COVID-19 Prevention In Low-Resource Urban Informal Environments

Bolstering The Uptake Of WASH And Hygiene Practices

An Agile Research And Strategic Recommendations

Our Compass

Our Purpose
To protect, heal and nurture in the relentless pursuit of a cleaner, healthier world

Our Fight
To make access to the highest quality hygiene, wellness and nourishment a right, not a privilege

Own → **Care** → **Create** → **Deliver**

About BSI

The ***Banega Swasth India*** programme is an evolution of the flagship **Dettol Banega Swachh India**, a 5-year programme which began in 2014 with a mission to reach-out and improve hygiene and sanitation standards of 100 million Indians by 2020.

The programme complemented the Prime Minister led Government of India's Swachh Bharat Mission and contributed to the achievement of the targets under the Swachh Bharat Mission, paving the way for a clean, Healthy India. It is a multi-strand programme, which has made key contributions in enabling India's achievement of sanitation goals under the Swachh Bharat Mission, with its key pillars of Health, Hygiene and Sanitation, and the Environment.

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Project Backdrop and Focus Areas

Under the flagship program of Changing Behaviours - Creating Sanitation Change Leaders in 2015, Reckitt Benckiser and Jagran Pehel came together for a strategic partnership. The importance of provision of safely managed water, sanitation and hygiene services for preventing and protecting human health during all infectious disease outbreaks (including the COVID-19 outbreak) was understood.

Need for the Project

Communities living in low-resource urban settlements are highly vulnerable to COVID-19 exposure because of high population density and space constraints that increase transmission risks.

Poor hygiene behaviours due to absent or inadequate WASH infrastructure and inabilities to afford sanitation exacerbate the risks of contracting the disease. Poorly maintained toilets and shared bathing facilities in slums areas have become a significant reason for the spread of the virus as they increase interpersonal interactions and make it difficult to adhere to social distancing and hygiene practices.

Focus Areas

Emerging perceptions around COVID-19 and uptake of preventative behaviors

- Emerging perceptions in times of COVID around WASH practices
- Uptake of preventative behaviors during COVID-19 such as social distancing, mask wearing, etc. and identify key barriers and facilitators of these uptakes
- Shifts in risk perception around the use of shared toilets

Access to information and availability of resources

- Form and reach of messaging by the FLWs, NGOs and government authorities around COVID-19 disease, transmission and treatment, hygiene and other protective measures and its reception by the community.
- Issues around access to, usage and quality of available resources such as water, toilets, sanitation and hygiene products and health centres
- Infrastructural barriers due to COVID-19 to understand gender-specific biases and access restrictions, safety and risk factors.

Strengthening and facilitation of Service Delivery

- Perceptions and reactions of various service delivery personnel around COVID-19 transmission, sanitization and prevention.
- Issues around addressing grievance and maintenance of facilities.
- Recommendations for strengthening of public facilities and building resilience of the government at various levels

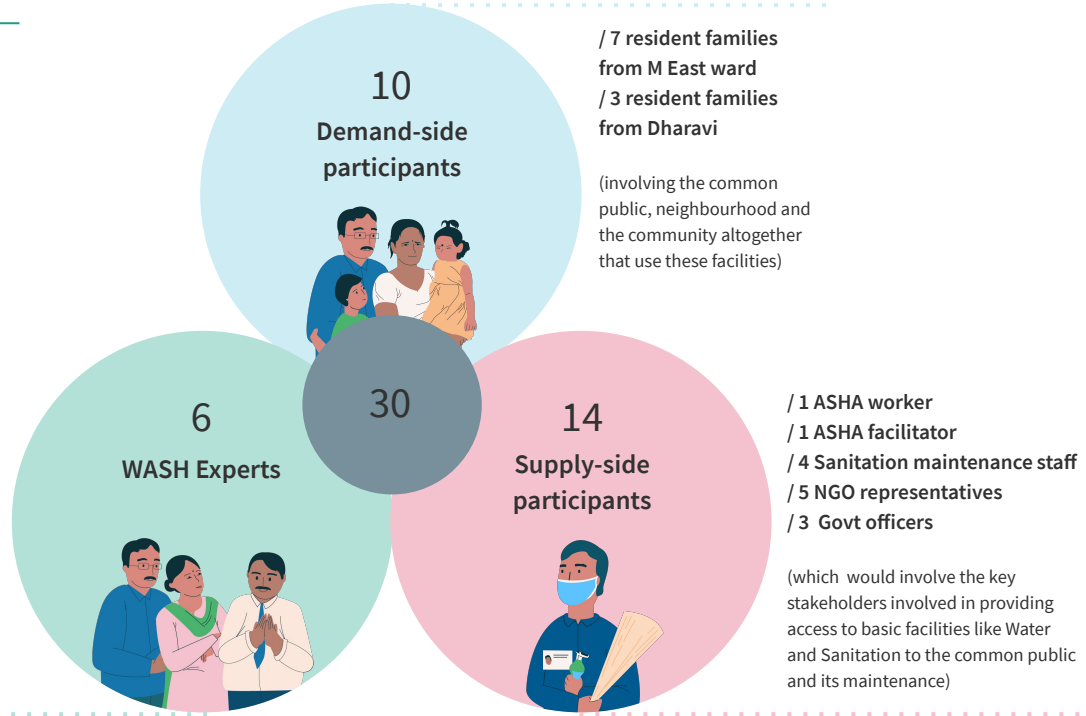
Recruitment sampling and Stakeholder mapping

Supply side and Demand side Bifurcation

To look deeply into the WASH sector, we had to explore the practices undertaken and activities performed by the people along with the facilities and infrastructural provisions available to them in the informal environment they live in.

