Tuberculosis, Homelessness, and the Politics of Mobility

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Abstract
The mobility that is associated with homelessness creates various challenges to those endeavouring to contain a tuberculosis outbreak or otherwise manage the disease. It is argued that one important dimension missing from current tuberculosis management initiatives is an understanding of how the larger social context influences the mobility of the homeless and creates conditions that are conducive to the spread of this disease. I address this relationship by situating the experiences of the homeless in Toronto within a broader discussion of agency, structure, and the regulatory politics of mobility and place.

Keywords: tuberculosis, homelessness, mobility, health

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Résumé
La mobilité des sans-abris crée différent défis pour ceux et celle qui cherche à limiter et gérer les dangers de la transmission de la tuberculose. Certains considèrent qu'une dimension importante aux initiatives de la gestion de la tuberculose consiste en une meilleure compréhension du contexte social qui influence la mobilité des sans-abris et qui crée les conditions propices à la transmission de cette maladie. Cet article vise à combler cette lacune en situant l'expérience des sans-abris à Toronto au sein d'une discussion basée sur la notion d'agent, de structure, de politiques et de règlements concernant la mobilité et l'espace.

Mots clés: tuberculose, sans-abris, mobilité, santé

Introduction

The burgeoning literature on the "social determinants of health" draws attention to how the economic and social conditions in which people live are correlated to their health status (Raphael 2006). Analyses using this perspective have uncovered a wide range of structural features of society that contribute to an individual's state of health, including: level of education, employment and working conditions, food security, gender, housing, income and its distribution, social exclusion, and the social safety net and employment security (Raphael 2006). The social determinants model arose in part as a response to earlier "lifestyle" or behavioural risk factor approaches to health which tended to individualize health problems by implicitly and explicitly attributing poor health status to personal factors such as levels of tobacco and alcohol use, diet, and physical activity. Newer perspectives attempt to recognize and reconcile both the structural and individual features of health by demonstrating how behavioural choices (i.e. agency) are heavily influenced by one's material and social conditions; thus recognizing that risk factors for disease do not operate in isolation but are embedded in a historical, cultural, and social context within which individual 'lifestyle' is constituted (Pearce and Merletti 2006).

Similar to the literature demonstrating the influence of structural matters on health status, the literature on homelessness has elucidated the relationship between structural factors and homelessness. It is clear that the wider structural context such as unemployment, poverty, lack of affordable accommodation, and cut backs in state welfare programmes all contribute to homelessness (Daly 1996a,b). For example, housing policies may influence a range of other factors that have significant consequences for homelessness, including: the amount of available housing, the degree of investment in public versus private housing, the liveable quality of the housing stock and so on. However, structural accounts

of homelessness have been criticized for tending towards structural determinism and neglecting the agency of homeless individuals and portraying them as merely pawns of the system in which they are unable to exercise any autonomy (Cloke, May and Johnsen 2008; DeVerteuil, May, and von Mohs 2009). Indeed, the broader debate between agency and structure is an age old one with which the social sciences have had to contend since their origins, and it is therefore not surprising to see manifestations of this debate in social scientific analyses pertaining to contemporary concerns involving the domains of health and homelessness. This debate, however, has special relevance for research in these two particular domains because of the associated policy implications arising from their common concerns over the regulation and social control of individuals.

In the case of health, this social control and regulation is expressed in two ways. First, it is seen in the strategies of health promotion that aim to change harmful individual behaviours related to sexual practice, diet, exercise, and alcohol and drug consumption. Secondly, a regulatory impulse lies at the heart of current neoliberal-inspired policies that place the onus on individual health-seeking behaviours—that is, forcing atomized individuals to actively seek out and access health services on their own, as inspired by a consumer ideology in which health is conceived not as a public right or social good but as an individual consumer "choice" for those who can afford it (see for example: Petersen and Lupton 1996; Sanford and Ali 2005). In the realm of homelessness the exercise of social control is seen in terms of the regulation of other particular forms of individual behaviour, most notably the mobility of the homeless persons, including the spaces they are allowed to occupy and the social relations and associations they are able to pursue. It is the regulation of these latter types of behaviour that policies and strategies of infectious disease control and containment also specifically target; and in this sense, there is a dovetailing of concern with respect to public health regulation of people's movement (through quarantine, isolation, and border control) and the regulation of the homeless—an insight made by Foucault (1979) in his work on the social control of the subaltern more generally.

As part of the tuberculosis case investigation strategies, the distinguishing of those infected from those who do not have tuberculosis is implicitly an othering process instrumentally carried out in the name of public health. Such a process however is not politically neutral. As shown throughout the history of public health, the "Other" who becomes redefined as a public health threat is often distinguished on the basis of race/ethnicity and "foreignness" (King 2003; Craddock 2008). This is clearly the case with tuberculosis in the North American context, but more than that, the disease also affects the socially disadvantaged more generally. Consequently, the othering process (and the subsequent control of the "Other") not only involves the distinguishing of the healthy from the non-healthy, or the domestic from the foreign, but central to the present study, the housed versus

the homeless—although there is of course considerable intersectionality between these categories.

One neglected aspect in most discussions of the othering process is the politics of mobility associated with the "Other." In this connection, May (2000) notes that "in the popular and legislative imaginaries, homelessness is connected to issues of mobility where mobility renders the homeless as the Other to the housed population, and therefore in need of direct regulation and control, or at least undeserving of aid" (p.740). Further, justifying the imposition of state regulatory control measures is the assertion that the homeless have made a conscious and voluntary decision on their part to be homeless, thus reducing homelessness to a "lifestyle choice," and in process, legitimizing the imposition of discipline and control measures over those who "chose" it (MacDonald 1995; Murphy 2009).

