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How can we nuance our understanding of homelessness?

Ashwin Parulkar

Case Brief

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Case No 1-0004

This Case Brief contains:

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Reframing Urban Inclusion

The opening set of cases produced by IIHS represents a focus central to our institutional mission, its teaching and its practice: urban inclusion. Through an on-going collaborative, multi-year research project titled 'Reframing Urban Inclusion', the 30 cases available on the website, www.cases.iihs.co.in include original teaching and learning cases commissioned and produced at IIHS through support from the Ford Foundation.

The cases were curated to address a particular set of challenges. The first is pedagogical. IIHS' stated aim is to be part of a global moment to re-think urban theory and practice from India, South Asia and the Global South. These cases are a key curricular and pedagogical intervention within that effort. Distributed through open access modes to encourage widespread, public and diverse forms of use, the cases seek to give scholars and educators in the Global South a new canon to teach with, that begins from and is responsive to place.

The second is more outward facing. India is at a critical moment in its urbanisation. The urban agenda has begun to emerge strongly on the national political register, and questions of how to shape policy agendas from housing to employment, planning to service delivery, are more pressing than ever before. It is our hope that these cases will therefore equally be used by and inform an evidence-based, empirically rich, conceptually grounded and reflexive practice and interface with policy.

Since 2013, the project has brought together leading academics and practitioners from different disciplines to identify and contextualise social and economic realities of Indian cities through the case method. We hope that they will provide new evidence of the possible opportunities and mechanisms for urban integration as well as build a conceptual and empirical foundation for politically, socially, and economically inclusive cities.

The project has three thematic foci:

1. Conceptualising Pro-Poor Planning

   Urban planning processes determine access to basic resources such as land, shelter and housing, livelihoods, mobility, and security. Inclusive urban planning is aimed at serving all the citizens of the city, reducing vulnerability and addressing exclusion from access to these basic resources.

   Cases in this theme (1) untangle the current state of urban planning and its effects on vulnerability and exclusion, (2) explore how meaningful participation can be more effective in pro-poor planning, and (3) highlight opportunities for, and instances of successful integration across agencies and organisations involved in urban planning.

2. Re-visiting Settlement Upgrading

   This theme seeks to expand and re-articulate debates on slums in India. The 'slum' is a form of an urban settlement that is situated at the intersection of land markets, new urban political economies, the efficacy of the state as a provider of housing to the poor, differentiated state-citizen relations, splintered urban infrastructure, questions of law, legality and planning, as well as conceptions of urban citizenship.

   Cases in this theme (1) explore the processes of settlement and resettlement, paying attention to the market and political forces that shape the outcomes, (2) broaden the scope of settlement transformation from spatial upgradation to impacts on other sites of transformation such as livelihoods and employment, and (3) explore alternative imaginations of 'property rights' and tenure regimes.

3. Re-drawing the Picture: Metrics of Urban Inclusion

   The dynamics of urban poverty and vulnerability are poorly understood. We know that the security of tenure, spatial coherence of urban infrastructure and service delivery, transit distances between livelihoods and living spaces, socio- cultural identities and social networks play important roles in inclusive cities. However, we have limited statistical data and information on the locational and distribution patterns of urban India.

   Cases in this theme (1) examine the use of data in urban decision making and identify potential sites for intervention, (2) provide a more contextual and holistic analysis of urban dynamics, moving beyond sector-wise administrative data collection methods, and (3) emphasise improvements in information and learning from experience for local decision making.

IIHS Case Method

The IIHS case is a work-in-progress that represents experiments in different forms of creating interdisciplinary and inter-sectoral cases, as well as a diversity of pedagogical environments to learn and teach with these cases. The opening set of cases is, thus, also in a sense, an experiment in form and teaching modes. Given this, we do not claim a singular 'IIHS Case Method' or any one form or definition of a case. Indeed, one of the explicit aims of case development at IIHS is to challenge conventional ideas of what case-based learning is.