To do this, it was decided to explore the domain of WASH from a dual perspective

Participants



/ 7 resident families from M East ward
/ 3 resident families from Dharavi

(involving the common public, neighbourhood and the community altogether that use these facilities)

/ 1 ex-service officer
/ 3 BMC Officers
/ 2 govt consultants

(experts from academic and research sphere who provided us with ward-specific important information)

/ 1 ASHA worker
/ 1 ASHA facilitator
/ 4 Sanitation maintenance staff
/ 5 NGO representatives
/ 3 Govt officers

(which would involve the key stakeholders involved in providing access to basic facilities like Water and Sanitation to the common public and its maintenance)

Protocols

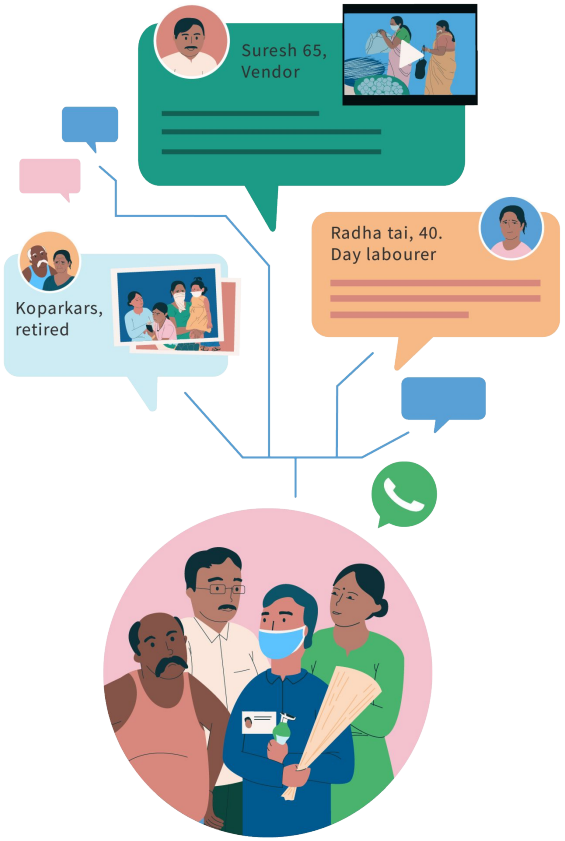
Women	Men	FLWs
17	17	6

Research Methodology

Remote Ethnography and Data Collection

Primary data collection was done by means of the telephonic interviews to abide by the prescribed norms of safety and social distancing. Jagran Pehel helped us in recruitment and building contacts with various front-line workers and community influencers and helped us to gain access to information from trusted government sources.

Over the course of three weeks in **August 2020**, we used different research tools and methods with 10 (7 families from M East + 3 families from Dharavi) participants with whom we interacted thrice spread across a week, 14 service delivery stakeholders and 4 WASH experts.



Methods Adopted

First Engagement
Interviews with new participants - mix of home-toilet users, community-toilet users and families that practise open defecation.

Telephonic conversation following participant-specific discussion guides.

Second Engagement
Based on themes identified in first round of conversations, we had deeper follow-up focus conversations.
** We included WASH specific conversations following participant-specific discussion guides.*

Identification of Gaps and Third Engagement
Based on gaps identified in the information collected, we had follow-up on their lifestyles and change in WASH practices through Journey mapping and whatsapp video-calls.

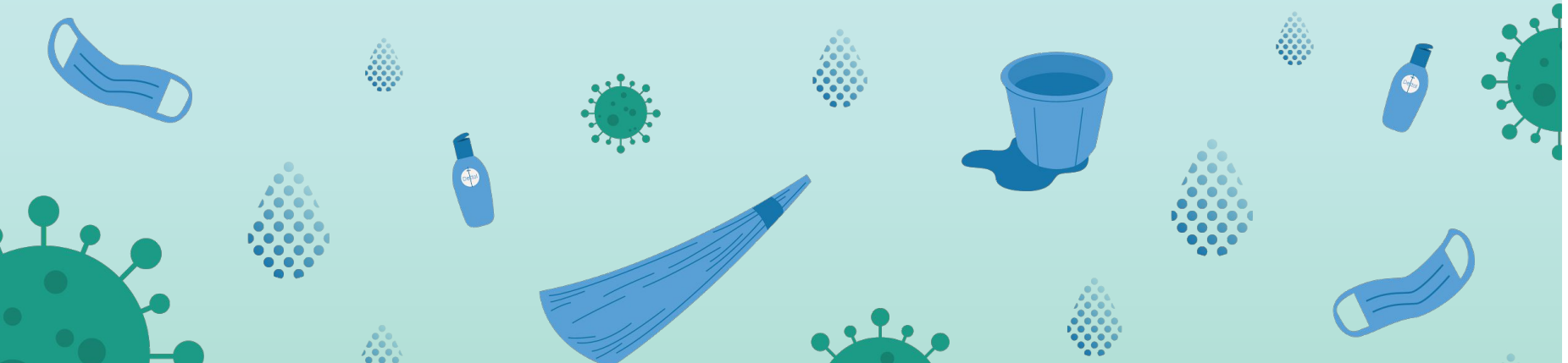
Triangulation of all Information
Corroborating data points from different stakeholders Families, FLWs, Informal Care Providers.

