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Research Article

Sociodemographic and Economic Characteristics of a Homeless Community in Delhi, India

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Abstract

Introduction: Homeless people are unable to get and maintain regular, safe, and sound houses or lack of fixed, usual and adequate night-time residence. Urban homeless people constitute the most marginalized and invisible category.

Objective: To study the sociodemographic and economic characteristics of homeless living at one such "night shelter" in Delhi.

Materials and Methods: In a conveniently chosen "night shelter" for homeless, 48 families were interviewed. Data was collected for 258 individuals. Data about sociodemographic characteristics, income, any addiction and self-reported health problems was collected.

Results: The average number of family members was 5.38. 51.94% participants were adult. Dependency ratio was 88.32%. 91.8% of adult subjects were illiterate. Illiteracy was more common among adult females. 67.74% children were out of school with a higher proportion of females among these children (53.66%). 18.55% children were working to support their family income. Average daily per capita family income was Rs. 113.02 94. 2% including children were addicted to a tobacco-containing dentifrice. Addiction to tobacco or alcohol was common among adults of both sexes (63%).

Conclusion: We observed that women and children form a sizable number among the homeless. Very little is known about the characteristics of this vulnerable population, which therefore requires urgent attention.

Keywords: Homeless, Sociodemography, Socioeconomic status, Addiction, Child labor, Out-of-school children

Introduction

Homelessness is a condition in which people, especially in urban areas, do not have a regular and secure dwelling. Homeless people are unable to get and maintain regular, safe, and sound houses or lack a fixed, usual and adequate night–time residence.[1] The term homeless includes people whose primary night-time residence is a shelter at ad-hoc housing situation. Street-dwelling people and people spending their time in unoccupied buildings are also termed homeless.[1] Recently, it is being increasingly recognized that population residing in temporary, insecure or physically ruined sub-standard accommodation is also considered as homeless.[1]

The legal definition of homeless varies from country to country.[1] United Nations defines homeless households as those without shelter falling in the scope of living quarters. They carry their few possessions with them, sleep in streets, in doorways or on piers or other spaces, on a more or

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less random basis.[1]The Census of India defines 'houseless population' as the persons who are not living in 'census houses'. A 'census house' is referred to as a 'structure with roof'. Census enumerators are instructed 'to take note of the possible places where the houseless population is likely to live such as 'on the roadside, pavements, in pipes, under staircases or in the open, temples, *mandaps*, platforms and the like'. They are described variously as homeless, houseless, roofless, shelter-less people, and pavement dwellers.[2,3]

It is to be noted that within this group, there are multiple degrees of vulnerability, for instance, the multiple vulnerabilities of single women, infirm and old, disabled, and persons who have special needs, and those involved in substance abuse. In addition to their social and economic vulnerability, these are also the groups that often have no kind of shelter whatsoever, and live in the open and are subject to various forms of exploitation and abuse.[2]

In October 2002, the scheme called "*Night Shelter for Urban Shelterless"* was launched by the Government of India, overriding all other earlier schemes. The modified scheme was now limited to construction of composite night shelters with toilets and baths for urban shelter-less. These would be in the nature of dormitories/halls with plain floors to be used for sleeping at night and for other social purposes during the day time, e.g., healthcare center, training for self-employment, adult education, etc. This scheme was finally withdrawn in 2005 because most state governments did not utilize even the limited funds properly, as were budgeted for them.[2] There is at present no national program for this most vulnerable population among the urban poor.[2]

The present study was planned to find out the sociodemographic and economic characteristics of the homeless living at one such "night shelter" in Delhi. The proportion of out-of-school children, working children, addicts, and families without any form of government identification were important secondary objectives.

Materials and Methods

Study Area: There are 262 night shelters in Delhi (Delhi Urban Shelter Improvement Board). These shelters are of three types: permanent shelters (for general and special groups like children, disabled, women, drug addicts), porta cabins, and tent shelters. Of these, 84 are permanent structures as described above.

Study Subjects: Study subjects were all residents of a night shelter home in Delhi. A family was defined as blood relatives including their wives/mothers, and sharing food. As rapport with the homeless population is essential for effective data collection, one shelter was conveniently chosen for this study. For this shelter, our department runs the mobile medical services, so our rapport with the community was good. All the people residing in the shelter were included in the study. One adult member of each family was the respondent in interviews. A total of 314 people from 79 families reside in the selected night shelter. All families for which at least one adult respondent was present were included in the study. Therefore data of 258 people was obtained in the study.