How then does a user know how to use cases? Pedagogical transactions will differ from case to case and indeed multiple options will be open within each case. Therefore, in order to aid users, all IIHS cases come with a set of consistent elements that help users navigate through the diversity of form and content. These are:

- **Preface:** Every case begins with an introduction by the case writer that describes their own approach to the case. How did the case writer frame the case? Why did they choose to structure it as they have? What were their intentions in writing the case?
- **Teaching Note:** The second shared case element is the Teaching Note. Here, the case writer lays out their imagination of how they would teach with the case in its current form. They suggest learning outcomes, pedagogical modes, learning environments and assessment frames. True to the diversity of the cases, each of these is particular to the case.
- **The Main Case:** This is the main body of the case—its core empirics, arguments, discourse and data. Across the cases, these come in different forms: PowerPoint presentations, audio-visual material, web interfaces, written text, and data visualisations.
- **Pedagogical Possibilities:** The next element lays out the case writer's suggestions on other ways in which the case could be taught, including in other disciplines or learning environments. These are not as detailed as the Teaching Note but offer a set of possibilities to the user to imagine other uses of the case than those laid out.
- **Case Archive:** The final element of the case is a library of documents—reports to interview transcripts, unedited footage to visual photo libraries—that act as an archive for the case. This repository allows users to also access a host of background and additional information necessary to navigate the larger contexts in which the case is situated.

Each IIHS case—regardless of the diversity of its form—comes structured with these elements. It is our hope that this recognisable framework will enable users to navigate easily across cases with very diverse elements and forms.

Case Note

In January 2010, media reports of homeless deaths in Delhi moved the Commissioners of the Supreme Court, an agency that monitors national welfare programmes, to urge the Supreme Court to mandate that cities build shelters. 588 people perished on the streets of Delhi that December and January, underscoring a 49 per cent increase in recorded deaths from 2006 to 2009—2,093 to 3,114 deaths, respectively (Zonal Integrated Police Network, Ministry of Home Affairs). Two weeks before the Commissioners' plea, the Delhi High Court filed its own public interest litigation after a newspaper reported that a homeless woman died shortly after giving birth on the streets (University of Chicago International Human Rights Law Clinic and Nazdeek, 2014).

The Supreme Court directed cities with populations above 500,000 to build one shelter for every 100 homeless persons in areas that had 100,000 residents. Local governments were to reserve 30 per cent of shelters for vulnerable groups and provide them with clean water, sanitation, means of securing identification, and access to primary health care, food and drug de-addiction programmes.

The government had discontinued a 2002 shelter policy in 2005 on the grounds that it was poorly designed,[1] and underutilised by state governments (Supreme Court Commissioner's Office 2014). The new shelter policy sought to ensure the physical security of homeless people and connect them to existing food, work and health programmes. This idea had the potential to fill a major gap in social service delivery in Indian cities. City officials typically mandated that beneficiaries have a Below Poverty Line identification card and proof of a fixed address to avail schemes, which had previously made the social protection system inaccessible to homeless people.[2]

Identifying the urban poor is critical to meeting the employment, housing and health care demands of India's growing cities. The 2011 census estimate of 377 million people

[1] For an extensive critique of the October 2002 'Night Shelter for Urban Shelterless' policy, please see, Commissioners of the Supreme Court (2014). The authors site a number of flaws with the previous policy, including '(1) dependency of soft loans from Housing and Urban Development Corporation (HUDCO) to finance shelters (2) it was a demand driven programme, based on the demand from local and state governments, which rarely came because of the invisibility, powerlessness and stigma of homeless persons and (3) marginal budget allocations.'

[2] Urban welfare programmes technically available to the homeless were in place well before the Supreme Court orders on shelters. These include a public works scheme (Swarna Jayanti Shahari Rozgar Yojana), water, sanitation and infrastructure (Jawaharlal Nehru National Urban Renewal Mission), public housing (Rajiv Awas Yojana) and food (Public Food Distribution System).

in urban India is predicted to reach 577 million by 2030 (McKinsey Global Institute 2010; Chandramouli 2011). However, there is no consensus on how many poor people live in cities.

