

# THE LAHORI GATE POLYCLINIC, NEW DELHI, INDIA

## BUILDING FOR AN INCLUSIVE CITY

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In 2008, our architectural studio in Delhi was approached by The Sir Sobha Singh Public Charitable Trust to construct a primary healthcare centre/Polyclinic in the heart of Old Delhi, one of the most densely populated parts of the city. Besides fulfilling its role as a PHC, the centre was intended to focus on early detection of HIV and TB patients. There was a higher than average prevalence of both these diseases in this particular part of the city due to very specific local conditions.

The proposed building was going to be situated on the erstwhile site of a tax collection building owned by the government of Delhi. While the land was owned by the government, the building was intended to be a gift to the city municipality of Delhi by the charitable trust.

The Sir Sobha Singh Public Charitable Trust was set up in 1961 in the memory of Sir Sobha Singh, who was one of the main contrac-

tors for the construction of New Delhi for the British Raj. Over the years, the charitable trust has run dispensaries, funded a large a number of 'Not for Profit' organisations across the city of Delhi, as well as constructed buildings for charities that they have donated to city organisations across Delhi. In the recent past, the trust had constructed a number of such buildings, with two of them being designed by our studio. The first of them was a rest home for the poor in East Delhi's Guru Tegh Bahadur Hospital, a facility that not only served East Delhi, but also treated patients from the semi-rural areas adjoining East Delhi. Most of the visiting patients were very poor and would be accompanied by their families to the city. The caretakers would not be able to afford paid accommodation and would end up sleeping on the road-side, or within the complex of the hospital. Which was not only unsafe from a health and safety point



due to the harsh Delhi winters, roadside accidents and the presence of vermin and dogs in the neighbourhood. The hospital requested the Trust to commission a building that would be a dormitory for the people accompanying their sick to the hospital. This facility was commissioned in 2003 when the Trust approached us and was inaugurated in 2006. The second health building commissioned by the Sir Sobha Singh Charitable Trust was this primary health care Centre near Lahori Gate Chowk.

### **LOCATION/SITE**

Lahori Gate Chowk, is a square located at the end of a hardware market and near the busy railway station of Sadar Bazar in Old Delhi. The site of the proposed Health Centre was a

few hundred feet away from the Lahori Gate Chowk, situated on one of the arguably most interesting sites within the city. The site given for the building was an old railway tax collection building that was dilapidated and unsafe for use. It was the last building on the road next to a large railway storage yard and abutting an ancient Mosque, the Lahori Gate Mosque to its North. Across the road, toward the East was an old disused city library which was the buffer between the site and the infamous GB Road, one of the busiest hardware markets of the city by day and its most notorious Red Light District by night. To the West of the site was a large tract of railway lines that serviced the Old Delhi railway station and the nearby Sadar Bazar Station, and on the narrow strip of land between the site and the railway lines was



a small slum settlement of about twenty-five to thirty dwellings.

The area around the Lahori Gate Chowk, being a commercial hub has a large number of itinerant labour that works around the railway yards as carrying loads to the hardware market and from there onwards to the other parts of the city. Most of the work related to moving hardware packages across this part of the city is done manually, either on two wheeled push carts or carried directly on the persons head and shoulders through the narrow streets of the market.

While there are laws that stipulate minimum wages for labour and limits on the

number of hours a person can work as well as safety precautions that must be followed while working, the implementation of these laws are nearly impossible within the existing conditions across most of India. As a result, the wages earned by the manual labour working around this area are abysmally low, and to be able to earn a living wage, the working hours are extremely long.

Most of the daily wage labour are migrant workers to the city where they barely have any social security nets to help them through difficult periods of their life. It is almost imperative to work every day to be able to survive.



Drug usage around the site was high, and it is understandable that the drug of choice was the lowest grade of unrefined heroine; Brown sugar, consumed by burning crystals on an aluminium foil and inhalation of the resultant fumes produced. Inevitably, there was a lesser degree of needle usage as well around this area.

Low nutrition, and fatigue caused by low pay and a long work day leads to low immunity, and the high infection rate of TB and the drug usage inevitably leads to a high prevalence of HIV and TB amongst the population in this particular area.

## THE BRIEF

The client approached us to create a primary care centre that focused on the needs of the local migrant population, particularly keeping in mind the high number of TB and HIV patients. This was not intended to be a hospital as much as an early detection and post hospital care centre for the patients infected with both these conditions. This intention of the client also aligned with their long-term goal of building health infrastructure for the city of Delhi.

