absenteeism rates among health workers are very high.

[8] Gupta (2012) argues that even though state is lamented for not taking care of its poor, for not being able to regulate the unwanted returns of its efforts, the state here is treated as some homogenous, cohesive unitary entity. He argues that state is encountered differently at different levels by the people. It is not a 'singular reality'. I, however, in this paper treat state as a singular larger entity, which devises the policies of health care, disseminate the resources through its various off-shoots and role players, such as doctors and other paramedical staff in health care institutions to its population.

II.   Role and Control of the Community

The maintenance and control of health and healthcare notions by communities under the garb of their tradition and culture is a critical dimension which needs to be factored into the paradigm of health care.[9] The culture and/or tradition of a community cannot be eulogised as sacrosanct without questioning the beliefs and practices which may deny voice to the alternate beliefs and practices of the people who are part of that community.

The maintenance and control of health and healthcare notions by communities under the garb of their tradition and culture is a critical dimension which needs to be factored into the paradigm of health care.[10] The culture and/or tradition of a community cannot be eulogised as sacrosanct without questioning the beliefs and practices which may deny voice to the alternate beliefs and practices of the people who are part of that community.

Some of the beliefs and practices of a community become so engrained and entrenched in the everyday worldviews of its members that they are hardly ever put to question. They become as Bourdieu (1990) defines, the habitus which are:

> Systems of durable, transposable, *structured structures* predisposed to functions as *structuring structures* […] Objectively 'regulated' and 'regular' without being in any way the product of obedience to rules, they can be collectively orchestrated without being the product of the organising action of a conductor.[11]

Culture, thus, becomes a two-way street which not only is system of learned behaviour shared amongst a collective, but a systemic control over individuals within the boundaries defined by cultural collectivity.[12] Fields of academic enquiry have romanticised the conceptions of 'us' and 'them', providing the thesis and anti-thesis of 'us' differing from 'them', often inadvertently leading to atomisation of these entities. However, there is a growing acknowledgement (Marcus and Fischer 1986 (1999), Bourdieu 1990, Gupta and Furgeuson 1992, Das 1995) of the 'othering' within the realm of 'us' as well. This othering within the 'us' creates a chasm leading to the formation of hierarchies and patterns often pushing the 'other' within 'us' through the maze of inequities and inequalities. These hierarchies create an ambience of inherent deprivations on the basis of caste, class, gender and even geography, which Farmer has called as the phenomenon of "structural violence" (Farmer 2003). This in-built categorisation has a direct influence and impact on the health of 'group of people' and populous.[13]

Even if these alternate ways of critically accounting for the role of culture as a mechanism of systemic control are emerging and acknowledged, why is it that these notions are not acknowledged in the field of health itself? Even if studies acknowledge that people give reasons as "did not feel the need to utilise the service (Ante-natal care, Natal care, Post-natal care, and immunization coverage)" (Pahwa and Sood 2013), then what are the factors that explicate this statement? Even if it is acknowledged that women do not go to hospitals if not

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[9] One of the earliest definitions of culture was given by Tylor (1871) as "that complex whole which includes knowledge, belief, art, law, morals, customs and any other capabilities or habits acquired by man as a member of a society".

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[11] cf. Lizardo (2009)

[12] See Das (1995)

[13] I have purposefully used the phrase 'group of people' in place of population or 'community'. It is not to contest the vulnerabilities of health amongst populations or communities. But certain groups within them are even more susceptible owing to the forces of structural violence described by Farmer (2003, 2010) either subduing or altogether silencing these voices of dissent.

accompanied by their husband as one of the reasons for not availing the ante-natal care (DHS Pakistan 2006-07), what are the reasons for this high dependency? Is it the fear of security of the body? Is it the restriction on movement of the female body without chaperoning? Who decides these parameters? If it is not the state mechanism interfering in this realm, is it not the role of societal mechanism and the rubric of cultural controls in the form of traditions, norms and sanctions for what is to be done and not to be done? There is no absolute academic silence on this aspect of questioning the very practices of culture. But why is this academic voice not heard as it is in projecting the role of state in perpetuating structural violence? Is it because it would go against the celebrated dogma of cultural relativism? What is the reason for this "apolitical silence[14]" of academia? As Farmer (2003) points out:

> […]that what outsiders see as obvious assaults on dignity may in fact be long standing cultural institutions valued by a society […]many found themselves unwilling to condone social inequity merely because it was buttressed by cultural beliefs [...] "culture" does not explain suffering it may at worst furnish an alibi

Thus, in both arguments there is a government of 'the other' through which Foucault's "regimes of practice" (Dean 1999) emerge. In this context these regimes of practices were associated with the notion of health. Within this were multiple regimes fed by and in return adding to, modes of knowledge and expertise such as medicine, norms, identities, etc. These regimes and modes of knowledge get entangled with multiple and interlinked institutions (the economy, polity, the family, ethnicity, patriarchy, etc.) with inherent agents of control.

Keeping these arguments as the backdrop to our critical examination, in the forthcoming section I will focus on the observations through works of other scholars in the field of health. Even after more than six decades of independence, the historicities between the state and community influence the health of the 'Indian' populations.

III.   Women's health: Cases of vulnerability

One of the most vulnerable social groups is that of women.[15]Women's health has gained even higher priority with the establishment of the Millennium Development Goals.[16] Amongst these goals, Goal 5 focuses on improving maternal health and the control of maternal mortality. With acknowledgement garnered to the MDG's, the international gaze has shifted to certain sections of the world. A broad range of studies have started focusing on the 'developing world', for example, to measure the extent of the success achieved in reaching the respective goals set . This places 'national' standards in comparison to international standards and the gaze is even sharper this time around than it was when the first approach towards 'health for all' commenced with the Alma Ata declaration of 1978. MDGs were not the starting point for determining the vulnerabilities faced in the field of health, especially for women. There are numerous studies (Sanneving et al 2013, Jeffery and Jeffery 2010, Liese 2010, Corriel 1991, Jambia 1996, Sesia 2009, Behague and Storeng 2008) which account for the processes behind these vulnerabilities. Even if it is assumed that the 'developing nations' have recognised the importance of working towards providing effective health services to their people, does such a realisation reflect their immediate focus of concern too? Is health their immediate focus of governance? What is the role and influence of cultural norms on issues set out in the MDGs? The prominence

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[14] See Castillo (1993), Farmer (2003)

[15] Women in itself a heterogeneous group on account of multiple factors like age, caste, class, ethnicity, religion, location, etc. Within the ambit of my arguments, I have used this group as one of the many agencies controlled by various structures and institutions.

[16] In September 2000, world leaders came together at the United Nation Headquarters in New York to adopt the United Nations Millennium Declaration to be achieved by all member nation with the deadline of 2015 – these came to be known as the Millennium Development Goals (www.un.org)

given to MDGs in general (and MDG 5) in particular has put more emphasis on promoting institutional deliveries to control maternal mortality. However, maternal mortality is not a localised occurrence: it is a process defined and described through histories of politics, economics and culture and the extant realities thereof.

With the above discussion, the influences of systemic cultural and state control impacting the health of women can be further understood through the micro-level, in-depth research conducted by Jeffery and Jeffery (2010) which focused on the implications of national level health policies (National Rural Health Mission and Janani Suraksha Yojana), particularly on women in a small village in Uttar Pradesh.

"Embeddedness" of NRHM and JSY in the 'local' contextualisation of health

To cater to the health needs of her population, the Government of India initiated the National Rural Health Mission in 2005.[17] Various NRHM provisions were intended to counter the three phases of delay in health services ─ delay in seeking treatment, delays in reaching a facility and delays to obtaining care once there (Jeffery and Jeffrey 2010). However, due to the intrinsic, highly administrative structure and top-down approach of the programme, the benefits percolated least to the people who needed it the most: the programme was fraught with inherent structural hierarchies making so-called "accessible services" yet again inaccessible. Jeffery and Jeffery (2010) pointed out that in evaluating:

> The success of policy initiatives such as NRHM […] it is vital to foreground and address the perceptions of those supposedly being served by such initiatives […] Clearly, supply-side problems need to be dealt with if 'safe' delivery is to become the norm […] But failing to respond to complaints about government health staff ─ about illegal demands for payment and demeaning and discriminatory dealings with patients ─ make it unlikely that women will readily opt for delivery at government institutions.