This is because current urban poverty estimates are based on data calculations of daily per capita expenses, which economists deem sufficient to meet basic needs like food, instead of from surveys of poor people in cities. The most recent poverty estimate was devised in 2009 by an expert group chaired by Dr. Suresh Tendulkar, which considered a person who lived in an Indian city poor if she spent below Rs.33 a day on such needs. By this rubric, 21 per cent of urban India, or 76.4 million people, were officially poor in 2009–2010. In 2014, an expert group chaired by Dr. C. Rangarajan proposed a new poverty estimate that included expenses on health, education and other non-food items, which raised the expenditure cut-off in cities to Rs.47. Nearly 100 million people in urban India would have been considered poor by this calculation.

The government did not accept the Rangarajan Committee revision. Policymakers had already acknowledged that the consumption based metric did not accurately measure poverty in India's growing cities. In 2012 the Planning Commission appointed a committee led by S.R. Hashim to draft a survey methodology to identify the urban poor. The Hashim Committee highlighted a key inconsistency. Information used by national policymakers to measure urban poverty—income and daily consumption expenditure—is difficult to gather in city surveys to identify poor people. States therefore devised their own survey methods, which led to unverifiable data that was inconsistent with national estimates, which resulted in the exclusion of poor people from the social protection system (Planning Commission 2012). An additional problem was that the central government did not permit the number of people declared poor by state governments to exceed the caps set by the Planning Commission.

The Hashim Committee called for a methodology that would account for urbanisation as a driver of future poverty, arguing that, given the inevitability of population growth and rapidly changing city spaces, 'the pressure on the existing amenities and health facilities will increase, leading to deterioration in the quality of these services and reduced access…for the poor, thereby increasing…deprivation, unless…special efforts are made to carry the poor along' (Planning Commission 2012).

The committee's methodology thus included dimensions of urban poverty it considered indicators of existing—and risks to future—deprivation that were not captured by poverty line calculations, such as inadequate housing (including homelessness), jobs held exclusively by the poor in unregulated urban informal economies, and public health hazards posed by limited access to sanitation, clean water and nutrition.

The committee grouped these deprivations in three 'vulnerability' categories, defining 'vulnerability' as the 'threat' families face to 'falling into poverty in the future'. A thorough analysis of each vulnerability is beyond the scope of this study. What is key here is that a vulnerability framework—conditions of poverty that portend risk to future peril—enables an accurate identification of urban poor groups who contribute to Indian cities but are routinely, perhaps systemically, denied access to basic services and city spaces due to discrimination, isolation or stigma.

The Hashim Committee's 'residential vulnerabilities' included the urban homeless. 'Social vulnerabilities' included Scheduled Castes and Tribes, 'who routinely face severe barriers to livelihood, food and dignified living.' Occupational vulnerabilities included people who work in jobs in the informal sector that entail 'low pay, low productivity and debilitating work conditions' such as 'daily wage earners, construction workers, hawkers, street children, sex-workers, rickshaw pullers and domestic workers.' The government conducted a survey of the urban poor based, in part, on the Hashim Committee's recommendations but have not published the data.

A vulnerability framework is a good lens to study poverty in Indian cities because it compels one to acknowledge the diverse range of poor people in a context where rapid demographic and economic changes may be outpacing city capacities and resources.
But what are the risks to the future poverty of homeless people, who are so visibly destitute? The 2010 shelter policy responded to the wide-scale deaths of homeless people. Does this mean that such deaths are what it takes for cities to officially acknowledge people on its streets? Are the hundreds of men sleeping head to toe tonight on the medians of Yamuna Pushta and the women and children knocking on car windows at Nehru Place dying in front of us?

Deciding on actions that should be taken by governments and citizens in a democracy to prevent unnecessary deaths is more difficult than agreeing on what actions, like violence, should be prohibited because they endanger life. Yet the notion that wide-scale destitution related deaths are a prerequisite to a government response to poverty reflects a dysfunctional society and government. How does India, a democracy with a constitution rooted in social justice, design policy to guide local services and institutions to make life better for large numbers of people suffering death inducing poverty?