Data Collection: A pre-tested, semi-structured questionnaire was used for the interviews. Verbal consent was taken from the respondents after informing them about the study. They could withdraw from the study at any point with no repercussions. Data was collected by trained staff over a period of one month (in December 2015). One family was interviewed only once. Families which were unable to be contacted over this period had to be excluded from the study.

Statistical Analysis: Statistical analysis was done using MS Excel, and SPSS ver. 12. Data was described as percentages and proportions.

Results

A total of 258 people from 48 families residing in the selected night shelter were surveyed. Non-response rate was 17.8% as families often go to their native places for extended periods of time. The average number of family members was 5.38/family (range 1 to 18 members/family).

134 study subjects were adult (age >=18 years) (51.94%), rest 124 (48.06%) were children (Table 1). 199 out of 258 (77.13%) came from various parts of Delhi, rest 59 (22.87%) had migrated from neighboring states like UP, Bihar, etc., few migrants were from far off places like Maharashtra and W. Bengal. 184 (71.32%) subjects were in Delhi since childhood. 17 (6.59%) subjects were here since less than 10 years. Rest (57, 22.09%) were here for more than 10 years.

Table 1.Gender-Wise Distribution of Study Subjects

Gender	Adults	Children	Total
Male	63 (47%)	62 (50%)	125 (48.45%)
Female	71 (53%)	62 (50%)	133 (51.55%)
Total	134 (100%)	124 (100%)	258 (100%)

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Mean age of adult study subjects was 34.81 (SD 14.45) years (range 18 to 80 years). Mean age of children was 6.63 (SD 4.4) years (range 0 to 17 years). Dependency ratio was 88.32%. Table 2 shows the age distribution of study subjects. Out of 134 adults, 125 (93.28%) had been ever married. Of these, 15 (12%) were widows/widowers. Out of the 124 children, one 17-year-old female was married.

Table 2.Age Distribution of Study Subjects according to Vulnerability because of Age Group

Age Group	Female (%)	Male (%)	Total
<1 year (infants)	6 (4.5)	3 (2.4)	9 (3.5)
1 to 5 years (one to five year old children)	23 (17.3)	13 (10.4)	36 (13.95)
5 to 10 years (children)	20 (15.0)	28 (22.4)	48 (18.6)
10 to 20 years (adolescents)	18 (13.5)	20 (16.0)	38 (14.7)
20 to 35 years (young adults)	38 (28.6)	31 (24.8)	69 (26.7)
35 to 55 years (middle age)	17 (12.8)	19 (15.2)	36 (13.95)
55 to 60 years (late middle age)	3(2.3)	2(1.6)	5 (1.9)
60 to 70 years (young old)	8(6.0)	7 (5.6)	15 (5.8)
70 to 80 years (middle Old)	0	2 (1.6)	2 (0.8)
Total	133(100)	125 (100)	258 (100)

Tables 3 and 4 show the educational status of study subjects. Majority, i.e., 91.8% of adult subjects were illiterate. Illiteracy was more common among adult females (53.66%) than adult males (46.34%). No one had received education higher than secondary school. Among children, majority, i.e., 67.74% children were out of school. Only 20.2% children were in school and 12.09% children were receiving non-formal education at the shelter itself. Among the children in school, 76% were male and only 24% were female. Therefore, a higher proportion of female children were out of school (53.66%) as compared to the males.

Table 3.Educational Status of Adult Study Subjects (n=134)

Educational Status	Male	Female	Total
Illiterate	57 (46.34%)	66 (53.66%)	123 (100%)
Up to primary school	5 (55.56%)	4 (44.44%)	9 (100%)
Up to secondary school	1 (50%)	1 (50%)	2 (100%)
Total	63 (47%)	71 (53%)	134 (100%)

Table 4.School Attendance of Children (n=124)

School Attendance	Male (%)	Female (%)	Total
Not in school	33 (39.29%)	51 (60.71%)	84 (100%)
In school	19 (76%)	6 (24%)	25 (100%)
Non-formal education	10 (66.67%)	5 (33.33%)	15 (100%)
Total	62 (50%)	62 (50%)	124 (100%)

None of the study subjects possessed any skill. They had not received any formal or informal training for any vocation. Therefore, most employed people were unskilled workers. Table 5 shows the occupations of the adult study subjects, segregated by gender. 13.43% adults were unemployed, with more females being unemployed than males. 23 children (18.55%), between the ages 8 to 17 and out of school, were working to support their family income. Table 6 shows their occupations. Male children were more likely to be working to support their families as compared to female children.

