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Coleman, H.L.S.

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Summary

A bleak picture of the mental and physical tolls of homelessness is emerging in countries of the 'global North' as data collection efforts become more coordinated. In global South countries such as India, however, the sheer magnitude and character of the health burdens that homeless people suffer remains only roughly mapped. Of what we know about the health conditions affecting these groups, studies across the global North-South divide have shown that these conditions are made worse by the difficulties the homeless face when trying to seek and use healthcare. As such, where housing insecurity exists, there are almost always informal providers of healthcare (e.g. non-governmental organisations [NGOs]) seeking to fill the needs unmet by the state. For example, informal healthcare providers in India have been hailed as often the only source of relief for homeless groups across the country. The task of NGOs and informal providers is thus to provide healthcare in a way that meets the health needs of homeless and inadequately housed populations, and avoids falling into the same problems that hamper healthcare service delivery by the state. This requires an understanding of housing insecurity and its links to health. This thesis investigates the relationship between housing security and health, departing from current understandings of this link which predominantly derive from countries in the Global North.

The vast majority of the literature studying the link between inadequate housing and health is weighted towards describing one direction of influence—that poor housing and homelessness causes poor health—even though studies have observed disease, mental health and stigmatised conditions acting as the trigger for chronic poverty, homelessness and loss of livelihood. Conceptualisations of homelessness in India emphasise its character as a form of non-citizenship and systematic exclusion, while India's policy responses to homelessness however, or lack thereof, have led authors to suggest the state sees it as an "individual responsibility to be housed", rather than recognising the state's role in the distribution of housing opportunities. One recent expression of commitment to the plight of homeless individuals was contained in the Indian government's Deendayal Antyodaya Yojana-National Urban Livelihoods Mission (DAY-NULM)—a nationwide urban poverty alleviation programme enacted in 2013. Yet, without efforts to change the formal healthcare structures that currently exclude the homeless,

alleviating their suffering will continue to fall to informal providers, NGOs and their own communities.

This thesis seeks to elucidate the pathways of disadvantage that link together the effects of homelessness on health, and the reciprocal effects of ill health on the disadvantage associated with homelessness. While the focus of homelessness interventions has shifted to the role of the state, we direct our attention towards interventions below its remit, where informal providers of healthcare in India fill the gaps in unmet health needs for homeless persons. Our aim is to strengthen the knowledge base about the relationship between insecure housing and health in India, from which service provision, advocacy and local policy interventions can depart.

The thesis studies homeless and slum populations in India, using theoretical framings that transcend the trade-off between individual and structural causes of disadvantage, namely, the social determinants of health, the social ecological model and social exclusion. We also explore contrasting conceptions of homelessness and inadequately housed groups. Contrary to conceptions of homelessness as a housing deficit, there is another way of understanding housing security that sees it as an embedded structure of kinship; a condition that is tradeable with other social and economic pursuits, and a political tool that can be used in the construction of a dominant idea of citizenship. The Indian Constitution has a place in this thesis to configure the sphere of personal liberty in which our study of advocacy takes place. The Constitution has moved from a position of recognising elements of homelessness as, either, violations of a fundamental right to life or parts of a fulfilment of a right to life (i.e., begging), to a position of recognising homeless people as rights holders with a claim on the state to housing. Our investigation also takes place within a wider tension where broadening understandings of homelessness have created greater difficulty in translating these understandings to health intervention. The main research question of this inquiry, therefore, is:

> How can the health of inadequately housed groups in India be understood and addressed through intervention, service provision and advocacy?

The scope of this question can be divided following the concepts and theories we have discussed, into constituent sub-questions:

> How can we understand the relationship between health and housing security in India?

How can healthcare services engage with the homeless in addressing their health needs?

How can health needs of homeless groups be addressed through local policy and advocacy?

The primary setting of this research is in Delhi, India where the Centre for Equity Studies (CES) manages dedicated healthcare outreach teams for the homeless, and with which this thesis engages. As both an informal healthcare provider to the homeless and advocacy organisation for homeless rights, following this NGO allows the study of different methods of intervening in the relationship between health and housing security. This organisation provided access to many of the stakeholders sought for participation in this research, while also sharing quantitative data previously collected on the health burdens and socioeconomic profiles of homeless groups. The inquiry takes an *engaged, multiple case study approach,* meaning I was engaged in CES' active purpose of addressing the health needs of the homeless, and doing so to produce situated understandings based on active connections with the practice. For the purposes of reflecting on this research within a wider discussion on interventions for the homeless, the case studies that comprise this thesis are faceted for the analyses in different perspectives of the inquiry.