The 2010 court order on shelters addressed this question by interpreting homeless peoples' right to shelter as part of the Constitutional Right to Life (Article 21):

> Article 21 of the Constitution states that no person should be deprived of his life or personal liberty except according to the procedure established by the law. Over the years, this court's jurisprudence has added significant meaning and depth to the right to life. A large number of judgments interpreting Article 21 have laid down that the right to shelter is included in the right to life.
> —Supreme Court I.A. Nos. 94 & 96 in Write Petition
> (Civil) No. 196 of 200, 23 January 2012

> It must be the endeavor of each State to ensure that in compliance of Article 21, the life of homeless people be properly protected and preserved.
> —Supreme Court, 27 February 2012

This was the latest in a series of Court decisions that forced local governments to act when large numbers of poor people died because they could not access essential services. The 2010 shelter orders were in fact an extension of a public interest litigation on the right to food, filed in June 2001 by the People's Union on Civil Liberties after people in rural areas of six Indian states died of starvation at a time of drought, national grain surpluses, and defunct local food, nutrition and public works programmes. The Supreme Court ordered governments to implement these programmes, thereafter including poor people's 'right to food' under the constitutional right to life.

There is, of course, a need for knowledge to inform policy. Recent scholarship on homelessness has examined relationships between key deprivations faced by homeless people, like health burdens and other risks, such as the lack of access to public institutions, psychological trauma, and mortality. In Delhi, nearly 80 per cent of people who die on the streets are working-age men. Lung and respiratory diseases, including high rates of tuberculosis, are causes of death in two-thirds of these cases (Kumar et al, 2009; Chaudhary et al. 2013; Saurav et al. 2014). Ethnographic research on 18 homeless adults who sought healthcare in Delhi hospitals showed that each had concurrent, serious physical and mental ailments like post-traumatic stress disorder and tuberculosis, which served as barriers to suitable treatment (Prasad 2011). In a study on 25 homeless women with mental illnesses, Gopikumar and her team found that the main reason for landing on the streets was economic shock—the death of a main income earner in extremely poor families (Gopikumar et al. 2015).

Armstrong uncovered relationships between drug addiction and psycho-social risk factors as well as drug addiction and HIV risk behaviours among homeless men in Delhi. Drug users who reported being either severely depressed or having thoughts of suicide were four times and twice more likely to share needles, respectively. The main indicators associated with higher risks for thoughts of or attempts at suicide were homelessness, housing insecurity and broken relationships with family members (Armstrong et al. 2013; Armstrong et al. 2014).

Field research on vulnerabilities faced by homeless people may better inform public and policy discourse than findings from homeless surveys, which vary considerably. The case of Delhi is striking. The 2011 Census recorded 46,724 homeless people in Delhi while the United Nations Development Programme survey estimated over 55,000 people (United Nations Development Programme 2010). A 2011 survey conducted by the Commissioners of the Supreme Court records nearly 132,000 homeless people (Commissioners of the Supreme Court 2011). A survey by the 2014 Delhi Urban Shelter Improvement Board—the nodal agency responsible for the construction and maintenance of shelters—records only 16,670.

Components and Materials

The stories in this case chronicle how homeless men and women on the streets and in shelters of Delhi experience vulnerabilities to further impoverishment—primarily, health ailments, job insecurity, isolation and, in the case of women, gender. These narratives describe the experiences of people who received services from a shelter and outreach programme at the Centre for Equity Studies, where I was the project head at the time of this research. In addition to exploring vulnerabilities experienced by homeless people, these stories follow the outreach efforts of social workers—shelter caretakers and field outreach workers—and public institutions like hospitals, to provide care or ensure access to social services for homeless people.

The outreach programme consisted of one shelter for homeless women in Jama Masjid, two shelters for homeless men in Yamuna Pushta and a mobile street medicine clinic that provided health services to homeless people on the streets of Delhi.

One health recovery shelter in Yamuna Pushta provided primary health care and referral services to hospitals for 60 men a time, including patients with tuberculosis, HIV/AIDS and physical injuries. The neighbouring shelter was open to all homeless men and provided counselling, access to health facilities and identification cards. Chapters 3, 4 and 7 of Part I detail the outreach efforts of caretakers from the open shelter to reach out to men on the streets. Chapters 11, 12 and 13 of Part I tell stories of three men (one with both tuberculosis and HIV, one with tuberculosis and one with HIV) who received care at the health recovery shelter and are no longer homeless. In Part II of this case, Anhad Imaan and I detail how shelter caretakers from Yamuna Pushta shelters helped men exit homelessness, either by reconnecting them to their families or enabling them to get jobs and rental rooms in Delhi through partner NGOs.