It is worth noting that the process of othering the homeless may in fact be implicitly seen as part of a larger socio-political process described by Neil Smith's (1996, 1998) "revanchist city" thesis. The revanchist city refers to the disturbing urban condition in which the dominant group takes revenge on those considered as "public enemies" of the bourgeois political elite and their supporters (Slater 2010). The list of "public enemies" is long, including: minorities, the working class, feminists, environmental activists, gays and lesbians, recent immigrants, and the homeless (Slater 2010). These groups are blamed by the middle classes for not only the economic difficulties they face, but for the perceived lack of safety associated with urban public spaces. The expression of revanchism is seen in many forms—concerted attacks on gays and the homeless, feminist-bashing, and public campaigns against political correctness and multiculturalism. One expression relevant for this paper pertains to the introduction of municipal legislation that outlaws begging, panhandling, loitering, consuming alcohol and sleeping in public spaces in an effort to "cleanse" homeless people, panhandlers, prostitutes, squeegee cleaners, squatters, and graffiti artists, from those public areas in which tourists, visitors, and middle-class and wealthy residents frequent (Mitchell 1997). It should be noted that in the political and social conditions predicated by revanchism, the regulation of mobility plays an increasingly critical role in the efforts of the dominant group to contain the threat ostensibly posed by the Other. This is seen for example in the 1980s when New York City mayor Ed Koch attempted to buy the Gibber Hotel in the Catskill Mountains for the purpose of transporting 600 homeless individuals out of Manhattan, or more recently in 2007, when the City of New York had financed one-way airfare and bus tickets for 550 homeless families (Stewart 2009).

Tuberculosis as a Disease of Social Structure

Tuberculosis (TB) is a life-threatening respiratory disease caused by the *Mycobac-*

terium tuberculosis that is spread through exhaled droplets arising from coughing, sneezing, spitting, or talking. The droplets can circulate widely in confined spaces and can be spread to others quite readily in poorly ventilated and crowded quarters, such as those found in many homeless shelters, hostels, and jails. In at least ninety percent of the cases, those harbouring the TB bacterium may not be contagious as the body's immune system is able to contain the threat, rendering what is referred to as an inactive or latent case of the disease in which the individual is not infectious. It has been found that, on average, an active case of TB will infect approximately 10 to 15 others before detection and treatment occurs (Lackner 2003). If the immune system of a latent case is compromised at a later date the TB may become reactivated with the concomitant restoration of potential for spread. The weakening of the immune system can occur for various reasons, including: infection with HIV/AIDS, poor nutrition, substance abuse, untreated diabetes, chronic pulmonary disease, and the physiological impacts of mental distress (HCH Clinicians Network 1999). These immuno-compromising factors may themselves be linked to larger structural issues, and in this way, TB itself may be thought of as a disease that is linked to the social structure. For example, poor nutrition is readily linked to lower ranks in the social class hierarchy, which in turn increases the chance of activating latent TB cases. More generally, it is clear that TB preferentially affects those marginalized in society; a fact made glaringly evident by the finding that the rate for developing TB is 200 to 300 times greater for those in the homeless population compared to the general population (Tuberculosis Action Group 2003)). Several conditions have been identified as amplifying the risk of TB for homeless people, including: inadequate access to the basic determinants of health, such as housing, income, and nutritious food; substandard and overcrowded shelter conditions; forced migration of shelter users; pre-existing health conditions; barriers to effective health care; problems in the corrections system; and immigration and refugee issues (Tuberculosis Action Group 2003).

Mobility, Place, and Infectious Disease

As a result of the significant role broader structural factors play in the aetiology of the disease, tuberculosis has been referred to as a 'social disease' or 'poverty's penalty' (King 2003)—that is, a disease that preferentially affects the marginalized. In this light, TB control programs that focus only on the biological causes of TB, to the exclusion of the multiple behavioural and socioeconomic contributions to the disease, will ultimately fail in effectively addressing the underlying factors that facilitate the disease diffusion in the first place (Ho 2004; Gandy and Zumla 2003). Indeed, existing approaches such as "risk-factor" epidemiology, which "control for" factors, essentially take out the influence of the context in which

marginalized people, such as the homeless, live, thereby effectively eliminating structural considerations from the analysis of TB diffusion (Byrne 1998; Kim et al. 2005). Similarly, research efforts based on purely biostatistical techniques, those that narrow the analytical focus to the epidemiological basis of exposure and disease, often fail to capture the complex and nuanced linkages among cases, contacts, and places they interact and how these contribute to an outbreak of TB (Kim et al. 2005)

The homeless have limited control over whom they are in contact with, while at the same time, the transient nature of homelessness often results in the number of potential contacts changing dramatically on a daily basis. Consequently, the constant exposure to large numbers of other people who are likewise marginalized and socially excluded creates especially suitable conditions for the spread of infectious disease. This makes it very challenging to identify contacts; a point verified by DNA fingerprint analyses of TB outbreaks that have revealed that not only was much more TB transmission taking place outside the household than previously thought, but that the transmission often involved persons for whom no close contact to another case could be found (Klovdahl et al. 2001). It is therefore not surprising to learn that generally speaking, current contact tracing procedures do not reliably identify homeless people who are infected during an outbreak (Barnes et al. 1997). Nevertheless, the process of case-finding and contact tracing are the crucial and necessary elements at the heart of existing TB control programs (Klovdahl et al. 2001). In light of the above, the critical issue in improving or assisting contact investigation is to incorporate data on contextual and place-based factors when analyzing the complex relationship between tuberculosis and homelessness. One way forward in this regard is to gather relevant qualitative and ethnographic data with respect to the biophysical and social environment in which the homeless find themselves. Thus, in his study of tuberculosis amongst Chinese immigrants in New York City, Ho (2004) citing Nations (1986) notes that, "only with detailed anthropological observations of people going about life as usual is it possible to achieve a good understanding of the complex causal chains in disease etiology." Furthermore, this orientation has already been found to be useful by physician and anthropologist Paul Farmer (1997), who uses the case study of one patient's biography, including the patient's travel patterns in Haiti, to illustrate how the emergence of antibiotic resistant strains of TB were the result of the complex interplay of individual agency and what he refers to as "structural violence" —that is, how the social structure of society, informed largely by economic criteria related to the unequal distribution of resources and power, results in the constraining of individual agency of subaltern people, thereby placing them in harm's way.

Adopting the above analytic orientation, I will specifically draw upon qualitative data related to the movements of the homeless in Toronto, while keeping in

mind the integral role that *place* plays in the transmission of tuberculosis—that is, enhanced transmission under conditions of crowding and poor ventilation. Place and mobility are of course interrelated, in that people obviously move between different sites, but in the context of homelessness, mobility takes on even greater significance. Indeed, it has been asserted by May (2000) that the very experience of homelessness can only be understood in terms of the experience of movement —of varying kinds and at a variety of scales.

