THE RIGHT TO SHELTER AS A DETERMINANT OF PUBLIC HEALTH: ADDRESSING THE HUMAN RIGHTS OF PAVEMENT DWELLERS IN URBAN INDIA

Vibhanshu Dubey, Research Assistant, Artificial Intelligence and Law, CNLU, Patna.[1]

ABSTRACT

Shelter is foundational to human dignity and health, shaping exposure to environmental hazards, psychosocial stress, and access to essential services. In urban India, pavement dwellers—households living on sidewalks, roadside margins, and other public spaces—face extreme deprivation marked by insecure tenure, frequent evictions, and systematic exclusion from water, sanitation, and health services. This paper argues that the right to shelter, recognized under Indian constitutional jurisprudence and international human rights law, is a core social determinant of health for pavement dwellers.[2] Drawing on case law, treaty obligations, public health evidence, and urban policy frameworks, it examines how shelter deprivation drives communicable and non-communicable disease burdens, maternal and child health risks, injury, mental distress, and malnutrition. It critiques eviction-led governance models and gaps in housing and health programs, and proposes a rights-based package including legal safeguards against forced evictions, low-cost rental and transitional housing near livelihoods, universal basic services irrespective of tenure, integrated health and social outreach, and participatory governance.[3] Reframing shelter as a public health imperative and a justiciable right is necessary to realize equity and resilience in Indian cities.[4]

[1] Research Assistant, Artificial Intelligence and Law, CNLU, Patna.
[2] International Covenant on Economic, Social and Cultural Rights, art. 11(1).
[3] Committee on Economic, Social and Cultural Rights, General Comment No. 4: The Right to Adequate Housing (Art. 11(1) of the Covenant) (1991).
[4] Committee on Economic, Social and Cultural Rights, General Comment No. 7: The Right to Adequate Housing: Forced Evictions (1997).

Introduction

Shelter is more than a roof; it is the enabling condition for privacy, safety, family life, and access to water, sanitation, and health care—preconditions for a dignified life.[5] The Indian Supreme Court's substantive due process jurisprudence has recognized dignity as intrinsic to the right to life under Article 21, which courts have read to include shelter and related essentials.[6] Pavement dwellers, among the most marginalized in India's urban fabric, typically inhabit precarious spaces—pavements, under-flyover margins, and rail-side corridors exposed to weather, pollution, traffic, violence, and displacement.[7] The health consequences are profound: heightened infectious disease transmission,[8] chronic respiratory conditions, injuries, mental distress, malnutrition, and poor maternal and child health outcomes.[9]

While policy attention has focused on "encroachment removal" and slum rehabilitation, pavement dwelling is often treated through a law-and-order lens, sidelining human rights and public health.[10] Yet international and domestic legal frameworks recognize the right to adequate housing and require safeguards against forced evictions and denial of basic services.[11] This paper synthesizes legal doctrine, public health literature, and programmatic evidence to argue that realizing the right to shelter is integral to improving population health and achieving urban equity.

Conceptual Framework: Shelter as a Social Determinant of Health

Public health recognizes social determinants income, education, employment, housing as structural drivers of health inequities. Housing and shelter shape health through material exposures, psychosocial pathways, and access to care. For pavement dwellers, material exposures include outdoor living, extreme heat and rainfall, ambient air pollution, noise, and proximity to traffic and rail hazards. Psychosocial stress arises from constant insecurity risk of eviction, harassment, theft and stigma; chronic stress increases cardiovascular risk and mental health burdens. Access barriers include lack of address or documentation for welfare

[5] Maneka Gandhi v. Union of India, (1978) 1 SCC 248.
[6] Chameli Singh v. State of U.P., (1996) 2 SCC 549.
[7] Olga Tellis v. Bombay Municipal Corporation, (1985) 3 SCC 545.
[8] World Health Organization, Housing and Health Guidelines (2018).
[9] Ministry of Health and Family Welfare, Government of India, National Urban Health Mission: Framework for Implementation (2013).
[10] ICESCR, art. 11(1); CESCR General Comments 4 and 7.
[11] Convention on the Rights of the Child, arts. 24, 27; Convention on the Elimination of All Forms of Discrimination against Women, arts. 12, 14.