Caretakers at Jama Masjid provided homeless women counselling, identification cards and access to health programmes—for them and their children. Chapters 5 and 6 of Part I detail the attempt to provide health care to a homeless woman in Jama Masjid.
The mobile street medicine clinic consisted of a physician, nurse and two social workers who

visited eight locations in Delhi five nights a week to provide health care and referral services to hospitals for homeless adults and children. Chapters 1,2, 8 and 9 of Part I chronicle the attempts to provide health care to men, women and children on the streets.

The goal of the programme was to provide health care and social support to homeless people to enable them to live with dignity. I was part of the social service system at this time and chose a descriptive method of storytelling to maintain a measure of objectivity that would allow the reader to enter this world viscerally. The narratives are windows into how homeless people receive health services and the extent to which street and shelter services improve living conditions marred by poverty and illness, find employment or exit homelessness. The stories, in this context, include successes, failures and outcomes that remain unknown.

Exhibit 1 is a photo of a woman getting her eyes checked in a van.
Exhibit 2 is an excerpt from the conversation with Javed Khan, programme manager of Yamuna Pushta.
Exhibit 3 is an excerpt from a narrative where men talk about how they are trying to get off drugs.

Exhibits

Exhibit 1: Checking Woman's Eyes in Van

Photographer: Atish Patel

Exhibit 2: Excerpt from Conversation with Javed Khan, Programme Manager, Yamuna Pushta

'I can say this without any hesitation that the men at the Pushta are all different. If I ask myself this: Why are these men at the Pushta? Why do some of them, who can actually afford to lead better lives, are never able to leave that space? Is there something about the Pushta that makes them stay back? I don't know.'

'When we decided to start the programme, it was clear to us that this will not be easy given the footprint that most men had created for themselves at the Pushta. Perhaps the biggest obstacle to this programme was that these men were unwilling to, or were not able to, speak about their past. It took us a while, therefore, to get them to trust us. If I were to point out problems in specific, this would take a while.'

In these conversations, Javed Khan shed light on some of the main obstacles that the team faces as they try to identify men for counselling.

No memory of a probably horrid past: 'Many of the men diagnosed with a mental disorder, are unable to remember their address. Some of them are clueless as to why they are at the Pushta. Many of them are in such a bad shape that they cannot recognise anyone or anything. Such men either have a psychiatric or a psychological condition. Two elderly men identified by our field staff, were both in such a bad shape that they did not know where they would get their food from. They had not bathed in a while and had defecated multiple times in their trousers. They had absolutely no control over their actions, and it was very clear that something terribly traumatic had happened to them—perhaps an accident, or a violent attack, or prolonged displacement.'

Severe addiction to alcohol and drugs: Most men start drinking after coming to the streets. Some aspire to be free from home and responsibilities, and make a conscious decision to either consume drugs or alcohol. Alcoholism is pervasive at the Pushta. It has been very difficult for my team to engage with addicts. Truth be told, most alcoholics find it difficult to leave the Pushta, not just because they are addicted, but because it is in that space that they enjoy anonymity and autonomy. A place where they are not accountable to anyone, and no one, to them. One of the strategies that we employed in such circumstances, was to speak to them about their problems, not as if they were 'their' problems but as problems of the world. For instance, Vicky, a resident of the Pushta who was an alcoholic would not listen to me if I counselled him with respect to his problems. I would therefore say 'How sad is it that we all have so many problems in our lives' instead of 'Vicky, it is so sad that you have so many problems in life,' or 'These habits make us weak and undignified' instead of

'Vicky, these habits make you look weak and undignified'. As a consequence, Vicky would not be enveloped by momentary guilt, but instead develop a genuine concern about his addiction. Once he stopped drinking for an entire month only on reflection from such conversations.'

'There were of course, several other obstacles we had to confront. While we were successful in helping some men, we weren't with others. This was not because we did not want to help these men or thought them to be beyond help, but because we found ourselves inadequately equipped to resolve their problems, which were so complex and difficult to decipher. We are confident that we will figure out ways to equip ourselves better in the near future.'