Methods and Data

The study consisted of a convenience sample of 172 individuals who were interviewed in two downtown Toronto drop-in centres from June to August 2007. The interviews were conducted by two graduate students and one faculty member from York University, and were based on a semi-structured format in which interviewees were asked about various aspects of their lives, such as: sleeping arrangements, use of drop-in centres, relationships (i.e. who they interact with), length of time spent homeless, experiences regarding migration to Toronto, health and nutritional status, income, and questions regarding their knowledge and concern about TB, as well as the compilation of basic demographic information. The interviews were transcribed and subjected to NIVO analysis to assist in grouping together the data in logically consistent themes, such as those related to "pathways to homelessness," "relationships," "typical daily routine," "accessibility issues," "health," "hygiene," "nutrition," "knowledge and awareness of TB," "activities engaged in for income," and "level of life satisfaction."

In terms of basic demographic information, the average age of the interviewees was 42 years and about 73% were male. The average age at which people in the sample became homeless was 28 years (ranging from 8 to 64 years) and the average number of months that people were homeless was 149. Over a third were born in Toronto, while over 80 percent were born in Canada. Close to 10% of the sample was diagnosed with TB (an additional 4.1% were unsure). Real names of people and places were not used in any interview excerpts that were cited.

The sample confirms De Verteuil at al.'s (2009) observations that the homeless consist of a remarkably heterogeneous group with varying experiences based on personal circumstances, age, gender, and ethnicity. They contend that this diversity is often ignored, thereby resulting in the depiction of the homeless as a homogeneous and largely androgynous group. While it is true that each individual has unique experiences, the purpose of my analysis here is to gain a general understanding of the homeless experience in order to understand the politics of mobility associated with homelessness more generally, realizing of course that this politics has specific implications for specific types of homeless people.

Tuberculosis and Mobility Across Large Spatial and Temporal Scales

With respect to tuberculosis, the issue of large distances traversed by the pathogen is inextricably, if not implicitly, tied to the issue of immigration. Immigration status has been consistently linked with tuberculosis in both popular and academic accounts. For example, a report by the Public Health Agency of Canada (2004) noted that two-thirds of the country's TB cases were foreign-born and that it was even higher amongst recent arrivals (within the last five years), while an article in the *Toronto Star* newspaper reported that, "experts expect the incidence to rise as immigration swells from countries where TB is epidemic" (Ogilvie 2008, n.p). Immigration was also cited as a significant contributing factor to the resurgence of TB in the United States during the mid-eighties and nineties, since those who were HIV-infected were more susceptible to TB and it was said that many HIV-infected people immigrated from areas such as Latin America and Southeast Asia where HIV was more common (HCH Clinicians Network 1999).

It should be noted that superficial understandings of the relationship between TB and immigration runs the risk of promoting stereotyping, scapegoating, xenophobia and the adoption of an excessive emphasis on nationalism and biosecurity —that is, securing the border and restricting international mobility under the mantle of public health security. Susan Craddock (2008) notes that at first sight a focus on immigration and biosecurity seems justified from an epidemiological viewpoint, given that the statistics over the past decade seem to indicate that the "foreign-born" do constitute the majority of TB cases nationally. Such statistics however are nevertheless misleading because "the reality of both the epidemiology of TB and its larger social context is more complicated." In fact, in contradiction to conventional understandings, recent studies based on advanced DNA fingerprinting technologies (that enable a precise tracing of TB case transmission) have uncovered evidence suggesting that foreign-born individuals were not responsible for the majority of new cases of TB transmitted within American cities (Craddock 2008, 190 citing Chin et al. 1998; Borgorff, Behr, Nagelkerke, Hopewell, and Small 2000; Bloom 2002). Indeed, some supporting evidence of this finding is found in our sample where the proportion of foreign-born individuals with TB was 4.5% less than those who were Canadian-born (1/18 versus 10/143), while Hwang (2001) found that more than half of all TB cases amongst the Toronto homeless were due to recent transmission rather than reactivation of latent TB.

The analysis of the relationship between TB and immigration therefore requires a more subtle understanding of both the biological and social factors involved. One key consideration in accurately conceptualizing the true nature of the TB-immigration relationship is to consider the fact that TB can remain latent for many years until reactivated by compromises to the immune system. For this reason, contact investigations of TB must make careful distinctions between those

cases that are the result of recent transmission (e.g. 'secondary cases'), and those that are the results of reactivation of old infections (King 2003). Many immigrants are forced to move because of traumatic circumstances such as economic deprivation, natural disasters, political instability and wars in their home country; adding to this may be anxieties and problems faced in the resettlement process in the host country. Such experiences, in turn, can stress the immune system, thus leading to the activation of latent infections in recent immigrants (King 2003).

To study the contextual and systemic factors involved in the relationship between TB and immigration is much more difficult than simply individualizing disease incidence to the infected. In light of these types of insights, King (2003) concludes that,

> blaming 'immigration' for the increased incidence of tuberculosis vastly oversimplifies an extraordinarily complex problem regarding the causes of tuberculosis incidence and transmission. Focusing too closely on the role of individual carriers of the tubercle bacillus diverts attention form the more complicated socioeconomic and structural problems that contribute to the spread of tuberculosis (p.39).

Furthermore, to consider only the country of origin of the individual as measure of risk overlooks how multiple, locally-based economic and social experiences may shape whether migrants acquire tuberculosis under the local circumstances of the locality in which they now live. Thus, the notion that tuberculosis is transmitted from 'high-incidence' to 'low-incidence' countries may have less utility than recognition that particular neighbourhoods in different cities have their own unique structural characteristics that promote the spread of the disease (King 2003). For this reason it will be helpful to focus greater attention on the local circumstances in which the homeless are embedded; particularly with respect to how policies which deal with place (such as housing, shelter, incarceration, hospital, etc.) impinge on their movements in daily life.