2 | Learnings From The Field

- COVID-19 and Community Responses
- WASH Implications
- Supply-side Responses

2.1 | Covid-19 and Community Responses

The responses of both the communities in context towards the COVID-19 pandemic, of course, depended on the resources and services made available to them, but also on the ability of these communities to receive and accept these resources and services. Differences in geography, diversity of community, economic activity and other macro factors, justify their different responses to the pandemic. Let's take a look at these factors here -



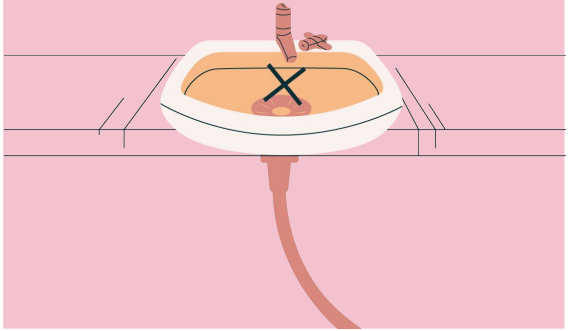
Factors responsible for Community Responses

1. Hardships - Part and Parcel of life

Hardships seen as regular event in one's life- mentions of having seen numerous ups and downs, crisis that they have had to live through and mechanisms they have had to adopt to deal with them- being out of work, being in debt, illnesses, medical emergencies, deaths in the family and so on

2. Infrastructural Deficiencies leading to loss of control and difficulty in compliance

Often families of 5-7 members live together in a single room house, in congested areas with narrow lanes and stacked homes and a use common community sanitation facility, face issues of water supply/ dirty water, garbage disposal and so on.



3. General lack of Trust and Skepticism towards Authorities

General lack of trust on anything government- Association of government with bad infrastructure, poor services (stations, hospitals, processes for getting work done), poor redressal and grievance mechanism driven by the need to mint money more than general welfarism.

Factors responsible for Community Responses

1. Hardships - Part and Parcel of life

- Having seen the worst, they feel more prepared to deal with whatever life has to throw on them.
- There is a general attitude of 'nothing can stop us/ we cannot let anything stop us' - the hand to mouth existence necessitates constant fight to rise above the crisis to ensure survival. Fear of survival precedes fear of any topical crisis.

- **Covid, just another hurdle to overcome:** Lockdown was hard on these communities, with jobs being stalled and savings getting depleted, getting back to work superseded any fear around Covid.
- **Return to work/ increased mobility pushing fear of covid to the sidelines:** The pressure to get to work and ensure a steady flow of income, led to the men/ workings member developing thick skin towards covid, almost becoming indifferent to it.
  - Sense of 'I am the earning member'' and cannot let covid divert me from fulfilling the responsibility of providing for the family
  - Seeing others going about their day made them more accustomed to it and more confident of continuing with becoming more fearless at the face of covid- 'i am strong enough to overcome it'.
- **Women/ stay at home members still show higher propensity to adopt measures to safeguard against covid:** stay at home members include old members, young kids and homemakers. With limited mobility there is still low efficacy in terms of being completely indifferent of covid
  - Higher fear around old and young members- owing to the understanding that they are most at risk with covid
  - Homemakers are in a dilemma- feel responsible for keeping home safe, at the same time feel lack of control with other members starting to go out of home. In the process trying to balance things- ease down her anxiety around corona and at the same time doing her little bits at home to ensure some safety

"It was very obvious that the slums would become the hotspots because of overcrowding and congestion. More than almost 200 people use the same community toilet, not because they want to but that is all they have access to. We know and even they know it is dangerous and that the toilets can be contaminated, but what other option do they have?"

- Megha Phansalkar (Founder, TISSR India)

"How long are we supposed to just sit here. A month, two months are fine, but what after that? These people won't feed us our entire life. I have to do something to keep my family alive. "

- Family respondent

Factors responsible for Community Responses

2. Infrastructural Deficiencies leading to loss of control and difficulty in compliance

- The infrastructural / physical realities surrounding them becomes a determining factor- impacting how they respond to covid and WASH, restricting what all they can do/ adopt/ continue

The living conditions and infrastructural realities surrounding them made it difficult to adopt best/ ideal practices, which in turn made them more unperturbed about covid. The lack of control led to them developing the attitude of 'what can i do'. Forcing them to continue living their life the way they were before covid.

- Accessing public facilities: in spite of fear of covid at the start one could avoid social gathering and going out, but one could not avoid going to Public toilet, stand in queue, touch surfaces and taps touched by others and so on.
- Social distancing a luxury of the rich: living in cramped spaces, many people in a small space, roads/ passages not wide enough to ensure distancing, not enough space around shops/ vendors to maintain distance, need to line up at toilet or public water tap
    - Public transport: no control over ensuring safety, a necessary evil- crowded, overflowing, rubbing shoulders with strangers

"There are huge limitations to how much infrastructure can be provided within Mumbai's slums because of land issues - the belief is that providing them with better facilities will only encourage more encroachment and squatting, at the same time the expectation is that people will abandon slums that are in abysmal conditions, but that does not happen"

- Anand Jagtap

"With most of their families at home, men of the house usually stay and sometimes even outside in the gullies. The hot and humid weather outside makes it difficult for them to keep their masks on all the time."