## THE DEVELOPMENT OF THE BRIEF AND CONTEXT OF PUBLIC HEALTH BUILDINGS

One of the most seminal health buildings built in the 20<sup>th</sup> century is the Finsbury Health Centre in London, designed by the architect Berthold Lubetkin and the Tecton group in the late 1930's just before the Second World War.<sup>1</sup>

<sup>1</sup> You can take a look at the Finsbury Health Centre at Historic England Homepage, available here: <https://historicengland.org.uk/listing/the-list/list-entry/1297993>



Situated near a slum, the Finsbury Health Centre came up at a time when the conversations around the role of modernist architecture in society under the influence of the Soviet Revolution and consequent work of the constructivist movement in USSR and Bauhaus in Germany were at their peak. The political, aesthetic and social positions that formulated the design direction for the Finsbury Health Centre were a dramatic shift from earlier thinking in Britain about the role of government and the place of the ordinary citizens in a society distinctly divided along class lines. Ideas of universal access to healthcare, and the responsibility of the state towards its citizens in health, education and social justice were now firmly entrenched within society and architecture was beginning to facilitate some of these conversations into



reality. The Finsbury Health Centre was one such important building that not only placed the idea of the importance of health and the role of the government towards its citizens, it did it through a strong modernist language that was considered the new language of architecture for a more equal world of the future. The building brought bright light into the entire healthcare facility, it considered and adopted new ideas of light and ventilation for all the spaces, but more importantly it rose out of its surrounding poor neighbourhood as a beacon of hope for the future.

For me personally, there were many parallels that I as an architect could see with the social condition of 1930's London and the Delhi of nearly a century later. The site of the Lahori Gate Polyclinic was situated in one of the

poorer parts of the city, surrounded by railway lands and slum clusters, it was also intended to come up in one of the most vulnerable parts of the city.

The cue for the design intent was taken from the ideals laid out by Lubetkin and the Tecton group in the early part of their practice in England, however, the cultural and political realities of urban India are different from those of pre-war England.

#### THE DESIGN

If one was to look at the relationship that citizens of the country have with the State it would not be difficult to say that the relationship is one defined by fear. This fear is present in the dealings of the citizens with Law enforcement,

the Administration, the Judiciary as well as the Health services. During our research of health facilities across the city, it was evident that the architecture deliberately or inadvertently added to this relationship of fear. To dismantle this hierarchy, the design of the building had to try and be democratic, welcoming and become a beacon to the neighbourhood.

Recalling ideas of a modernist architecture designed and built for the people, the Polyclinic façade was designed to create transparency as a contrast to normal government buildings and we chose bright colours to emphasize the importance and centrality of public buildings built for a community.

### **FLEXIBILITY**

Preliminary discussions with the stakeholders revealed that a certain amount of flexibility built into the design was desirable as the nature of the working of a neighbourhood health centre was fluid, particularly during times of ailment specific health camps that are often held in neighborhoods. This flexibility had also to be built in keeping in mind the possibility that the Delhi government was considering moving a team of senior doctors to be positioned at the clinic on a rotational basis. This would require surgeries for individual practitioners which would in turn require a different spatial configuration than if the building was to be used as a more traditional Primary Health Care Centre.

### **LIGHT AND AIR**

Usually smaller government medical facilities due to budgetary constraints, are not air conditioned, and this facility was no exception, and did not have any centralized cooling or heating designed for it. However, the site of

the building benefitted from a large open tract of land towards the railway lines. This created a great opportunity for the building to benefit from the natural breeze blowing across the city and allow for natural cross ventilation of air through the building, something that is harder to achieve for buildings that are hemmed in on all sides. Keeping the air changes in mind, particularly for a medical facility, the building was designed almost like a sieve, allowing for a great deal of cross ventilation and penetration of natural light throughout the floor plate of the building.

### **THE ARCHITECTURAL PLAN AND INTENT**

The entrance to the building was a double height well-lit space from where the patients would get their appointments slips and then navigate themselves to the respective surgeries where doctors would be stationed to examine them. A dispensary was designed on the ground floor of the building to distribute the prescribed medicines to the patients and an additional space for a visiting General Practitioner and a nurse were also located on the ground floor.

The four-story building was designed such as to create clinics for the doctors on the lower two floors and have a small dormitory and two individual rooms for patients to stay overnight on the upper floors. The ability of the building to be able to allow accommodation to patients for short stays allowed it to programmatically become a cross over between a health care centre and a Hospice.

The Delhi government health department wanted to explore the idea of being able to observe certain patients in a smaller facility like this to see if certain health solutions could be found more locally, rather than having





to refer patients with milder or less serious ailments to the overburdened large city hospitals.

This building was designed to explore a number of health, architectural and community outcomes, and because it was constructed and funded outside the parameters of the Government official design criteria, it afforded the Health Department a certain design freedom to push certain boundaries of health deliveries outside of the bureaucratic framework and to put to practice certain beliefs and theories that had been successfully achieved in other territories and states.

### THE CONSTRUCTION PROCESS

The building was designed as a simple rectilinear form that had to be cost effective, have an environmentally low footprint and allow a greater degree of insulation to reduce the ambient temperature as it was not mechanically cooled. Designed with a concrete frame with fly ash bricks as the infill structure, it took considerably longer to construct than a similar building of this nature would have on another site.