The Microgeography of Homelessness

Earlier research on the microgeography of the homeless tended to adopt a 'migrationist approach' that conceptualized the movements of the homeless in terms of a rational and conscious search for resources and services (Rahimian, Wolch and Koegel 1992; Wolch and Rowe 1993). Undoubtedly, such rational proclivities do play a role in homeless mobility, as inevitably an inordinate amount of time is spent on obtaining essential needs that the housed often take-for-granted, such as where to eat, drink, sleep, rest in safety, receive welfare payments, obtaining help

from family and friends, or going to places to find relief from boredom and everyday troubles (Wolch and Rowe 1992). However, the limitation of such a "rational choice" model is that it tends to downplay other types of rationality as well as the role of emotion in the mobility of the homeless (Cloke et al. 2008). In reality, different types of rationality play a role in the decisions that are faced daily. For example, the interview excerpts below illustrate the range of various affectively-based motivations and instrumental rationalities that influence decisions to use drop-in centres:

> *Nick* (male, 35 – 39 years old): Every time I go there, um, I stayed there for a long, long time. That was one year. I'd just sit inside. I just eat and sleep and that's it.
> *Interviewer*: Why is that when you're there you spend most of your time there?
> *Nick*: Well, you don't have to leave. You can stay in there all day long. Like I'll get up around nine, then I'll go and eat in the room. And there's a computer room and I end up staying inside. It becomes too comfortable. So I lose motivation.
>
> *Interviewer*: What keeps you from going to the drop-ins?
> *Roger* (male, 50-54 years old): It's not fun. It's not fun. I used to, but it's not fun to become high on the radar. You become… people start, you know, want to know your story, want to know who you are and you kind of get entrenched in the system and yeah, as a result I've become persecuted to tell you the truth.
>
> *Peter* (male, 35-39 years old): No I'd rather not go to any of them if I don't have to.
> *Interviewer*: Why not?
> *Peter*: Cause I'd rather sit in the park and read. Don't have to listen to the drama. I just don't like to get caught up in the rat race. That's pretty much what the drop-ins are.
>
> *Mike* (male, 40- 44 years old): No man. I don't like any of them. They degrade you. There's only a couple that people actually come and talk to you if you're sitting by yourself.
>
> *Chris* (male, 50-54 years old): There's no love behind the counter [with reference to a particular drop-in centre]. You go to the brother's there, they got good food there because they care. You know. They care. You go to 40 Maple [drop-in centre] and you've got Momma, you've got Bob, you've got Mike. They're all cooking. One big happy

> family. And it's a drop-in. I mean there's hundreds of people go there. But you can tell they're doing it with love. It tastes so much better if it's made with love and respect. They don't just throw it at you. And they bring it to you, you know, just some respect.

The interviews also revealed that similar to the case for drop-ins, decisions to use homeless shelters were influenced by personal concerns in addition to competing rationalities, especially those related to safety and security, all of which played a key role in mobility:

> *Tom* (male, 60-65 years old): [Outreach worker] says you want to come with me sir? At Sherbourne Street. I said no. I don't go in those places. He says can you tell me why? I said people take your shoes, they take your sweater, they take any darn thing. That's why I take my chances on the street. Yes, I'm very sure. I said do me a favour. Next time don't kick me because you're going to be on the ground if you do. And then he went. And then it was very cold.

> *Gerry* (male, 40-44 years old): Um, it's crazy. It's drama. It's drugs. It's all kinds of wheeling and dealing and staff who are like whatever. Like it's all a fricken universe. Scary and crazy and dirty and no place to be. I don't feel comfortable there. I just don't like it.

> *Lisa* (female, 20-24 years old): Yeah, cause when you're outside you feel like kind of free. It's hard to explain but I feel safer outside.
> *Interviewer*: Feel safer compared to what?
> *Lisa*: To being like in a shelter or staying at a friend's house cause a lot of places they have like bedbugs and stuff and it's not like really safe and stuff.
> *Interviewer*: In what way is it not safe?
> *Lisa*: Cause you don't know what the person can do to you when you're asleep. You know, if you're in a park at least you can like, you know, cause there's bushes and stuff. I usually sleep in the bushes so nobody can see me and stuff. That's the trick of being in the street.

Although mobility patterns were mediated by individual considerations, this did not necessarily imply that the homeless have a great deal of autonomy. In fact, as we shall see, homelessness represents a mode of existence characterized by a heightened degree of control and surveillance. It must be kept in mind therefore that any expressions of individual agency that the homeless have necessarily takes place within a highly regulated environment. That is, in contrast to the housed,

the mobility of the homeless is influenced to a much greater degree by involuntary forces, such as the police, the welfare system, and local business attitudes and behaviour towards the homeless (Wolch and Rowe 1992). As supportive social networks and stable daily paths of the homeless profoundly influence their coping abilities—in terms of their ability to successfully obtain food, clothing, shelter, personal security, income and/or employment, social services and social support—their enforced, involuntary movements, on the other hand, will disrupt such capabilities and will make coping more difficult (Wolch and Rowe 1992).

The Regulation of the "Homeless City"

Cloke at al. (2008) observe that the temporal and spatial dimensions associated with the experience of homelessness are very different from those who are housed. For the homeless, the city becomes reconstituted in terms of the regulatory staging of various institutional spaces (such as hostels, drop-ins, detention centres, rehabilitation programs) as well as some non-institutional places (such as parks and public space). As a result of this reconstitution, the space that the homeless traverse and occupy represents a 'homeless city'. In the present-day regulatory environment, the homeless city is characterized by restricted choice, and an imposed structuring of time, movement and contacts of the homeless, with the character of a given homeless city varying according to the particular configuration of policies that govern the agencies, institutions, and spaces with which the homeless interact. For example, DeVerteuil (2003) notes that under neoliberal policies, institutions that deal with the mentally ill and the homeless are under governmental pressure to minimize their case loads and costs (as well as to privatize their services) as part of larger strategy of "new poverty management." Poverty management refers to:

> those spatial and temporal structures designed to regulate and manage the spillover costs associated with so-called disruptive populations…[where] the state and other institutions and elites promulgate specific poverty management techniques that range from supportive (e.g. affordable housing) to the ambivalent (e.g. allowing the third sector to set the homeless agenda) to the punitive (e.g. anti-homeless ordinances) (DeVerteuil at al. 2009, p. 656).

The adoption of such initiatives leads to the fragmentation of service providers, and to the lack of an explicit continuum of care that encourages:

> the circulation and institutionalization of so-called 'disruptive' populations across a diverse array of unrelated, time-limited settings

> —including standard residential dwelling units, shelters, jails, prisons, hospitals, rehabilitation centres, single-room occupancy (SRO) hotels, and the street" (DeVerteuil 2003, p.361).