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Table 5.Occupations of Adult Study Subjects

Occupation	Male	Female	Total
Un-employed	8 (42.10%)	11 (57.89%)	19 (100%)
Balloon seller	30 (50.85%)	29 (49.15%)	59 (100%)
Rickshaw puller	11 (100%)	0	11 (100%)
Drum beater	7 (100%)	0	7 (100%)
Laborer	7 (77.78%)	2 (22.22%)	9 (100%)
Toy seller	7 (53.85%)	6 (46.15%)	13 (100%)
Housewife	NA	9 (100%)	9 (100%)
Begging	1 (14.29%)	6 (85.71%)	7 (100%)
Balloon making	0	6 (100%)	6 (100%)
Others#	2 (50.69%)	2 (49.31%)	4 (100%)
Total	73* (50.69%)	71 (49.31%)	144* (100%)

*Multiple responses (Total of men is more than 63 as some men work more than two jobs like balloon seller and rickshaw puller.) #Others include waiter, mechanic, cleaner, flower seller

Table 6.Occupations of Out-of School Children

Occupation	Male	Female	Total
Balloon seller	7 (46.67%)	8 (88.89%)	15 (62.5%)
Dhol player	3 (20%)	0	3 (12.5%)
Mechanic	1 (6.67%)	0	1 (4.2%)
Rickshaw puller	1 (6.67%)	0	1 (4.2%)
Toys seller	3 (20%)	1 (11.11%)	4 (16.7%)
Total	15 (100%)	9 (100%)	24* (100%)

*multiple responses (one boy worked as balloon seller and dhol player)

Daily per capita family income varied from Rs. 16.66 ($ 0.25) to Rs. 400 ($ 6.02). Average daily per capita family income was Rs. 113.02 ($1.70) (SD=Rs. 79.98 ($1.20)). Average daily income of adult study subjects was Rs. 196.08 ($ 2.95) (range Rs. 50 ($ 0.75) to Rs. 800 ($ 12.04)). For similar work, income of working women was consistently lower than that of men. Average daily income of children who were working to support their families was Rs. 132.61 ($ 1.99) (ranging from Rs. 50 ($ 0.75) to Rs. 400 ($ 6.02)). Six families (16.67%) were below poverty line (Rs. 47 ($ 0.71) per capita per day national poverty line for urban areas). Majority (251/258, 97.29%) had no dependents in the village. Only four families had some land in their native villages. Only 31 of the 258 (12.02%) study subjects had at least one of these government ID cards (Aadhar card/ ration card/voter's ID/birth certificate).

Information on self-reported morbidity among family members was sought. 39 out of 258 (15.12%) subjects reported some health problem with themselves and/or their family members. Of these, 6 (15.38%) had physical disability and 4 (10.26%) reported mental illness. Rest 29 (74.36%) reported physical ailments like excessive weakness, breathing problems, tuberculosis, paralysis, skin infections, cough and cold, etc.

Addiction to tobacco (smoking and chewing) and alcohol was very common. All study subjects [excluding the very young and very old (5.8%)] had habit of using "Gul Manjan", a tobacco-containing abrasive powder used for brushing teeth. Children as young as two or three years of age were exposed to this form of tobacco. Cigarette/bidi smoking, tobacco chewing and alcohol intake were common forms of addiction among adults of both sexes (63%, all males and some females). They were using these substances almost every day.

Discussion

Homelessness makes a family vulnerable. The basic problems of the homeless are need for shelter, warmth and safety, personal security, privacy, hygiene and sanitary facilities, space for preparing and storing food, etc.[1] Rapid growth of urban population leads to homelessness as urbanization and industrialization causes migration of people from nearby villages for employment. Often, stigmatized individuals, addicts, mentally ill, physically disabled, etc., find themselves turned out of their homes and villages, and they have nowhere to go except the streets. Many times, people lose their homes to rapid growth of geographical boundaries of the city, and the compensation they receive is not enough to help them find appropriate housing.[1] Rural area of Delhi has reduced substantially from 2001 to 2011. The number of villages has also declined from 165 in 2001 to 112 in 2011.[4] A lot of people migrate to Delhi from villages to seek better

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opportunities for education and employment. A majority of the unorganized workforce is comprised of these migrants. High cost of living pushes these families to live in ever-increasing slums and other sub-standard housing conditions. Further, misfortune causes families to come on the streets.