enrollment, disrupted continuity of care due to evictions, and distance from facilities. A rights-based approach reframes shelter not as charity but as a state obligation with measurable public health returns.[12]

Legal Foundations: The Right to Shelter in Indian and International Law

1) Indian constitutional jurisprudence

The right to life under Article 21 has been interpreted to encompass the right to live with human dignity, which the Supreme Court has linked to shelter and basic amenities. In ***Olga Tellis v. Bombay Municipal Corporation***[13], the Court recognized that pavement dwellers are not trespassers in the conventional sense and that their eviction affects life and livelihood; it mandated procedural safeguards. In ***Chameli Singh v. State of Uttar Pradesh***, the Court stated that the right to shelter includes adequate living space, safe and decent structure, clean surroundings, and basic civic amenities like water, electricity, and sanitation.[14] Subsequent cases have reinforced due process in evictions, the obligation to provide alternative accommodation in certain contexts, and humane treatment of the urban poor. Although jurisprudence balances competing public interests planning, environment, traffic—it consistently affirms that evictions cannot be arbitrary and must respect dignity and due process.[15]

2) International human rights law

India is a State party to the International Covenant on Economic, Social and Cultural Rights (ICESCR), which recognizes the right to adequate housing (Article 11). The UN Committee's General Comment No. 4 outlines adequacy criteria: legal security of tenure; availability of services, materials, and infrastructure; affordability; habitability; accessibility; location; and cultural adequacy.[16] General Comment No. 7 prohibits forced evictions and requires genuine consultation, reasonable notice, legal remedies, and provision of alternative housing where needed. Related obligations flow from the Convention on the Rights of the Child and CEDAW, requiring states to safeguard housing conditions necessary for women's and children's health

[12] National Health Authority, ABDM: Health ID Policy Documents (Govt. of India, various).
[13] (1985) 3 SCC 545.
[14] *Chameli Singh v. State of U.P.,* (1996) 2 SCC 549.
[15] *Ahmedabad Municipal Corporation v. Nawab Khan Gulab Khan*, (1997) 11 SCC 121.
[16] CESCR, General Comment No. 4 (1991).

and safety. Domestic courts increasingly look to these norms to interpret socio-economic rights.[17]

Epidemiology of Pavement Dwelling and Health Impacts

1) Population profile and living conditions

Pavement dwellers are concentrated in megacities—Mumbai, Delhi, Kolkata, Chennai, Bengaluru near employment hubs and transport nodes. Many are circular migrants working in informal sectors—construction, vending, domestic work, waste picking with income volatility and no social protection, making even low-end rentals unaffordable. Makeshift shelters built from tarpaulins and scrap lack secure storage, lighting, and thermal protection; nights are fragmented by noise and policing; women and children face higher risks of harassment.[18]

2) Disease risks and outcomes

Communicable diseases: Overcrowding and poor WASH drive diarrheal disease, acute respiratory infections, and tuberculosis; vector exposure increases dengue and malaria risk. Limited cold chain or storage complicates food safety and medication adherence.[19]

Non-communicable diseases: Prolonged exposure to traffic-related air pollution and dust elevates risks of asthma, COPD, ischemic heart disease, and stroke; chronic stress contributes to hypertension and metabolic disorders.[20]

Maternal and child health: Inadequate antenatal and postnatal care, hazardous environments, and malnutrition contribute to low birthweight, preterm delivery, and neonatal morbidity; immunization is hindered by mobility and documentation gaps.

Injury and disability: Proximity to high-speed roads and rail lines increases road traffic injuries; cooking in cramped, flammable settings increases burns; monsoon flooding raises drowning and injury risks.

[17] Vishaka v. State of Rajasthan, (1997) 6 SCC 241 (use of international norms in fundamental rights interpretation).
[18] Human Rights Law Network, Report on Urban Homelessness and Access to Services (various city studies).
[19] FSSAI, Food Safety Guidance for Street and Peri-Urban Settings (various).
[20] Health Effects Institute, State of Global Air (latest India section).

Mental health: Insecurity, stigma, and exposure to violence correlate with depression, anxiety, substance use, and trauma symptoms; barriers to mental health services are significant.