- Apnalaya NGO

"People ask us, 'we barely have water to cook our food at home, how do you expect us to wash our hands so often?'. Handwashing is a luxury for the people living here."

- CORO NGO

Factors responsible for Community Responses

3. General lack of Trust and Skepticism towards Authorities

As a result developed a sense of 'to each their own' - one has to mend for themselves and not expect government to come to aid at the time of dire need

- While true of both the wards, the strength of sentiments much stronger in M-east- Feeling of been long ignored by the authorities.
- Dharavi being a popular settlement generates more news, therefore gets more attention from NGOs and civil society. As a result, relative to M-East Ward, Dharavi get more government support too.

'To each their own' - the same sentiment manifests itself even in the context of covid

- While the lockdown required of them to completely comply by government directives, the easing up of the same has led to families paving their own way, starting to question the government intentions.
- Misinformation: lack of trust in authorities leads to people turning to other sources they trust and associate with - immediate community members (friends, neighbors), social media (WhatsApp), religious leaders and influencers. This gives rise to beliefs like- 'covif is a scam for the benefit of pharma companies', 'it is not as big as made out to be', 'it is just like flu'....
- Misalignment: most directives seen as too disconnected with their realities - using sanitiser too often when it is expensive, social distancing when travelling by public transport/ public toilets
- Contradictory information: Families who tested positive, reported of not having had major complications. Others heard stories of friends and family recovering from covid, again with little or no complications. As a result information coming in through official sources does not match their experiences in terms of severity of Covid- leading to more skepticism

"There is sometimes a bias in the way authorities treat certain dwellings; they do not do it consciously but they hesitate to be available to them without the support of NGOs."

- Apnalaya NGO

"The government has been bringing so many new and weird things, I have a feeling this is also some kind of political drama. COVID is just a hoax."

- Family respondent

"How long are we supposed to just sit here. A month, two months are fine, but what after that? These people won't feed us our entire life. I have to do something to keep my family alive."

- Family respondent

Variance in response to COVID-19

While one is constantly becoming less cognizant of Covid and steering their focus away from it, the fear is still there though at varying degrees. How one perceives and responds to covid also depends on the nature of family constitution.

With vulnerable members

Young kids under 10, older members above 50-60 or members with chronic illnesses.

Highest compliance to WASH practices

Understanding that they are most at risk- seen as vulnerable population

While mothers ensure safety for kids, older members themselves limit their movement to outside of home

With stay at home mom

Fearful of the impact of Covid and the increasing instances of the same

Her reference points are still the information given out at the time of the lockdown- trying to make sense of the same in the context of her changed reality

Also sees it as her duty to ensure do her bits

Limited mobility- not built confidence by experiencing the world outside which is starting to resemble the pre-covid times

With older kids

Starting to socialise, meet friends

Many also go to work and thus the experiences of travel is normalising their perception to covid

Difficult to control- have a mind of their own and also frustration sweeping with having stayed indoors for long, leading to non-compliance

With working parents

Change in Attitude- 'dekha jayega', 'all fate', 'not in our control'

Earning taking precedence over fearing covid

Few days of going out for work instills the confidence that 'i can manage'/ 'it is not as serious'

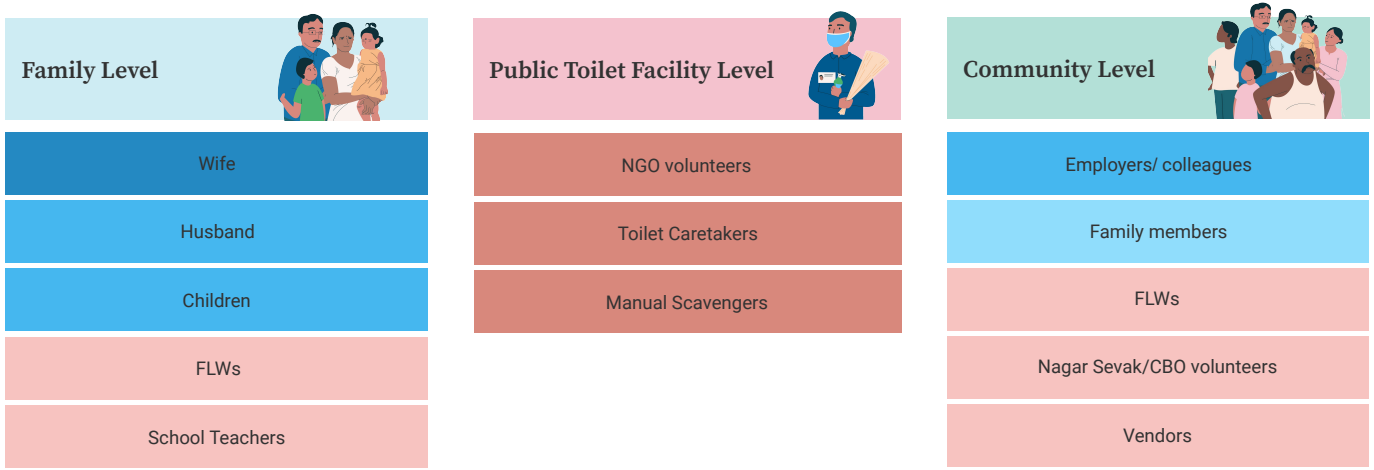
Lack of time to ensure adoption and continuation of WASH practices- inconvenience sweeping in

High — Low

Levels of Interaction

Response to the pandemic and its effect on uptake of necessary WASH practices are influenced by interactions and communication across different levels - Family level, Public Toilet and Facilities Level and Community Level. All of these levels within themselves have interaction of key stakeholders who play a major role in motivation and influencing people to uptake certain WASH behaviours, by increasing risk perception of transmission of the disease, enhancing control over individuals, increasing mandate in and around the level, and many others.