These conversations with Mr. Khan reveal an interesting fact: Alcohol addiction and psycho-social health are evidently two broad areas of concern. Why do these exist or many a times, co-exist?

Exhibit 3: Excerpt about men trying to quit drugs

ROCKY (26-28 YEARS)

Tall, lanky, permanently red eyed and cheerful, I saw Rocky—as he is popularly known—for the first time during the UTS event on 1 October. Rocky, sat on a desk that the staff had put outside the recovery shelter. He took part in the event with interest and enthusiasm.

In the next few days, Ashwin and I met him coincidentally, next to the tent behind the main shelter at the Pushta. He looked nothing like what he did at the UTS event. His shirt, covered in mud and scraps and fringes of turpentine. He scanned us from head to toe with his bloodshot eyes, unable to stand still. He was highly inebriated .

'Do you want to know something? I love my friends and my family. I am an able bodied, intelligent man, and I need not be here.'

'I see. Where are you from Rocky?' 'Himachal. I have a family back home. I came here a couple of years ago, and I cannot go back home now.'

'Why is that?'

'I am an alcoholic. I've tried several times, but I cannot live without my daily dosage I need to drink every single day. You know, to tell you the truth, I think most men here are just lazy and don't want to do anything with their lives! I don't like staying with these men. Some people are really nice, especially the staff.'

'I hate to head out unless it is for work. I hate going to the bridge that goes towards Jama Masjid. People in this part of town are sadists. It's each man for himself there. I can guarantee you, that if you walk down that bridge, you won't come out alive. The Pushta was like this as well, it was very unsafe. I remember I helped in the construction of this shelter, here. It wasn't there when I first came here. I have a lot of respect for Satyavir, who has been like an elder brother to me.'

Rocky did not stop talking for over an hour.

Rocky has a family back home. He studied in a school in Gwalior as a child, where his father worked at a textile factory. He had to stop studying there, because he could not cope with the syllabus. He dropped out of school after class 5 and went back to his native place in Himachal to work with his grandfather. He finished his schooling through an open school in Ganga Nagar. He then got admission into a B.Sc. programme in a government college but dropped out after the first year. He worked at a textile factory for a brief period, where he earned Rs.4500 a month, all of which he sent back home to his dad.

Rocky lives in a joint family back home, where his uncles, aunts, cousins, granduncles and aunts along with his parents all live under one roof. His family had a dispute over their property for a while.

'His uncle claims that the house they live in is rightfully his, and that his father had not allowed him to take ownership of the house or their property in the way he was entitled to do so,' said Satyavir on 27 September, 2013.

One day, when a dispute broke out between his uncle and his father, Rocky tried to intervene. His father was extremely angry at something he may have said. He told him to get lost and not intervene in matters that entail such high levels of responsibility. He blamed Rocky for being irresponsible towards himself and his family. Humiliated and hurt, Rocky came to Delhi, where one of his maternal uncle's ran a travel agency annexe (he owned a couple of cars and rented these out to other travel agencies, in case they did not have enough cars). Here, his uncle put him to work on a salary of Rs.5000 while he earned an extra Rs.3000 as commission. It was then that he got addicted to alcohol.

'Rocky took several tourists to different parts of the country, mostly within Northern India. He would drive his clients across Rajasthan, Himachal and Punjab.'

Cabs, buses and other travel agency vehicles usually have an understanding with restaurants and dhabas located between one's point of departure and destination. Agency drivers bring tourists or clients to a selected number of dhabas. If you've ever travelled by bus from one city to another, you would have noticed that bus drivers stop only at particular restaurants and dhabas. The same holds true for taxis rented from agencies. At these selected dhabas, all taxi drivers have an understanding that for bringing tourists and clients to those dhabas, the driver's food would be served free of cost. Moreover, taxi drivers are also entitled to alcohol. Rocky, would drink every time he'd stop at a Dhaba with which his office had an understanding. Gradually, he began to drink a lot, and quit his job as a driver.'

Teaching Note

Module: 'Vulnerabilities to Death Inducing Poverty of Homeless Adults' (3 hours 25 minutes)

Participants: Students or government officials
Two teachers/facilitators will lead the exercise

PART I (1 HOUR 10 MINUTES)

One or both of the teachers will lead the classroom in a group discussion guided by questions below and all the readings in the Primary Case Form folder. Following this discussion, students will be split into two groups for an exercise with respect to specific readings before reconvening for Part III of the module.