The homeless are an invisible group. The world over, homeless people have been largely misunderstood and ignored.[5] Urban homeless people constitute the most marginalized and invisible category even within the urban poor.[6] The Census of India enumerated the homeless for the first time in 2001.[6] Since then, many surveys have tried to estimate the exact number of the homeless in Delhi. A Delhi government initiative, Samajik Suvidha Sangam's Homeless Survey (2010), pegged the number at 67,151.[7] It has also been noted previously that for every homeless counted, there is at least one who is missed.[6] The homeless do not have any proof of identity like ration card, voter's ID, etc.[7] As a consequence, lack of address proof renders them even more vulnerable and they are deprived of many beneficial government schemes.

We observed that there were a higher proportion of females among the homeless community; also families with young children were common. Juvenile and senile dependency has been reported as a common feature among the homeless population.[1] In our study also, we observed a dependency ratio of 88.32%, i.e., for every 100 individuals in the economically productive age group, there were 88 dependents (children <15 years and elderly >65 years). This is much higher than the dependency ratio observed for whole of India, i.e., 53% (2014).[8] Poor educational status and lack of vocational skills was a common problem observed in previous studies too.[1] The homeless were more likely to be doing petty jobs involving manual labor due to lack of education and skills.[1] These jobs commonly were not regular and thus the income was not fixed. Although in the present study, the number of families below poverty line is less, the other families (above poverty line) also do not have a secure source of regular income due to the nature of their occupations. This makes them vulnerable to economic hardship all too often.

Addiction to tobacco and alcohol was very common among our study subjects. An alarming observation was that very young children were being exposed to "Gul Manjan". In India, there is a widespread misconception that tobacco is good for the teeth.[9] Tobacco products are popular as a dentifrice in different parts of India, and children also use such dentifrices.[10] Tobacco containing dentifrices are used not only for cleaning the teeth, but also to get the "kick" out of tobacco.[10] It is also highly addictive. In spite of a law banning the use of tobacco in toothpastes, such products are freely available in the market, without mentioning tobacco as one of the ingredients.[10] "Gul Manjan" is an oral tobacco powder which is rubbed over the gums and teeth.[11] A considerable amount of nicotine (2–216 gm) can enter the oral cavity on using such toothpastes/toothpowders.[10] In children, there is greater retention of dentifrice than adults, due to incomplete rinsing, which is ultimately ingested by them.[10] Presence of nicotine in these dentifrices even in low concentrations and regular use can lead to addiction and oral mucosal lesions.[12] Once a person is addicted, quitting is very difficult, irrespective of the form in which he uses it.[10] Therefore, exposure of very young children to nicotine in the form of dentifrices is an urgent public health problem. Also, the high prevalence of addiction to tobacco and alcohol among adult study subjects warrants attention. Self-reported morbidity was found in about one in every seven individuals. It could be even higher but lack of knowledge and absence of all members at the time of study could be the major reasons for this observation.

There is an urgent need to redefine the term "homelessness" in the Indian context so that reliable data can be generated.[13] Holistic programs that cover various social, cultural, economic, and health aspects are needed for this population.[13] Aadhar, India's largest population database, managed by the government organization Unique Identification Authority of India, and schemes for below poverty line families should recognize the presence of homeless people, whose lack of home address prevents access to these schemes.[13]

Some collaborative initiatives by the governmental and non-governmental organizations for outreach services, e.g., Health Initiative Group for the Homeless (joint initiative of Aashray Adhikar Abhiyan (initiative for right to homes), Institute of Human Behavior and Allied Sciences and Delhi State Legal Services Authority in Delhi and Koshish meaning "effort" by the Tata Institute of Social Sciences in Mumbai and Delhi have tried to address a few of these issues, especially the issue of homeless-ness.[13-15] But these efforts are too few and far between.

Limitations of the study include a small sample size from only one homeless community in Delhi. As observed in previous studies, the homeless by virtue of being homeless are a very difficult population to reach. Other challenge is their wariness of strangers and rapport building is time consuming. Therefore, we selected one community living in a government shelter so that we are able to reach the study population. We observed that the homeless living in these shelters were little better off as compared to those living in the streets. Therefore, the generalizability of this study is limited to the homeless population residing in shelters in Delhi. As we had a good rapport with people, response of the study subjects during the interview was excellent. Therefore the internal validity of the study is good.

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Conclusion

We observed that women and children form a sizable number among the homeless. Illiteracy and unemployment was rampant. Children were less likely to be in school and were working odd jobs. Lack of vocational skills impeded chances of having a stable and well-paying employment even in adulthood. Lack of government identity cards caused them to miss benefits of government schemes. Addiction to tobacco and alcohol was very common, and an alarming observation was addiction to tobacco among very young children. There is an urgent need to focus research on the unique requirements of this vulnerable population group and efforts should be made to mainstream them.

Conflict of Interest: None

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