We look at these levels to understand the different patterns of behaviours, recognize the key players and finally come up with probable interventions that may influence or motivate people at these levels for a proper uptake of WASH practices for a healthier lifestyle. These levels have key stakeholders that consist of both supply as well as demand side of the community spectrum. The key on the side provides an idea about the contribution level of key stakeholders within each level.



Covid response across different touch points

While there is a general decline in the risk perception towards covid- this risk perception manifests differently at different physical spaces one engages with.

Two factors determine the nature of engagement with each of these spaces - **perceived risk** and **sense of control or efficacy** to deal with that risk.

How they respond to covid with reference to each of these spaces also impacts their WASH behavior around these spaces...

Home Level

Moderate to low perception of risk - home is usually considered a 'safe-space'
Higher sense of control - high efficacy to manage things at home and do whatever needed to ensure safety of all.

Lapsage in uptake of protective behaviours outside of home also leading to some amount of relaxation at home - sense of 'how would just staying safe inside of home keep us safe'

Public Toilet Facility Level

Higher perception of risk - public space accessed by many in the vicinity
Low sense of control - few instances of limiting touch at toilet and maintaining social distancing

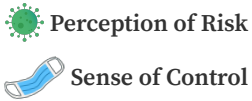
A necessary evil- doing the little one can but leaving it most on fate

Community Level

(Market spaces, public transport, healthcare facilities, work space)

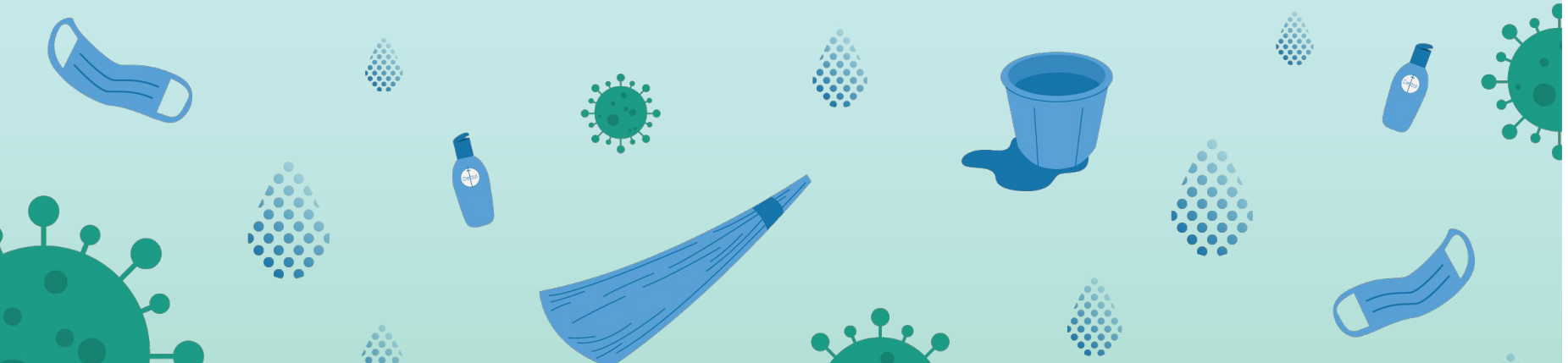
High perception of risk - crowded areas, no possibility for social distancing, lack of alternative
No sense of control - there is nothing much one can do

Feeling of helplessness, resulting in the attitude 'dekha jayega' - need to leave it on fate, also leading to non-compliance in other spheres



2.2| Implications on Wash Practices

The changing perceptions of risk, access to more information and the change in levels of mandate in and around the three levels that we talked about earlier, have influenced a change in uptake of WASH practices in the community. There are triggers and barriers that work at each of these levels that influence - motivate/demotivate the uptake of WASH practices. Let's look at these here -



WASH across different touch points

The perception around Covid-19, with variables like risk perception and sense of control, has impacted people's WASH motivation - the drive to adopt WASH Practices as precautionary measures against covid-19. These pointers give an idea about how these variables change from one level through the next.

Home Level

High WASH motivation

Low risk of transmission - home is usually considered a 'safe-space'

Higher sense of control - high efficacy to manage things at home and do whatever needed to ensure safety of all.