The presence of petty criminals, drug users and the proximity of the slum cluster abutting the building made the task of finding a contractor agreeable to construct the building difficult. Over the course of three years that it took to construct, two contractors had to change, and four site supervisors and three site engineers quit their jobs to work elsewhere. The progress was slow, however with regular meetings with the stakeholders the importance of creating such projects for the city were constantly reiterated. It was not always the best or the most convincing argument, but it was an important reminder of one of the more prevalent realities of our city. However,

besides some petty theft of material and the occasional pockets that were picked, the fear of the area was far greater than the reality of the imagined crime.

### THE COMPLETION AND THE INAUGURATION

Towards the end of 2010, the building was nearing completion, and the Sir Sobha Singh Trust was keen to have the local Member of Parliament of the ruling party come to inaugurate the building. After reaching out to the politician several times, a date three months from the completion of the project was given to the trust and the health authorities of Delhi.

After a thorough clean-up of the building and the surrounding site, the Polyclinic was sealed up and was to remain so, in its pristine condition awaiting the politicians' inauguration. Inaugurations are an important part of the political and cultural life of public institutions, as they give political mileage to the representative politician and an opportunity to speak to their constituency, but it also gives the donors and the institution press and publicity.

Buildings once complete grant us as architects very small windows of opportunities to be able to photograph the building in its unoccupied state. This is truer for public buildings as they, once operational, become a beehive of activity and a certain type of architectural imaging becomes nearly impossible. Ten days before the inauguration of the building, early one morning two of us from the architectural studio and an accompanying architectural photographer went to the building to photograph it. As we approached the building, it was clear that there was something considerable differ-

ent about the site. The building was the last building on the site next to a cul-de-sac. After the cul-de-sac, the building was surrounded by small clusters of slum dwellings; three clusters of three to four huts on the south side of the building between the railway stock yards and then a larger cluster of perhaps twenty to twenty-five homes towards the west of the building between the building and the railway tracks.

These homes had been present on the land surrounding the building for the past several years from before we began the construction of the building to during its construction and up to its completion, however, when we approached the building to photograph it, we realized almost immediately that none of the homes remained surrounding the Polyclinic.

We first noticed the missing homes to the south of the building and then as we moved around the building to continue our initial recce, we noticed that the entire group of twenty-five hutments towards the side of the railway were no longer there. In their place just a large mound of dismantled and broken walls and plastic sheets remained.

I think the horror of the situation did not dawn upon us for a few moments. Upon finding out from the neighbours and residents of the area, conflicting narratives emerged. Some claimed that there was a voluntary exodus, but the majority very clearly said that there had been a forced eviction drive to remove the hutments in time for the politicians' inauguration of the building.





The irony of the situation that the very people for whom the building had been built, the socially and economically weakest and the most vulnerable, were the very first to be displaced from their homes for the inauguration of the very building built to serve their needs was not lost on anybody.

Now, several years after the inauguration of the clinic, upon revisiting it, the building appears to be in use, not to its full working potential, but substantially, and while a great degree of opacity has been brought to the building through individual actions of the occupiers in the form of opaque partitions and fabric dividers, what still stands out is the original design intent of the building; a contemporary beacon for the community, that serves, if not the entire neighbourhood, a substantial part of

it by helping them through conditions like TB and HIV.

What did become apparent is that while political will might be the strongest determinant of the health and wellbeing of a society, architecture continues to have the ability to positively impact societies and neighbourhoods even with small gestures.

It is sad that as I write this piece, just a few days ago, the Supreme Court of India has passed an order to evict 250,000 slum dwellers who have built their homes on the periphery of railway land in the Capital city of Delhi.<sup>2</sup>

Nearly all these residents are from the economically most vulnerable communities

<sup>2</sup> For further documentation, see Annie Banerji (2020) or Express News Service (2020).

that work as daily wage labour in the cities unorganized waste and recycling sector, and none of them are eligible for any compensation or rehabilitation. There are already petitions being filed that rightly state that demolishing the homes of the people on the tracks would amount to pushing them further into poverty and that those being evicted should be provided compensatory housing before they are evicted. However, such solutions themselves remain complex and much more nuanced in reality. Most past compensations have displaced evicted people to the periphery of the city where earning livelihood is next to impossible and transport costs to travel across the

city prohibitive. There has been a lot written about directives and actions of the government aimed at slums across urban India by activists and academics. As a practicing architect, I have attempted to share a specific experience of engaging with a small sliver of the city while trying to build a public health building. However, while there have been initiatives that have improved the quality of life for the residents of our cities, as a result of the extremely fast pace at which our urban footprint is expanding, singular and occasional interventions will not be able to create equitable and just societies in the near future.

## REFERENCE LIST

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