Central to these developments are questions related to the social control of "disruptive populations," or more specifically to our topic: how are the movements of the homeless regulated? To address this question we need to first consider where the regulations are enforced, because it is at specific sites in the city that state and institutional officials impose their power over the mobility of the homeless.

The following summarizes the range of places those interviewed gave in their response to a question regarding their typical daily activities. I have grouped the places together on the basis of the function each place served for the interviewee, but it should be noted that some places served multiple functions (e.g. place to sleep and pass time). Also at this point it should be noted that one limitation in the interviews is that some individuals understandably may not want to give certain types of information about place, such as where drugs are picked up, where valuables are stored during, where cheap food can be found and so on (Cloke et al. 2008).

Places to pass time. Shelters, coffee shops (sometimes to use their washrooms), drop in centres (to visit mental health worker, counsellor, to have some company, to watch movies), couch surfing at friends or relatives homes, shopping centres and malls, gyms, parks, hockey rinks, parking garages, library.

Places to sleep. University campus, heated grates, building stairwells, subway stations and trains, churches, shelters, city hall (Out of Cold program).

Places associated with the obtaining of resources and care. Drop-off points to receive blankets from van, food banks, street health clinic and health bus (for methadone, needles, condoms), drug and alcohol rehabilitation site (for group meetings).

Places associated with work and financing. Money Mart (to cash street allowance cheques), office to pick-up Ontario Disability Support Program (ODSP) cheques, caregiving and volunteer work at shelters and homes, street corners to sell the Outreach newspaper, restaurant work (dishwashing, washroom cleaning, washing floors), sex work related places, and truck pick-up points to go on-site to do casual labour such as: loading trailers, roofing, moving furniture, demolition/renovation, paving driveways, construction, painting.

The contours of the "homeless city" are defined by these diverse settings and the mobility of homeless individuals is circumscribed by these diverse settings.

One overriding feature of the individual daily paths taken by the homeless through the homeless city is the lack of spatially fixed stations, such as a specific

home or job site which lend permanence and structure to daily life. Consequently, a time-space discontinuity (Wolch & Rowe 1992) arises where the homeless are compelled to go to different sites during the day to meet their basic needs. A natural outcome of this is the development of alternative social relations that are not reliant upon a spatially fixed home base or workplace:

> These social relationships, which can occur at variable (although typically proximate) points in urban space, appear to substitute for fixed stations in the daily path. This allows for the re-creation of some sense of time-space continuity, shapes successive daily paths, and can impact the life path (Wolch and Rowe 1992, p.117).

Notably, some of the places in the homeless city are more likely than others to represent sites in which the social control of mobility is exercised. In particular, the degree and nature of social control may vary according to the social value attributed to different locations by the dominant group (i.e. the housed). Varying along a continuum, some spaces are considered as "prime" and others as "marginal" spaces within a city (Duncan 1983). Accordingly, the homeless may be forced to occupy these marginal spaces which are valued less by the mainstream and where the stigma associated with the "spoiled identity" (Goffman 1968) of the homeless are least likely to taint the spaces and activities of the "normal" people (Cloke et al. 2008). Interstitial sites located within prime space, such as, building stairwells, parks, shop doorways, and areas of subway stations, that are sometimes commandeered by the homeless for private use (for example, to sleep), are especially subject to greater surveillance, discipline, control, and enforced movement. It is clear that recently, social control efforts have been directed at various interstitial sites, as seen for example through the modification of park benches so that they are circular or have a middle bar preventing people from lying down on them. Similarly, the regular watering of parkland by an automated sprinkler system that follows a random timetable prevents sleeping in those areas, while the removal of public washrooms channels the movements of the homeless away from certain areas. Aside from these physically based mechanisms, other forms of social control include pressure from condominium associations, business, residential and neighbourhood groups and offices to force the homeless away, as well as the deployment of police and private security guards to prevent the homeless from entering interstitial sites in prime spaces of the city.

The intensified regulation of the homeless and interstitial sites through stricter policing and shifting boundaries of gentrification are clear manifestations of how revanchism is expressed in the daily lives of Toronto's homeless:

> Pat (gender and age unspecified): Yeah. You can't sleep in the park cause I was lying down on the bench one day. It was nice out and I was getting drowsy cause it was so hot. I was all relaxed. I was relaxing. I've been sleeping too much lately. And I was relaxing and then the bicycle cop, police officer says no you can't sleep in the park.

> George (male, 45-49 years old): I mean I try to be discreet because I mean the last few years they're putting the… you know, they see you, tell you to move. They're real nasty. They'll tell you to get the fuck off. Faced changes in the neighbourhood. It's not all poor people any more. There's been complaints constantly about it. Like Allen Gardens. It's a very nice neighbourhood compared to what it was 20, 30 years ago around here. Some guys I know got tickets for sleeping on a bench. Even sleeping up. One guy I know he worked all night at a temporary agency and then he goes … you know, you can't book into a hostel during the day to sleep so he sits up on a park bench in Allen Gardens. [laughs]. They're waking him up. They give him a fine for sleeping in the park. He wasn't laying out. He was sitting here like this. Yeah. They actually threw him a ticket. Well he didn't care. He threw it away. Just for that. And like me, he just came off work. Oh yeah, it happens a bit. Yeah.

Housing and Homeless Mobility

A review of the biographies gained through the interviews revealed that some were not continuously homeless. Rather, many experienced 'episodic homelessness' involving short-lived periods of homelessness over the years because of intermittent unemployment (May 2000). During these bouts of homelessness such individuals would temporarily stay at relatives or friends homes (i.e. couch surfing) or in shelters until more long-term living arrangements were acquired. These types of arrangements may themselves add to the mobility experienced by the homeless, as implicitly noted in one of the interviewee responses:

> Becky (female, 25-29 years old): Um, I have my couch and my hours and as soon as he comes in he wants to walk out of his house and we have to go with him or whatever he does. When he's gone for the day we get to sleep in the house all day and when he comes home at night he wakes us up and we have to leave. He works during the day so we get to sleep during the day. When he comes home at night we have to leave.

Attempts to acquire long-term housing were frequently met with difficulties due to the insecurity and precarious nature of private rental accommodations for some low-income individuals:

> Graham (male, 40-44 years old): Um, I was living on Campbell Street and it was all right. It was like a rooming house. We were all paying the rent. And the landlord didn't pay his mortgage for six months. And they came in, the sheriffs, and we all got kicked out. Five o'clock in the morning. We didn't know anything about it. They didn't pay the mortgage on it, right and we got kicked out. We paid our rent but the owner wasn't paying the mortgage for the house. So … he was one of those fly-by-nighters making money. I guess he had thirty welfare cheques going there a month apparently. Nobody even there.