Need to empower the household with necessary tools and information to push for better better uptake of WASH practices and higher compliance

Public Toilet Facility Level

Moderate WASH motivation

Higher risk of transmission - public space accessed by many in the vicinity

Low sense of control - few instances of limiting touch at toilet and maintaining social distancing

Need for physical nudges to push for better uptake of WASH practices and higher compliance

Community Level

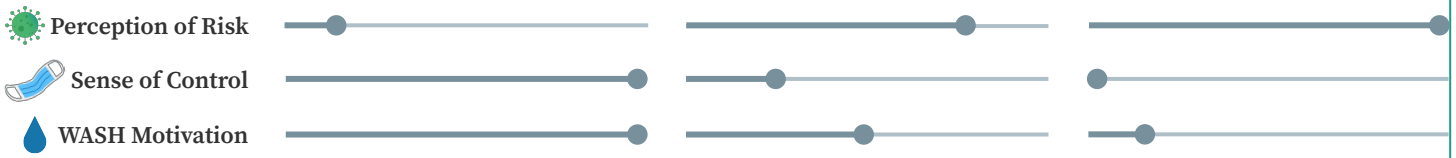
(Market spaces, public transport, healthcare facilities, work space)

Low WASH motivation

High risk of transmission - crowded areas, no possibility for social distancing, lack of alternative

No sense of control - there is nothing much one can do

Need to create stronger community networks for better flow of right information along with equipping communities with necessary tools to ensure safety



Home Level

Home is considered a ‘safe space’ and the following stakeholders act as key players that contribute to maintenance of risk perception within the home level ensuring better uptake of WASH practices and higher compliance. Family members, especially the decision makers in the household - the man/husband/father and the woman/wife/mother - play key roles to ensure safety within the home and keeping themselves as well as their family safe.

Perception of Risk
Sense of Control
WASH Motivation

Woman/Wife/Mother (Homemaker)

Home is basically a woman’s domain and lockdown increased the burden of cooking and cleaning, adding onto catering to more demands from her family throughout her day. She took the responsibility to ensure safety of her family against the virus, keeping home a ‘safe place’ for everyone by setting up the new rules, do’s and don'ts, ensuring adoption of certain practices, demanding purchase of particular cleaning products for maintaining immunity, etc.

Women became overworked and were burdened by increased workload, leading to a higher sense of ‘self’- she saw herself as the power center of the house, responsible for the well-being of all the members.

“I am always worried about my husband who still goes out to work. What if he becomes positive? I have a disabled kid at home, we cannot afford to get sick, either one of us. The most I can do for them is give them kadha and warm water at home and wash his clothes separately to keep sanitisation.”

Man/Husband/Father (Head of the household)

Home is usually seen as the domain of a woman and she being more equipped to deal with matters of the house, men were found supporting her in the endeavour, purchased products she asked for and adhered to the rules set by her during the initial lockdown.

Men have more and easier access to a variety of information sources (WhatsApp, friends, family, community elders, colleagues, news channels). They, thus, act as a filter, deciding which piece of information needs to be adhered to and carried forward, conforming to a set of beliefs and perceptions around the disease.

"I was out of work for more than 2 months. I had to go out and find some work. My wife was worried for me and would take many preventative measures so that I do not get virus. She was taking care of all of us."

“My wife asked me to buy dettol liquid for home. She makes sure to add a few drops in our bathing water, it is believed to kill all germs."

Frontline Workers, School Teachers

With lockdown, children are attending school through online classes, bringing the teachers into their home spaces.

FLWs on the other hand interact with families, but with increased work under covid limit their visitations to families of interest- affected/ with vulnerable members.

There is high trust and credibility on these players, however it does not translate into them playing any direct role in uptake of any WASH practices around covid at the home level.

Key Barriers

Given the following major barriers that have lead to lapsage in WASH behavior, the current realities resemble the pre-covid-19 times. People are only continuing with basic minimum measures like wearing masks, washing/sanitising hands, limiting touch at the public toilets, etc. Below are the reasons for discontinuing specific WASH practices -

Changed realities

- With lockdown opening up and members starting to cross the familiar and controlled internal environment to move to the outside world- there is a sense of loss of control and feeling a sense of inability to ensure safety outside of home
- Women became the task masters, enforcing certain do's and don'ts around WASH practices at home. However with members getting out for work and other things she has lost the control, leading to decline in a lot of WASH practices adopted during the lockdown
- 'Now' is mostly characterised by adhering to basic minimum- masks and hand washing/ sanitising.

Affordability

- With increased mobility, the usage occasions for sanitisers, mask, hand wash has increased- increasing the dependence on products/ use of products
- Also with all members starting to go out separately- need to have separate sanitisers and masks for each rather then just 1 at home for all
- This has increased the burden on the family in terms of expenditure- leading to rationed behaviour or cutting down on practices that incur cost (buying separate soap for hand wash, lizol/ phenyl use, boiling water)

Resistance from other members

- Sense of frustration sweeping in with having been in lockdown for a while- leading to lapsage from certain practices and lack of cooperation from other members
- The young and men in the family are starting to meet friends, go out- mothers finding it difficult to stop them.
- Now is mostly characterised by adhering to basic minimum- masks and hand washing/ sanitising. Other precautionary measures on decline.

Infra deficiencies

- While there is a realisation that uptake of WASH practices is more critical with lockdown opened up - woman finds her physical environment non-conducive to adoption of best behaviour
- No facility to keep water and soap at entrance- No space or causes inconvenience to neighbors
- Most have washrooms at the end of the house- necessitating entering the house/ fear of contaminating the house when coming from outside
- Having to use public toilet- thus cannot control the hygiene there

Public Toilet Facility Level

With congested neighbourhoods and literally no space for personal sanitation, community toilets are the only place men and women can relieve themselves of shame of defecating in the open. The following stakeholders act as key players that contribute to maintenance of risk perception at the Infrastructural level ensuring better uptake of WASH practices and higher compliance. Women and the community toilet caretakers play key roles to ensure safety keeping themselves as well as their families safe.