Part I is intended to provide context for the discussion on the following question: 'what major deprivations do homeless people face in addition to the lack of shelter that require specific public policy responses?'

The students will be responsible for all of the readings in the case repository to facilitate the group discussion. The learning outcome of part I will be to lead students to develop thoughts on:

(a) deprivations that make homeless people vulnerable to chronic and/or death inducing poverty. These do not have to be limited to physical deprivations but can also be discussed in matters of social isolation, mental and/or psychosocial burdens and areas of human development such as education, safe and secure livelihoods, etc. (note: it is important for the teachers to lead students to a discussion on the difference between deprivation and vulnerability; where the deprivation is a condition of suffering due to the lack of an unmet and basic need and vulnerability is the state of being prone to the risk of calamity or persistent insecurity);

(b) required public policy responses; and

(c) actors—governments, civil society, academics, media—who are required to participate, and in what ways.

With regard to (a), students should become aware of the difference between deprivation and vulnerability. Deprivation is a condition of suffering due to the lack of an unmet and basic need. Vulnerability is the state of being prone to the risk of calamity or persistent insecurity. In terms of homelessness, students should be guided into a discussion into how X deprivation makes homeless men/homeless women more vulnerable to Y, Z, etc., kinds of insecurity. This discussion will be central to the exercise in Part II.

Key Questions for Part I

1. Identifying basic deprivations among homeless people (20 minutes):

   (a) What are the key deprivations of people on the streets and shelters in terms of a basic standard of living in the chapters you have read?

   (b) Should any of these deprivations be considered violations of human rights? Why or why not?

   (c) How does homelessness play a role in these deprivations (i.e., health burdens) in terms of the causes and outcomes of a particular mental and/or physical condition or state of mind and the extent of access to public services?

2. The preface explains that the recent government response to homelessness through shelters is an improvement from the past. These policies still, however, represent a minimalist approach to reducing poverty—in terms of seeking to reduce death versus improving the overall quality of life for people on the streets (20 minutes).

   (a) What are the critical deprivations that make poor people on the streets and in shelters vulnerable to death inducing poverty?

   (b) What responsibilities should governments assume to respond proactively?

3. What responsibilities and/or coordinated efforts with civil society are necessary? Is a rights-based approach necessary to ensure such a proactive response? Identifying gender-specific vulnerabilities with respect to safety and health concerns of homeless women (20 minutes).

   (a) Are there any discrete differences in the nature of homelessness among adult homeless females and males? What, if any, are they, in terms of health, health access, livelihood, safety and education?

   (b) Homeless adult males dominate these narratives. Does this reflect the author's own bias? What techniques, methods and resources do you think are required to further highlight the lives of homeless women and what do you believe it could add to our understanding of homelessness and urban poverty?

4. Brief wrap-up of Part I and preparation for Part II (10 minutes).

PART II

Break up into two groups (1 hour 30 minutes)—Group A and Group B.
Group A's discussion and exercise will arise out of these readings: 2.6 Fatima, 2.10 Amit Kumar, 2.11 Kishan Bahadur, 2.12 Kabir, 3 Off the Mean Streets—*Caravan* article).
Group B's discussion and exercise will arise out of these readings: 2.1 Street Medicine, 2.2 Hanuman Mandir, 2.3 Yamuna Bazaar, 2.6 Fatima, 2.7 Streets to Shelter, 2.8 Sarai Kale Khan, 2.9 Sai Baba Mandir, 4.

Group A

Taking off from the group discussion, the teacher will lead the group to delve further into gendered differences of homelessness with respect to health problems and access to health care faced by Fatima, Amit Kumar, Kishan Bahadur and Kabir. The learning outcome for this portion of the discussion is to lead students to an understanding that health problems are not merely an outcome of homelessness but, in the case of men, can be one of its causes. In some cases, such as Fatima's, accessing health care is sometimes a challenge due to negative environmental and social influences that can make the difference between life and death. The teacher should lead students towards questions on accessibility of services in Delhi as well as in other areas of the country that migrants come from, since some of these stories show how men sought care in Delhi when they were turned away from hospitals in their hometowns.

