# OFF THE MEAN STREETS

*Attempts to address homelessness must begin by understanding its complexities*

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When the Rangarajan Committee submitted its report on the national poverty rate to the new minister of state for planning at the end of June, it suggested raising the urban poverty line to a daily consumption rate of ₹47 per person. If accepted by the new government, this revision will nearly double the official number of poor people living in India's cities to a staggering 103 million—roughly equivalent to the entire population of Bihar. In the next decade and a half, the country's urban population is expected to increase by more than half to 577 million. As overall population growth and rural-to-urban migration add more and more people to existing cities, and create new cities as well, the number of urban poor is only likely to grow. So, too, are the pressures on municipal governments and the state to reduce socioeconomic inequality and provide for the needs of our cities' most deprived people.

To be successful, any attempts to alleviate urban poverty will need to look more closely than before not only at specific challenges facing India's urban poor, but also at the variety of experiences within this growing demographic. In 2012, the government-appointed Hashim Committee acknowledged the difficulties in identifying the urban poor and implementing social policies for them. The committee found that in order to design and deliver successful interventions it is "not enough only to know who the poor are and where they live. It is also important to know the precise nature of the vulnerability and deprivation that they face, as also the extent of such deprivation, both absolute and relative." In a recent unpublished paper, the former Planning Commission member NC Saxena argues that urban poverty should be measured and addressed on the basis of a number of factors, including lack of access to basic services such as health and sanitation, and abysmal shelter conditions. This fits with research by Siddharth Agarwal, a past president of the International Society of Urban Health, on health inequalities within urban India. Agarwal found that large disparities exist in basic health indicators between the poorest 20 percent of people living in cities and the rest of India's urban population. (For example, of every one thousand children born to the country's poorest urban families between 2005 and 2006, 73 died before their fifth birthdays—almost twice the rate of other urban children.) But although these disparities have been acknowledged in the context of discussing social inequality, little extensive research has been done, and urban-policy makers have not addressed the conditions of the very poorest of the urban poor—the homeless.

Last September, 38-year-old Vikas arrived at a health-recovery shelter for homeless men on the banks of the Yamuna river in north Delhi run by the Centre for Equity Studies. (Until recently, the centre also oversaw the National Resource Team for the Urban Homeless, which I head; the team is now a part of the Association for the Rural and Urban Needy.) Two years earlier, while working in a factory in Chandigarh painting and welding spare parts for cars, Vikas had fallen seriously ill, suffering long bouts of diarrhoea and coughing up blood for weeks at a time. He sought treatment at a local government hospital, but was turned away because he lacked proper identification. He then travelled to his in-laws' home in Bihar, and spent his savings—about ₹18,000—on treatment at a private hospital, where he was diagnosed with tuberculosis. A year later, however, his health still hadn't improved, so he left his wife and infant daughter and headed for Delhi in search of better services. He arrived in the capital with no money, and was turned away from a local hospital because he couldn't pay. He spent the night on the street, and found the shelter the following day.

"When he came to me, he was coughing up blood," Pradeep Bijalwan, the shelter's physician, told me. Vikas, he said, looked pale and famished. Bijalwan referred him to the Rajan Babu Tuberculosis Hospital, a primary healthcare centre in north Delhi that provides free tuberculosis treatment to the poor as part of the country's Revised National Tuberculosis Control Programme. Vikas was prescribed a standard six-month regimen of antibiotics, and lived at the shelter during his treatment. By this April, he was tuberculosis free. He started washing dishes at a factory canteen to save money to return home and, this summer, reunited with his family in Bihar.