A consequence of episodic homelessness and the precariousness of the private rental market was that individuals were forced to move frequently over varying periods of time:

> *Interviewer*: And how many times have you moved since last summer?
> *Mike* (male, 40-44 years old): Holy. One, two, three, four, six times. The housing situation in Toronto if you live in a rooming house you've got to contend to the rats, to the bugs, to the people stealing food, so you've got to go from place to place quickly.

> *Victor* (male, 45-49 years old): Uh, one place I was there four months. Another place I was there a month. And then I was in the shelter for two months. The last place I lived I was in there seven months. I moved out and then I moved back in for another month. Moved back out again. Just a lot of hookers and everything like that. And I was working.

> *Interviewer*: How many times have you moved since last summer?
> *Gene* (male, 40-44 years old): Um, about four.
> Interviewer: Was that between shelters?
> *Gene*: No, no. I lived in [such and such] Homes in Parkdale. And then I went to my sister's. And then I moved in with a girl that was working on the street. And then I came here.
> *Interviewer*: How long did you stay at each place? So how long were you in the [such and such] homes?
> *Gene*: From November to August so it was about nine months.

Interviewer: And how long at your sister's?
Gene: About a month and a half.

Interviewer: And how long did you stay in each of those places?
Graham (male, 40-44 years old): Uh, I'd say about four or five months each one I guess.
Interviewer: Any particular reason?
Graham: Either bed bugs or landlord don't pay his fuckin' mortgage
Interviewer: So they were apartments?
Graham: Yes. Or rooming houses, whatever.

Interviewer: And how many times have you moved since last summer?
David (male, 50-54 years old): Probably three times. But, you know, it's been like a bounce back and forth. I'm in the process just now… well I ended up in the same place a couple of times. I'm in the process, like I've been on the street for a couple of weeks now and I'm in the process of arranging to get a place. I found a place. I just have to arrange funding.
Interviewer: And so how long did you stay at each place since last summer? Like you say you're bouncing around.
David: Oh geez. I stayed a month at one place, three months at another place, and then the very first place previous to that it was about three years.

The quotes above show how low-income tenants in Toronto experience displacement arising from the closure or the deconversion of affordable rooming houses and bachelorette buildings. From the 1980s onwards, the number of these types of rental accommodations has dwindled for a variety of structural reasons, including: gentrification, a lack of profits for landlords, NIMBYism from middle-class residents' associations, new zoning restrictions, and closure due to illegalities and poor safety standards (Slater 2004). The shortage in affordable housing was further intensified with the passage of a City of Toronto by-law that prohibited the development of rooming houses or bachelorettes in certain parts of the city as well as changes to the Provincial Rent Control Act in June 1998 that eliminated rent control on vacant units resulting in efforts by some landlords to rid themselves of existing tenants so that they could subsequently raise the rental price of their accommodation (Slater 2004).

The frequent and enforced movement of the homeless was not limited to those braving the rental housing market but also to those using shelters. This was an outcome not only of the way in which the overall shelter system operates, but because of the conditions within the shelters themselves. Murphy (2009) notes

in her study of the homeless in San Francisco that transience was a key feature of the system overall, primarily because many shelters had a maximum length of stay, such as two weeks, after which time people were required to leave that particular location. Transience was further entrenched because the basic operating guidelines, such as the hours of operation, curfews, and available services varied from shelter to shelter; and even at any given shelter, they seemed to shift with some frequency (Murphy 2009). A similar situation was evident in Toronto. For example, the city's Out of the Cold Program encourages transience as each site operates only for one night a week and has no consistent standards, while the program's sites are geographically dispersed throughout the city (Tuberculosis Action Group 2003). Thus, for example, Ray, a 45-49 year male remarks that: "Well last winter I stayed in the Out of the Colds so I was in a different church basement every night." Due to these circumstances, people must travel large distances on a nightly basis during the cold winter months for shelter. At the same time, the amount of money city shelters in Toronto receive from the government is based on the number of people utilizing their services, that is, the shelters operate on a per diem (per bed) basis (Gaetz 2008). Some shelters, particularly those outside the downtown area, receive an amount that covers only one-third of their expenses (Clutterbuck and Howarth 2002). Consequently, there is a built-in tendency to have a high turn-over of people, which contributes to the overall transience of the shelter system alluded to by Murphy (2009).

Life within the shelter system is highly regulated in different ways. In Toronto, individuals can only enter and leave the shelter at particular times, while certain shelters ban alcohol, drugs, and visits from relatives. Further, informal practices may also exert a regulatory effect. Cloke at al. (2008) note, for instance, that sometimes residents themselves develop codes of behaviour that must be adhered to if confrontations and violence are to be avoided. The interviews revealed that both of these types of factors had significant implications for the forced mobility of the homeless:

> *Nick* (male, 35-39 years old): Spent a couple hours at the drop-in. When the weather is good I just stay outside in the park. I can't go into the shelter cause I have a lot of coming in late so that if you come in late three times you get a restriction, 48 hours. And if it happens again you get a restriction for a month. So it's happened a couple of times so I'm not able to go there for a month. A couple other shelters, I used to go to 60 Richmond. It's closed. There's the Slater House. I don't like to go there so I prefer to stay in the park. The one place shut down and the other place I can't go there for a month because I've been late. If you come in after eleven o'clock you get like a...

> *Interviewer*: Restriction.
> *Nick*: Yeah, you do three of those in a month and you're restricted from the building. So it's happened twice. Now I can't go for a month so I just stay outside.

> *Martin* (male, 40-44 years old): Well wintertime they got Out of the Cold programs. I don't mind them. If I can get to them I can at least get to sleep. It's easier to get to sleep in there. The shelters people always pop in, yelling and screaming and you can't do nothing about it. If you take the situation in your own hands then that's when you get in trouble and that's when I get myself into trouble. So I most of the time just sleep in the street.