The exercise will involve the students designing specifications for a health shelter for homeless adults. The design of the shelter should consider these questions:

(a) Should there be separate facilities for men and women? If so, what specific considerations should be given to women and children's facilities?

(b) Should there be outreach services on the streets and in other shelters in the area? How would they be linked?

(c) What would be the nature and extent of linkages between the health shelter and primary, secondary and tertiary hospitals?

(d) How much ownership of such shelters should the government take? What civil society partnerships may the government form to implement this initiative?

(e) How can such initiatives be linked with existing mandates such as the National Shelter Policy and the National Urban Health Mission?

(f) How would homeless people be involved in the planning, operation and monitoring of the programme and policy?

Group B

The teacher will lead the group in exploring the idea of 'outreach' with respect to the homeless, as read in the selected stories, how to bring homeless people to shelters and provide health care and other services as a means of reducing their vulnerability to suffering. What are the practical and ethical challenges of providing services and care to people on the streets? How can government officials, NGOs and volunteer citizens groups undertake such efforts?

The learning outcome of this portion would be for the teacher to lead the students towards ideas about the kinds of outreach, identification and care and support on the streets that may be essential as part of a road to recovery.

The exercise will involve students designing an outreach programme that links homeless people on the streets to public health and safety institutions, such as police departments and homeless shelters. The design of the programme should consider these questions:

(a) What kinds of deprivations and vulnerabilities would outreach teams be tasked with identifying? What kinds of teams of specialists, government officials, NGO members and volunteers would be required?

(b) How would these outreach services link to services in shelters, drug de-addiction programmes, hospitals, livelihood training programmes, nutrition centres, etc.?

(c) How would an outreach programme be included as part of government policy? What civil society partnerships may the government form to implement this initiative?

(d) How can such initiatives be linked with existing mandates such as the National Shelter Policy and the National Urban Health Mission?

(e) How would homeless people be involved in the planning, operation and monitoring of the programme and policy?

PART III (45 MINUTES)

The teachers reconvene the two groups to go over their proposed policy. The learning objective of this component would be to attempt to merge the health shelter and outreach programmes in a cohesive manner. The teachers may then do a 10–15-minute wrap-up session on what the students observed and learned.

Accessing the Full Case

The full content of this case is open-access and downloadable at www.cases.iihs.co.in.

The full content of this case includes the following documents:

Folder A: Introduction to the Case

- Terms of Use and Agreement
- Reframing Urban Inclusion
- IIHS Case Method
- Teaching Note

Folder B: Main Case

Narratives

- Night Out: Street Medicine
- Night Out: Hanuman Mandir
- Night Out: Yamuna Bazaar
- Ethical Considerations of Working with Homeless People in Difficult Circumstances
- At the Pushta
- Fatima
- Streets to Shelter
- Sarai Kale Khan
- Sai Baba Mandir
- Homeless in Delhi: In Search of Healthcare (Part I: Amit Kumar)
- Homeless in Delhi:I n Search of Healthcare (Part II: Kishan Bahadur)
- Homeless in Delhi: In Search of Healthcare (Part III: Kabir)

The Process of Rehabilitation of the Homeless at Yamuna Pushta, Kashmere Gate

Off the Mean Streets (Caravan Magazine)

Rajasthan could become the first state to draft a homeless policy (Scroll.in)

Folder C: Case Archive

- Audio Files
- Bibliographies
- Street Medicine Photos (Photographer: Atish Patel)

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About the Author

Ashwin Parulkar has been working on issues of homelessness since 2013 and has formerly managed men and women's homeless shelters in Delhi. His research on hunger and the implementation of right to food programmes in rural India is the subject of two forthcoming books. One is a co-edited volume on key debates on the right to food in India, to be published in 2017 by Orient Blackswan. The other is a narrative non-fiction account of government responses to starvation deaths in Bihar, Madhya Pradesh and Jharkand, to be published in a volume on destitution in India by Speaking Tiger Books Ltd., also in 2017. He was educated at Syracuse University and Case Western Reserve University.

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