Nutrition and food security: Income volatility and lack of storage favour energy-dense diets with low micronutrient diversity; child stunting and underweight remain elevated among urban homeless and pavement-dwelling populations.[21]

Structural Drivers: Economics, Urbanization, and Policy

Housing precarity for pavement dwellers emerges from systemic drivers: speculative urban land markets and restrictive zoning that constrain affordable supply; unregulated, discriminatory low-end rentals; and welfare systems tied to proof-of-address that exclude those without tenure. Urban governance frequently prioritizes beautification and traffic management, resulting in recurrent evictions and relocations to distant peripheries, disrupting livelihoods and schooling and worsening health access. These patterns reflect structural exclusion rather than individual failure.[22]

Policy Landscape: Programs and Gaps

India's urban housing programs have historically emphasized ownership-led models and in-situ slum redevelopment that often bypass the houseless and highly mobile. The National Urban Livelihoods Mission (NULM) includes the Scheme of Shelters for Urban Homeless (SUH) to provide 24×7 shelters with essential services, but coverage remains inadequate relative to need, and quality and accessibility vary. Women-only and family-compatible shelters are scarce, and admission practices can be restrictive. Public health outreach to pavement clusters is inconsistent, and WASH access is often fee-based, distant, or unsafe, particularly at night resulting in open defecation and heightened disease risk. Disaster and climate planning often overlook outdoor-living populations, despite rising heat extremes and flooding in cities.[23]

The Public Health Case for a Rights-Based Shelter Policy

Preventive investment in shelter and basic services reduces communicable disease

[21] UNICEF India, Urban Nutrition and WASH Vulnerabilities Reports (various).
[22] Delhi High Court jurisprudence: Sudama Singh (2010); Ajay Maken (2019) on evictions and rehabilitation.
[23] IMD and MoHUA, Heat Action Plans; NIUA/NDMA guidance for urban climate resilience.

transmission, emergency care use, and long-term disability costs. Improving shelter stability and WASH access enhances child growth and learning, adult work capacity, and overall productivity—yielding intergenerational gains. Homelessness complicates outbreak control for TB and respiratory infections; secure shelter and hygiene infrastructure are essential for vaccination, isolation, and continuity of care. With intensifying heat waves and urban flooding, dignified shelter and water access are core climate adaptation measures for health protection.[24]

Ethical and Human Rights Considerations

A rights-based approach requires dignity, autonomy, non-discrimination, participation, and special protection for women, children, older persons, and persons with disabilities. Evictions without due process and denial of essential services on the basis of tenure are inconsistent with equality and human rights obligations. Participatory planning with pavement dwellers improves fit, uptake, and sustainability of interventions. Safety measures lighting, women-friendly shelter design, grievance redress are essential.[25]

Evidence-Informed Interventions

1) Legal and policy reforms

Codify the right to shelter: Translate jurisprudence into statutory guarantees, defining minimum core obligations—protection from forced evictions, provision of essential services, and emergency accommodation.

Eviction safeguards: Require notice, consultation, social impact assessments, and accessible alternative housing within livelihood-relevant distances; avoid evictions during monsoon/extreme weather and school examinations.

Address-flexible inclusion: Permit self-declarations or community certificates for welfare, health insurance, and school admissions; decouple service access from formal tenure.

2) Housing solutions

Low-cost rental housing: Deliver well-located, flexible models—dormitories, women-friendly

[24] MoHFW, National Action Plan on Climate Change and Human Health (2018) and city plans.
[25] NHRC Advisory (2022); UN Women urban safety guidelines.

and family micro-units—near employment hubs, supported by viability gap funding and inclusionary zoning.

Transitional shelters: Expand 24×7 shelters meeting standards on safety, WASH, storage, childcare, and linkages to health and social services; integrate TB, NCD, immunization, and mental health outreach.

In-situ upgrading: Where feasible, provide communal taps, toilets, bathing spaces, waste collection, lighting, and shade; implement traffic calming and safe crossings near living areas to reduce injuries.

3) Essential services and health outreach

Water and sanitation: Ensure free or low-cost taps and toilets within a short walk; prioritize safety, lighting, and maintenance through community caretakers with municipal support.