The narrative clearly depicts the power play that comes into force in day-to-day interactions between the two spheres─the service provider(s) and the service receivers. The institutional structure of the medical facility becomes the stage where this power play is enacted on a daily basis. Not only is the power play observed between the highest level of hierarchy (the clinician's knowledge and medical parlance is the "esoteric practice") but also at the level of the service provider's attendant or those who make the "files", or even those who manage the files.

Another programme under the umbrella of the NRHM, called the Janani Suraksha Yojana (JSY),[18] commenced the same year. One of the important parameters to JSY is the provision of cash incentives for institutional deliveries to women above the age of 19 years and covering two live births.[19] Adolescent pregnancies have been acknowledged as important aspects of adolescent health by the WHO and according to the National Family Health Survey (NFHS-3), 16% of women between the age group of 15-19 years were already mothers or pregnant by the time of survey administration. The government-led Adolescent Reproductive and Sexual Health (ARSH) Strategy also recognises adolescent pregnancies. Yet at the same time limiting the provision of cash incentives for institutional deliveries from the age of 19 years and above, the existence and right of adolescent mothers is consequently eclipsed. Furthermore, numerous survey based studies (Pahwa and Sood 2013, Sanneving et

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[17] Despite the state level initiatives, India has not been able to achieve her target of reducing MMR to 109 per 100,000 live births by 2015 cf. Reddy et al (2012). With the change of the central government in India in 2014, the policy programme of NRHM has been changed to NHM (National Health Mission) with effect from the new budget session of 2015 of the country.

[18] JSY is the modification of the previously known National Maternity Benefit Scheme (NMBS). For details see NRHM details. Accredited Social Health Activist (ASHA) is the backbone of this scheme. An ASHA worker acts as a conduit between the pregnant woman and the institutional health facility.

[19] These incentives are graded on the basis of high or low performing states in terms of recording institutional deliveries.

al 2013, Vikram et al 2013, Malik et al 2013, Lim et al 2010, Vora et al 2009) have highlighted issues of redtapism and the delayed payment of incentives, the non-payment of incentives, non-cooperative attitudes of the hospital staff, and lacking JSY awareness as key reasons for limited access to the scheme. Jeffery and Jeffery (2010) further observed:

> There is widespread and lingering mistrust of government healthcare services […] villagers consider government services inadequate in terms of equipment, medicines and staffing but they also object to being treated in a dilatory, discourteous or greedy fashion by government staff.

This scheme was specifically designed to counter the economic poverty of women and to encourage the avail of services for institutionalised deliveries. However, some of the evaluation studies of the scheme revealed the structural and systemic hurdles which rendered the state initiative into the realm of burden rather than incentive. Often, the implementation of state initiatives evaluates the probable 'barriers to change' for the 'not-so-expected' performances. These barriers to change are more or less located in the domain of societal or cultural worldviews. There is no denying the inherent role of these realities as prescriptive structures of control but the shifting of blame to the purview of cultural historicities and cultural reality does not redeem the state apparatus and the paradoxes of its application. As Amrith (2007) argued, the problem of failure or the partial success of health programmes does not depend upon "native ignorance" and neither is the solution to be found in "health education". The problem depends upon the prior experiences of the people.

The community sphere also suppresses or controls the bodies of groups of individuals through the interstices of culture and its norms. In India, the acute penetration of patriarchal norms has always accentuated the preference for a male child (DeLugan 2013), specifically in some regions of the country.[20] This led to the acknowledgement of the 'missing girls' which were observed in the national sex ratio. Enactment of the Pre-Conception and Pre-Natal Diagnostic Test (PCPNDT) Act (1994) has increased the practices of unsafe abortions.[21] The inherent cultural ethos associated with aspects of gender inequality, malnutrition, inadequate medical care, son preference, and high fertility have all added to the burden of maternal mortality[22] compromising female health (Jeffery and Jeffery 2010). The presence of inherent power in social relations enables those in positions of authority to "mobilise a greater range of resources, symbols and meanings, authority and recognition, objects and services ─ in the institutional domains: political, economic and familial" (Kabir 1994). Indeed, Purewal (2010) explores that in the entire process of preference for a male child, women play two roles simultaneously: one of prominent and active agents of social change and the other as a part of the apparatus of gendered practices and inequalities defined by culture and economics. As Jeffery and Jeffrey (2010) mentioned in their research about the reluctance and/or staunch avoidance of women to use contraceptives:

> […] many children I have at present, if that many more are born in future, even then I wouldn't take anything to stop having children, or make the gap longer, even if I were to die […] death has to come one day or another. So what's there to fear about death?

Why is there the perception that 'I' would die rather than use the contraceptives for 'My' own health? This happens so because the 'I' gets separated from 'My', by virtue of the surrounding social-cultural ethos. The 'I' is

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[20] See Balen and Inhorn (2003).

[21] cf. Mathur (2008)

[22] Over the years, India has been able to project some change in the statistics of maternal mortality rates. MMR in India decreased from 390 per 100,000 live births in 2000 to 200 per 100,000 live births in 2010.

defined by, and identifies itself, through the eyes of the other innumerable 'we'.[23] The dictum is followed; individual life is mapped onto the collective socio-political-economic life of the populous.

The preference for a male child, control mechanism devised by the state machinery and bio-technological intervention has put at stake the health of prospective mothers. The bodies of females have been appropriated by the three dominant forces controlling and demarcating the boundaries around them. Another important observation is the focus of the analysis at the level of local. It is, therefore, necessary to acknowledge the significance of the local and to contextualise it in relevant frame of time and space.

IV.   Conclusion

India realises the precariousness associated with health and identifies, devises and implements mechanisms in the field of health. The 'extent of success' is often projected in comparative statistics and graphs. Often in the efforts to bring about a change, the structures of state and community act as a grind mill further accentuating the sufferings of certain groups of people. In order to at least bring semblance in the chaos and the struggles of people therein played out, it is important to document the biographies of their everyday lives; not only documenting their biographies but also putting these on a platform. Thus, voicing the untold experiences of suffering and bringing forth the acknowledgement of their everyday struggles.[24] Langer (1998) succinctly gives words to these thoughts, stating that:

> It may be useful to classify human misery in terms of social problems, but this rarely generates widespread concern. We need a special kind portraiture to sketch the anguish of people who have no agency because their enemy is not a discernable antagonist but a ruthless racial ideology, an uncontrollable virus, or more recently, a shell from a distant hillside exploding amongst unsuspecting victims in a hospital or a market square.

There are many more issues that could have been invoked in relation to women's health. But the moot argument here was to present how state and community produce mechanisms of systemic control over existence and the utilisation of health services by people. Women have been projected here as one of the many forms of agencies that are influenced by structural formations.

It was an effort to project certain similarities and concurrence of state apparatus and cultural ethos in placing the health of a certain group of people in a vulnerable position. There are always gaps between the extant realities and expected results. In between these gaps is the discourse of state, community and culture which either by juxtaposing with each other or by standing in contestation with each other puts health of people in vulnerable zone. Thus, creating or impacting the mechanisms of control over bodies in either case. There is not contestation that this may hold true for any other nation or community as well. The intention was to contribute, however miniscule, into the vast realm of understandings, debates and discussions that view health more than a field of biological, medical or technological intervention. There is need to have continuous dialogue and discourse over matters of health and healthcare, because they are not just indices of development, or lack thereof, but these are social processes in themselves.

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[23] As Murray (2006), states, "The nameless "we" who both commands and promises speaks to an equally nameless "you," a "you" who is only ambivalently included in the "we," if at all. Clearly, the life that you are commanded to sacrifice, the existence you are commanded to revoke, is not the same as the life that you are promised. So how is it that my singular life—the only one I have to give—can be mapped onto a collective political life, the life of a nation or of a people whose oneness is meant to be unquestionable?"

[24] See Kleinman, Das and Lock (1997)

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