It has been noted that many shelters in Toronto do not even meet the minimum United Nations standards for refugee camps with respect to public health standards, with as many as 60 people sharing the same washroom and sleeping in very overcrowded conditions (Toronto Disaster Relief Committee 2003); a point verified by those interviewed:

> *Brent* (male, 55-59 years old): It was, uh, just feeling depressed, rejected, couldn't stay at a shelter. Too many bed bugs and cockroaches. You didn't know, you'd wake up in the morning if someone's going to stab you cause you have to smuggle in beer and they know that you've got a beer or you may have a joint of marijuana on you. So I refused to stay in shelters. I'd rather sleep on a park bench.

> *Ted* (male, 45-49 years old): Slater House is hellish. That's a real institution there. As a last resort, absolute, absolute last resort I'll go there. It reminds me of penitentiary. I've worked in Kingston pen and I've been in the Don Jail oh, probably thousands of times over my ambulance career and Slater House is an atrocity. You guys should go there. And it's really close quarters.

> *Paul* (male, 45-49 years old): It's not so much the proximity of the beds, it's just there's so many beds in the place. Here's there's not all bunks. Like in the room I was in last night there were seven separate beds. In Slater House there's bunks everywhere. Floor to ceiling. It's a warehouse, it's a warehouse of people. You know what? In all the years I was going in there doing calls, it was just really humbling I'll tell you. I mean really, the other half or one third or whatever... it

> wouldn't be a third, maybe five or whatever percent of people that aren't working move into shelters. It's humiliating. Terrible.
>
> *Interviewer*: Can you tell me what the sleeping arrangements are like here for you? So how far apart are the beds in the room?
> *Justin* (male, 40-44 year old): I would say from here to... I would say about three feet. Oh, yeah. You always have your own bed. About six people around you at all times.

The Implications of the "Homeless City" for Tuberculosis Management

As alluded to above, it is well known that tuberculosis is a disease that disproportionately affects those who are socially and economically disadvantaged. The question is how exactly does this occur? To address this question a useful starting point is to consider Paul Farmer's (1997) observation that infectious diseases tend to "hide" amongst the poor because the poor are often socially and medically segregated from those whose deaths might be considered more significant. In the case of the urban homeless, this hidden dimension takes on even greater salience because of current regulatory policies that result in extreme social exclusion by sequestering the homeless to hidden recesses of marginalized areas of the city. These marginalized areas are often host to many of the service agencies that are used by the homeless, but at the same time such areas may be perceived as dangerous and stigmatized sites—as places of last resort (Wolch and Rowe 1992). The consequences to the homeless of being channelled into these types of area are significant and may include: a lowering of self-esteem, a shift in personal identity, and an altered assessment of life plans and goals (Wolch and Rowe 1992).

Literal social exclusion confounds tuberculosis control strategies because medical treatments can only be effective if cases and contacts can be found; and this is of course simply not possible if cases and contacts are well-hidden (Wallace and Wallace 2003). In this light, improvements in tuberculosis control strategies must be predicated upon learning first about the details of how the homeless condition leads to hidden cases, and in particular, the role that structural features related to policy and regulation play in this. That is, how does the politics of mobility create specific situations of risk to tuberculosis infection?

As illustrated by the instances reviewed above, revanchist policies have a direct impact on the mobility patterns of the homeless in several interconnected ways. First, the intensified surveillance and targeting of the homeless, particularly within the interstitial sites of prime spaces, may lead the homeless to adopt strategies of invisibility to avoid prosecution and harassment by the police and private security officers. This is perhaps an understandable reaction given that revanchist informed anti-homeless laws, by redefining what is acceptable behaviour in public

space, are essentially trying to annihilate the space in which the homeless *must* live, and in effect annihilating the homeless people themselves (Mitchell 1997). Under these conditions the homeless are forced to search for private spaces to occupy during the day (e.g. couch surfing), but this may further intensify the hidden dimension of homelessness.

Secondly, part of the revanchist-informed philosophy is to regulate through criminalization. As Mitchell (1997) notes, laws directed at the control of individuals in public space (e.g. vagrancy and loitering laws) have meant that the homeless cannot do what they must do in order to survive without breaking laws. As a result, many of the crimes that the homeless are convicted of are related to poverty, since it is only the destitute that are forced to use public spaces in socially unacceptable ways due to their inability to access private spaces such as washrooms (Tuberculosis Action Group 2003) or forced to commit crimes of a relatively minor nature such as jaywalking, possessing open alcohol containers, or sleeping on the sidewalk (Wolch and Rowe 1992). Criminalization of the homeless has also meant that at least half of those in correctional facilities are on remand, held simply because they cannot afford bail and have no fixed address (Wolch and Rowe 1992). Each month 250 inmates leave the Toronto Jail with no fixed address and have no choice but to go to shelters (Wolch and Rowe 1992).

The movement between jails to shelters represents one dimension of a larger phenomenon referred to as "institutional cycling," where the homeless are regularly moving between an "array of unrelated, inadvertent, informal, and inappropriate settings"—including not only jails and shelters but single resident occupancy hotels, hospitals, rehabilitation centres, and recovery homes (DeVerteuil 2003). Institutional cycling is a key aspect of homelessness and represents an important confounding influence in effectively tracing the spread of tuberculosis. It should be noted though, that this type of institutional cycling is itself part of a larger systemic development in Canada.

Unlike other countries that have been developing aggressive strategies to prevent homelessness and to move people who wind up homeless into housing as quickly as possible, the Canadian response continues to emphasize the provision of community-based services, including shelters, drop-ins, and soup kitchens (Gaetz 2008). This fragmentation of services coupled with the increased regulation of the mobility of the homeless has resulted in what DeVerteuil (2003) refers to as the development of service-dependent ghettoes that serve as institutional service nodes situated within already marginalized areas of the city. These "service hubs" provide a combination of social services and community facilities that cater to the daily needs of the homeless so that they are able to maintain their lives on the street (Wolch and Rowe 1992). A consequence of this is that the marginalized become increasingly confined to and dependent on existence in marginalized places. When speaking of the homeless as marginalized, it is important to remem-

ber that this constituency is not homogeneous, rather the homeless, as a group, are comprised of different types of socially excluded others. Homelessness is an outcome of a variety of individual and structural factors that include amongst other things: a lack income, deinstitutionalization, and domestic violence (Daly 1996a,b). A consequence of this variation is that the shelter system must deal with homeless individuals who have unique needs requiring a range of different services—a task that is quite problematic under the conditions of fragmented service provision. Under such conditions shelter workers now must deal with a diverse range of issues related to the failings of a variety of institutional systems such as: immigration, criminal justice, housing, social welfare, employment, and health (Gaetz 2008). Specifically, this may include, for instance: the closing of agencies that provide services to newcomers, especially in relation to settlement and employment (Clutterbuck and Howarth 2002), including the psychological and physical needs of refugee communities; cut-backs to discharge planning and prisoner re-entry (Gaetz and O'Grady 2006); decreases in public housing investments which make the search for affordable housing difficult (Hulchanski and Shapcott 2004); and the practice of discharging homeless individuals from hospitals to shelters despite their inability to function in this environment while recovering from illness (Hwang 2001).