This investigation is comprised of three cases, with each case focusing on different positions on the housing security continuum: from the position of greatest insecurity in homelessness, to relative greater security in shelters, and then finally in slums. The first case, comprising a single study (Chapter Four), reviews extant literature on the social determinants of non-communicable diseases (NCDs) in Indian slums. The second case, focusing on homelessness, is situated within the endeavour of standardising Street Medicine practice and is made up of three studies to this end (Chapters Five to Seven). The final case, again comprised of a single study (Chapter Eight), follows a network of advocates, researchers and legal professionals in Delhi who have pursued the construction of shelter for homeless individuals, across a range of court cases in the Supreme Court and Delhi High Court, spanning a twenty-year period.

The cases of this inquiry use methods tailored to their scope and research questions. In summary, the investigation comprises both desk and field research, mainly used in the analysis of secondary and primary data, respectively. The sources of secondary data include *white* and

grey literature—where the former includes published peer-reviewed scientific articles, and the latter includes technical and institutional reports, court case documents, newspaper articles, press releases and position papers—and quantitative data derived from Street Medicine records and surveys carried out previously. The primary data derive from field observations and interviews with Street Medicine team members and coordinators, formal healthcare providers, researchers of homelessness in India, homeless individuals themselves, petitioners in court cases, and their legal counsel. In certain cases, multiple sources of data were combined to substantiate the veracity of the observed measures or phenomena.

The final chapter of this thesis, Chapter Nine, draws across the three case studies to answer the main research question and sub-questions. The investigation finds that the health of people in slums, which we analysed for the specific case of NCDs (Chapter Four), can be understood beyond the biological production of disease. The symptomatic causes of NCDs in slums, such as physical inactivity—linked to the higher rates of cardiovascular disease in slums—bely diffuse networks of determinants that span the social reality of slum residents' lives. The quality of slums of 'being in the same place with the same people' has a role in structuring the dynamics of these determinants into the pathways that produce ill health. By the same token, this quality also produces in slums the makings of a local policy environment, where the effects of interventions may be shared across the populations. For the homeless individuals in Delhi, we analysed Street Medicine's treatment burden to provide the first empirical characterisation of the types of disease they suffer from (Chapter Five). While this burden is of great magnitude, we also found it was modified by characteristics of age, sex, location and season. Building on this, distinct sub-groups within Delhi's homeless population emerged as we looked further into the clustering of social characteristics across locations in the city (Chapter Six). Our analysis suggests the unique patterns in health outcomes across these sub-groups and locations is intertwined with other forms of exclusion they may experience, including financial and social exclusion, and exclusion from public goods. The qualitative study (Chapter Seven) of barriers faced in addressing health needs for homeless groups gave character to the multiple exclusions faced by homeless groups; seeing homeless existence enjoined within a stringent prioritisation of needs for survival. The constraints to agency, access and the reciprocal pressures created by multiple, competing needs shape the production of ill health in homeless individuals, and the ability to act on health needs.

For service provision to the homeless, this thesis advocates for engaging homeless groups in their care; not just as a therapeutic relationship or means to solicit input, but as a redrawing of the patient-provider divide to bring homeless individuals to the face of care delivery. Engagement is first about moving healthcare closer to homeless communities and minimising the expense of health seeking on homeless individuals. Homeless persons can and should form part of healthcare delivery methods, as community liaisons and conduits for translating healthcare services into formats amenable to their lived experience. Engagement can help better targeting, whether towards high needs patients or the largest coverage; it can be used for mapping the health and non-health resources local to communities; it can help organise forms of community-owned care and social partnership, and; it can form the basis of understanding the dynamics of ill health in communities, and where health needs sit alongside other social needs.

For local policy, our study of the social determinants of NCDs in slums reveal intermediate junctures in those pathways that were within the scope of local policy intervention. These interventions were not targeted towards personal attributes of slum individuals or structural drivers of disadvantage, but at a level where effects would permeate throughout the slum environment. Finally, in our analysis of the practice of advocacy for homeless groups in Delhi (Chapter Eight), we found our previous efforts to explicate the vast array of factors linking homelessness and health may not always be attuned to best solve the equation of 'what are the needs of homeless groups and what can be done'. In different arenas of argumentation, whether political, legal or scientific, this equation may be resolved quicker by explaining that a shelter in winter represents the right to live another night.