Vikas was relatively lucky. In the area surrounding Delhi's Jama Masjid, the Centre for Equity Studies runs a shelter for single homeless women. Last Diwali, one of 23-year-old Fatima's legs was severely burned when firecrackers from a nearby celebration set her pyjamas on fire. At the time, Fatima, who lived with her mother, husband and three children in a tent not far from the shelter, was high on heroin. She had been living on the streets since childhood, and had been a victim of domestic abuse. Some shelter staff found her in a local park the next morning and called a rescue service that specialises in taking homeless patients to hospitals. According to the staff, Fatima's husband later told them that a doctor and nurse at the hospital baulked at dressing her wounds because she "had not bathed and looked extremely dirty." Fatima refused to go to hospital again.

For two days, shelter staff and a volunteer nurse tried to convince Fatima's husband to allow the team to take her to another hospital. On the following day, the nurse concluded that Fatima would die if she did not receive immediate treatment. Fatima consented to be admitted to hospital

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again. Shelter workers stayed with her as she underwent successful skin-grafting surgery. The doctor said her leg would heal in three weeks, but only if she rested and ate a proper diet. At Jama Masjid, the Centre for Equity Studies has no specialised recovery shelter like the one in North Delhi. Instead, the centre's staff attended to Fatima on the street, where she lay on a makeshift cot. Her condition deteriorated. "Don't call the ambulance," she would say. "I will not go to the hospital. I will die." She was dead a few weeks later.

Like Vikas and Fatima (whose names have been changed to protect their identities), many homeless people in India often face disease and death with little to no support from their families, or from state institutions. Living on the streets compounds these problems; research confirms that access to adequate housing reduces the incidence of illness and health-related expenditure, and increases overall well-being. In one recent qualitative study of 18 homeless people in Delhi, the scholar Vandana Prasad observed that all of them suffered from multiple serious ailments, including post-traumatic stress disorder, chronic respiratory disorders, mental illnesses, tuberculosis and diabetes. The number and complexity of their health problems was a major obstacle in their attempts to access appropriate health care.

But Vikas's and Fatima's stories also highlight the fact that the causes and outcomes of homelessness are not uniform. Although some people become homeless because of their health, others are born on the streets, or are forced onto them in childhood. The most striking differences are between men and women. The women in our shelters tend to have experienced physical and sexual abuse, have poor health due to frequent pregnancies while being undernourished and have, at best, limited opportunities for safe work.

The problems faced by urban India's poorest people are most acute in the national capital, where estimates of the homeless population range from 17,000 to 150,000 (the upper limit being roughly equivalent to one percent of the city's total population). For example, Siddharth Agarwal found that the poorest fifth of children in Delhi were on average more stunted than their counterparts in other cities. According to his research, access to healthcare for pregnant women showed the largest disparities. Almost nine of every ten birthing women in urban India were assisted by a health-care professional between 2005 and 2006. For the poorest fifth, however, the rate was only five of ten. In Delhi, it was half of that: only a quarter of the capital's poorest pregnant women received any kind of assistance during labour.

A few important steps have been taken to tackle these problems at a national level. In 2010, the Supreme Court di-

rected city governments to construct one homeless night-shelter for every 100,000 residents. The order was part of an ongoing right-to-food case filed by the People's Union for Civil Liberties, in 2001, in response to evidence of starvation deaths in rural India. It was also a crucial acknowledgment by the courts that the problems of the poorest urban citizens are constitutionally linked to those of the rural poor (because, like other forms of extreme deprivation, they violate the right to a life of dignity that has been read into Article 21), while at the same time being distinct (because they require specifically targeted interventions). Two years later, the Hashim Committee proposed categorising poor urban populations according to residential vulnerabilities (identifying the homeless and those "precariously housed"), social vulnerabilities (using gender-based criteria to identify, for example, female-headed households), and occupational vulnerabilities (identifying those working in exploitative, informal or low-paid jobs).

This is a start. But not enough has yet been done to create programmes that recognise the variety of challenges faced by the vast numbers of people living in abject poverty in Indian cities. There are more Fatimas dying in the streets every day. If we can create accessible services for the urban poor that address the range of inequalities they face, perhaps we will see more outcomes like Vikas's in the future. ■