Primary health outreach: Deploy mobile clinics and urban community health workers with fixed schedules at pavement sites; deliver immunization, ANC/PNC, TB screening, NCD care, mental health support, and referrals; use unique health IDs not tied to address.

Nutrition: Enable on-site access to PDS via portable authentication; provide hot cooked meals through community kitchens; strengthen ICDS and school meal linkages for pavement-dwelling children.

Injury prevention and safety: Introduce speed calming, barriers, reflective lighting, and safe cooking spaces with clean fuels and fire safety kits.

4) Social protection and livelihoods

Portability: Ensure rations, pensions, and cash transfers are portable across wards and states with minimal documentation; leverage Aadhaar-based but rights-compliant mechanisms with grievance redress.

Worker protections: Simplify informal worker registration and access to insurance, maternity benefits, and accident coverage; offer skilling and placement services without making shelter

conditional on employment.[26]

5) Governance and finance

City-level equity plans: Map pavement dwelling sites; set targets for shelters, WASH, and outreach; integrate into City Health and Sanitation Plans and budgets.

Financing: Earmark urban health–housing funds with outcome-linked disbursements; use public land value capture and CSR partnerships to subsidize low-cost rentals and services.

Data and accountability: Conduct periodic social audits; publish coverage dashboards; appoint ombudspersons for eviction and service-denial grievances.

Implementation Challenges and Mitigation Strategies

Land scarcity near job centers can be addressed through public land inventories, adaptive reuse of vacant buildings, modular structures, and air-rights over transit/utility sites. Political resistance and stigma require public communication that frames shelter as essential public health and safety infrastructure and demonstrates cost-effectiveness. Administrative capacity gaps can be bridged by dedicated municipal shelter units and partnerships with credible NGOs and CBOs. Quality assurance needs enforceable standards, regular audits, and beneficiary feedback loops with transparent performance scorecards. Population mobility calls for flexible, low-barrier services with evening hours and interoperable digital records to maintain continuity of care.[27]

Monitoring and Evaluation: Indicators

Shelter coverage: Shelter beds per 10,000 urban residents; occupancy; proportion of women- and family-friendly slots; average distance to employment clusters.

Health outcomes: TB detection and treatment completion; immunization coverage; ANC/PNC uptake; under-5 stunting/underweight; diarrheal and ARI incidence; hypertension/diabetes control.

[26] Code on Social Security (2020) and welfare boards for unorganized sectors.
[27] ABDM/NUHM digital health records; migrant health portability initiatives.

Service access: Access to potable water and gender-safe toilets within 250 meters; wait times; user-reported safety/cleanliness.

Protection metrics: Number/share of evictions with/without safeguards; relocations within 5–10 km of origin; reported harassment/violence in shelters.

Inclusion: Enrollment in PDS, health insurance, and social security using address-flexible processes; issuance of community residency certificates.[28]

A Rights-Based Research Agenda

Priorities include longitudinal studies on health impacts of rental and shelter interventions; implementation research on integrating primary care, TB/NCD services, and mental health at pavement sites; cost–benefit comparisons of eviction/relocation versus in-situ services and near-work rentals; gender- and child-focused safety and education continuity studies; and climate-health evaluations of heat mitigation and hydration infrastructure for outdoor-living populations.

Conclusion

For pavement dwellers in urban India, shelter deprivation is both a human rights violation and a driver of preventable disease and premature mortality. Indian constitutional law and international human rights standards recognize the right to shelter and prohibit forced evictions without safeguards.[29] Realizing this right through enforceable legal protections, low-cost rental and transitional housing near livelihoods, universal WASH and primary health outreach, and participatory governance can substantially reduce disease burdens, enhance dignity, and build resilient, equitable cities. Treating shelter as a public health imperative aligns legal commitments with pragmatic, cost-effective interventions that improve lives and strengthen urban systems.[30]

[28] State innovations on community residency certification (NGO–ULB partnerships).
[29] Olga Tellis v. Bombay Municipal Corporation, (1985) 3 SCC 545.
[30] Chameli Singh v. State of U.P., (1996) 2 SCC 549.