Perception of Risk
Sense of Control
WASH Motivation

Toilet Caretaker, Sanitation Worker Manual Scavenger

Complete responsibility of maintaining the public toilet - collecting the fee, cleaning blockages/ pipes/ sewers of the public toilets, maintaining sanitization, raising complains with authority, as well as managing the crowd to work according to the national mandate lie on the toilet caretakers.
They were provided with hand sanitizers and infrastructural add-ons like tippy taps for hand wash, etc. They also monitored families on wearing mask and maintaining social distance in and around the public toilet facility.

"I am not saying they should clean the toilets or anything, that is definitely my work. But the least they can do is not break things or steal things from the toilets. They think the community toilets are govt structures and take out their anger on the govt by breaking things here. It makes things difficult for us as well as so many people using it."

"I was afraid that with lockdown in, I would also lose my job like the others, but fortunately my work became important more than ever. People started calling me themselves to get their MHADA toilets cleaned."

Community Members

Mostly limited to the use of the facility and no particular role to play in the maintenance or upkeep of the toilet, the community members lack a sense of ownership or responsibility towards the facility. Very few people mentioned that they ensured to pour water and flush properly to leave it clean for the next person and this is seen as the most they can do.

In many neighbourhoods, community members came forward to call sanitation workers to clean MHADA toilets (with no caretakers) in their areas.

Young Mothers

Women, especially young mothers, are fearful for the wellbeing of their young kids and have been cognizant that going to public toilets put them and their families at risk. While there is an understanding there is not much they can do about it, avoiding touch when at the toilet is the only thing in their control - so much so that the mothers have gotten themselves and their families into the habit of not washing hands at the toilet in order to avoid touching taps and the commonly used bars of soaps.

Key Barriers

Given the following major barriers that have lead to decrease in uptake of specific WASH practices, the current realities resemble the pre-covid-19 times. Besides the basic measures like wearing masks, washing/sanitising hands, etc. no other preventative behavior is followed. Below are the reasons for the lapsage in WASH behavior -

Infra deficiencies

- Single toilet facility catering to a large population - estimate 200-300 people per toilet which makes it difficult to keep it clean and maintain social distancing
- Improper drainage- water gets collected, drains gets filled up- leading to the need to clean more often, shut down few toilets leading to higher turn around
- Issues of water shortages at the toilet- making even basic WASH practices of washing hands at toilet a deterrent

Sudden removal of nudges

- Not just has the lockdown been lifted but so have been other checks and nudges that were enforcing/ ensuring compliance to best practices at public facility
- Mentions of wearing masks, maintaining social distancing, using sanitiser at public toilet at the initial phase- mostly out of the fear of police, or owing to presence of some physical nudges at public places (sanitizer, liquid hand wash, tippy taps at public toilets)
- With government (what public toilet represents) taking a back step- most families are also developing a sense of ‘it is not as serious’ leading to decline in WASH practices overall

Lack of community participation

- There is a lack of understanding among the users or knowledge needed to handle and maintain the facility properly.
- Lack of ownership of the facility; it is often believed since the constructed facility has been constructed by the govt, it is their responsibility to maintain it.
- Lack of attachment with the community toilets - Public toilets are considered a public interface and private or personal is usually kept separate. Added obligations like maintenance of the facility which is a public interface may often lead to decrease in use of the facility - people tend to move back to open defecation instead of coming forward to maintain the facility.

Community Level

Community level includes neighbourhood spaces and markets, where people meet and interact with other people from their neighbourhood or others. Interactions shape risk perceptions and attitude towards uptake of newer behaviours through information exchange. The following stakeholders act as key players that contribute to maintenance of risk perception within the community level ensuring better uptake of WASH practices and higher compliance.

Perception of Risk
Sense of Control
WASH Motivation

Frontline Workers

FLWs were expected to identify, test and care for the covid patients along with the doctors. This imbued a sense of 'I am important' or 'I am a professional' - driving them to give in their best.
This was further reinforced by certain nudges from the authorities that gave them a sense of being taken seriously and treated as professionals.

"It has been difficult in the beginning when we had no protective gears for ourselves, only a mask and a bottle of sanitizer. However, we tried our best to go door to door and check for symptoms in the areas, many of us fell sick and were even tested positive during that time."

Residents of the Community

People usually carry their masks whenever they go out of their homes because the risk of transmission is still very high. This creates a social pressure for other people to do the same. Although the uptake of proper WASH practices depends on the level of mandate in the area, such behaviours may also influence people to do the same.

Working members of the community are mandated to follow rules necessitated by their offices. It is necessary for all to wear masks and use sanitizers during their work hours. However, this was not followed when only colleagues are present, given the ease in authority that leads to ease in uptake of behaviors.

"There are many vegetable vendors and shopkeepers who ask people to wear masks when coming to buy things. Many are so strict that they don't sell to those who are not following proper preventative measures."

"Everyone is so tired of wearing these masks. They are very uncomfortable and suffocating. I have to wear it at the workplace or else we are not even allowed inside. Apart from that, things have gotten back to normal. I see barely anyone wearing masks on the roads and in the neighbourhood."