One important consequence of the fragmentation of services for tuberculosis management is that drop-in centres and shelters now attract large numbers of people from different backgrounds, including those who are episodically homeless (and the hidden homeless), the housed, and those mostly sleeping rough. As a result, shelters serve as key point of contact or convergence for different groups. This may also result in the over-crowding of shelters, thus raising the potential for tuberculosis spread by not only providing a greater number of hosts that can be newly infected but also because the stresses of living under such conditions may impact an individual's immune system thereby reactivating latent cases of the disease, while the constant turn over of people provides greater opportunity for community spread. The overcrowded and sometimes poorly ventilated conditions of institutions within marginalized spaces within the city play a significant role in the transmission of tuberculosis, and for this reason, efforts to remove rough sleepers from the street into institutions may have the unintended consequence of increasing the spread of the disease. In sum, the current conditions involving the fragmentation of services and institutional cycling may ultimately increase the chances of coming into contact with an infectious individual.

Leung et al (2008) suggest that to deal with infectious disease outbreaks, cities with substantial homeless populations should make an effort to coordinate public health efforts with homeless service agencies. This type of suggestion represents a more broadly accommodative stance to the problems of homelessness (another

example would be the increased provision of emergency shelters) as opposed to a more punitive strategy such as street sweeps and anti-homeless ordinances (De-Verteuil et al. 2009). In Toronto, some accommodative initiatives seem to have been adopted, as evidenced by the fact that three shelters now have built-in health services, and tuberculosis testing has been established at a range of sites, as attested to by many of those interviewed:

> Rod (male, 45-49 years old): Church. Jail. I always get tested all the time.
>
> Mark (male, 40-44 years old): I did the test at the Salvation Army. The TB people were there. They were there a lot in the winter actually. Probably about once every few months. They take your blood and test you for TB.
>
> Robert (male, 35-39 years old): Any time you go to a correction facility they immediately test you so I've been tested several times now. As well the nurses come around regularly to the shelters which is a really good idea cause these people who are going to be highest at risk of getting it.
>
> Kim (gender unspecified, 50-54 years old): I have it checked. Once or twice a year I have it. When you're going into the hospital they check. A lot of these places that offer coffee and donuts they will have them set up in certain areas every year too so there's no shortage of testing facilities.

During the unfolding of actual outbreaks, the establishment of TB testing facilities in those institutional locations frequented by the homeless makes sense in terms of narrowly defining the scope to urgently halt an outbreak that is already occurring. However, such an approach in the long-term fails to address the larger structural issue of how the transient nature of homelessness coupled with the conditions of institutions contributes to disease spread. For example, what remains neglected is how the fragmentation of services leads to institutional cycling; how a lack of affordable housing and the deregulation of the housing sector contributes to cycles of evictions and enforced movements; how revanchist and regulationist policies result in the movement of the homeless to marginalized areas of the city where tuberculosis can spread more easily in an undetected manner and so on. In this connection, Leung et al (2008) suggest that policies that promote movement of homeless individuals among different service sites (e.g. limits on the number

of nights a person can stay at a shelter) may need to be reconsidered, but again such initiatives may direct attention away from more permanent and effective upstream approaches that seek to prevent homelessness in the first place.

Conclusion

The mobility of the homeless is affected by a myriad of factors, but what is most noteworthy is the degree to which their mobility is regulated and forced in certain directions and between particular sites within the city. The resultant mobility and spatial patterns increase the risk of tuberculosis infection by creating circumstances well-suited for transmission of tuberculosis. In particular, institutional cycling between jails, shelters, hospitals, and drop-ins, coupled with the fragmentation of community services and the dispersion of concentrated community service sites throughout the city, ensures a high turn over of people under crowded conditions. The operating policies of the institutions with which the homeless engage often serve to build transience into the homeless experience, thus facilitating the spread of the disease. Increased mobility amongst the homeless was also a consequence of neoliberal-inspired new poverty management strategies that placed increased pressures on individuals to actively search for resources while at the same time reducing the available social support needed to acquire the necessities of life. This increases individual stress levels which in turn increases the likelihood of reactivating latent cases of tuberculosis. Finally, the displacement of the homeless into the marginalized recesses of the city due to revanchist policies aimed at eliminating the homeless from public space, and the cycles of eviction resulting from current housing practices and policies that favour the powerful, have resulted in episodic homelessness and a hidden homeless population that make contact investigation extremely challenging.

The current constellation of polices, institutions, and agencies are not geared towards stability and permanence. As such, any prospects to ending the homeless career end up being what Wolch and Rowe (1992) refer to as "shallow" exits where individuals leave the street only for temporary or unstable accommodations, resulting in a continuing and renewed risk of homelessness. The ability to pursue a "deep" exit—involving a move to a permanent, affordable dwelling that enables stabilization and opportunities for longer-term support (e.g. jobs)—is hindered by community service delivery that is directed at helping people cope from day-to-day instead of facilitating long-term changes in the client's life that could be pursued through stepping stone measures such as transitional housing or tenancy support programs (DeVerteuil, et al., 2009). These are indeed unfortunate developments from a public health point of view because any effective solution to curb tuberculosis amongst the homeless will necessarily need to be based on a more structurally-informed upstream approach that seeks greater permanency in housing and the establishment of a coordinated network of people and agencies

(i.e. social capital). If such an emphasis is adopted, tuberculosis would no longer have a place to hide. Such an upstream approach would not only help prevent tuberculosis transmission, but would enable public health officials to more effectively investigate cases if an outbreak did occur. For an upstream perspective to be adopted however, the current policy emphasis on the "control" of the homeless must be replaced by one based on the "care" of the homeless.

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