Shopkeepers/ Vendors

Understanding the risks associated with the disease, many shopkeepers and local vendors have made it a norm that they'll sell only to people wearing masks. They command certain kind of behaviors, like wearing of masks or use of sanitizers, becoming a positive nudge for uptake of certain WASH practices. On the whole, people tend to trust and reach out to them even more.

Key Barriers

Given the following major barriers, there can be seen a consistent lapse in the community WASH behavior. The current realities of both the communities resemble the pre-covid-19 times. Besides the basic measures like wearing masks, washing/sanitising hands, etc. any other preventative behavior is barely followed. Below are the reasons for the lapsage in WASH behavior -

Sudden withdrawal of checks and nudges

- There was strictness during the early phase of lockdown around movement and necessary preventative measures like mask wearing while moving about in and outside the community.
- With ease in lockdown, and markets opening up, there was an ease in mandates - lesser police force around, more people roaming about without masks, etc.
- With ease of mandate and lesser social pressure around, mask wearing and the general perception of risk lowered giving people a sign of relief about getting back to “normal”.

Lack of proper channel of communication

- Increase in recoveries without a vaccine being available created confusion about the lethality of the disease.
- Most news channels kept updating the national numbers for covid cases - deaths and recoveries; this created a gap in understanding for many people because they would view it from a level as close as the community level. They would find it difficult to understand the big number of cases in comparison to a few scores of cases in their community of 5000 families.
- Lack of presence of a system of grievance for the people to record and ask questions about the measures to follow, etc.

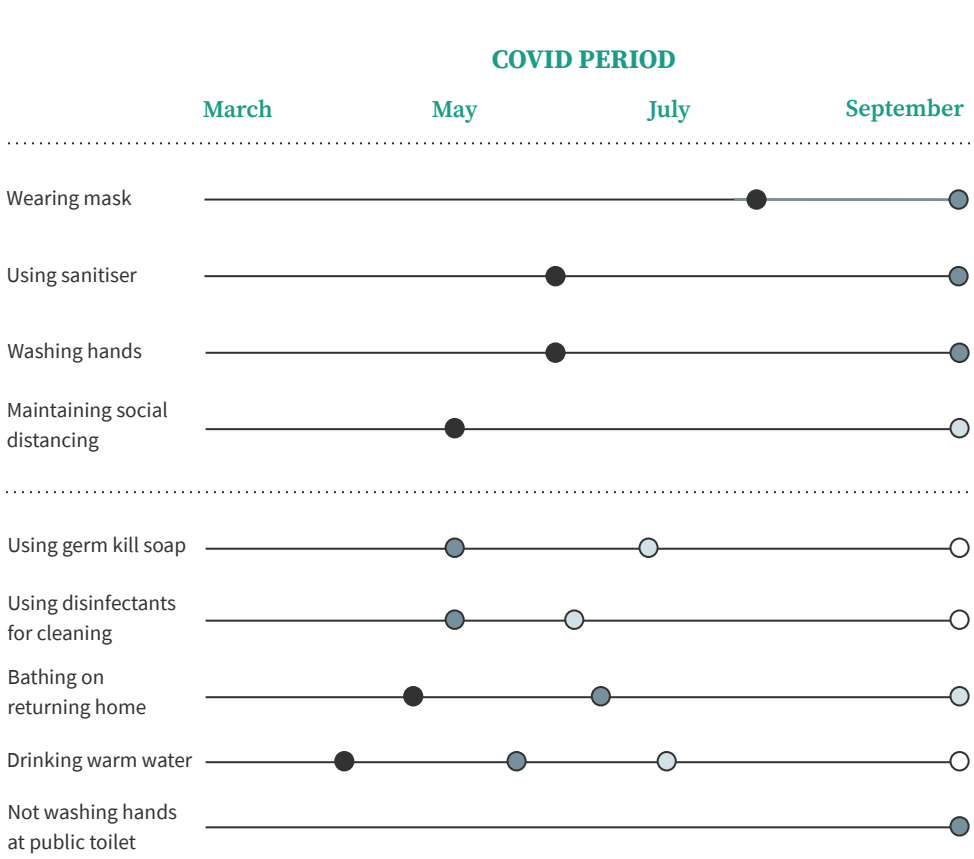
Public transport the black spot

- With lifting of lockdown, there is barely any control over ensuring safety in the public transports.
- Although it is mandated to wear a mask when onboard on buses, crowd management is not one of the things that has been in check.
- Buses are crowded, overflowing, continuously contaminated seats, hand-rests, etc.

Lack of community participation

- With a general lowering of risk perception among the community members and lack of mandate around, people have become negligent about use of masks in public spaces.
- Lack of proper and constant communication with nagar sevaks/flws post lockdown has motivated people to believe covid period is over lowering the overall risk perception.
- Movement is back to usual and authoritative mandate is limited to only a few spaces like workplaces, red-lights, etc nudging a further decrease in mandated uptake of such measures.

WASH in a snapshot



Triggers for continuation:

- Positioned as the most critical to follow/ musts
- Constant reinforcement through different channels of traditional, mass and social media
- Stamp of authority - from the government/ doctor approved

Barriers leading to discontinuation:

- Cost implications- expensive,needs individual usage
- Inconvenience- remember to use, feel suffocated in mask
- Unrealistic- difficult to follow when outside, impossible to avoid crowd while in public places (local, market, toilet)

Triggers for continuation:

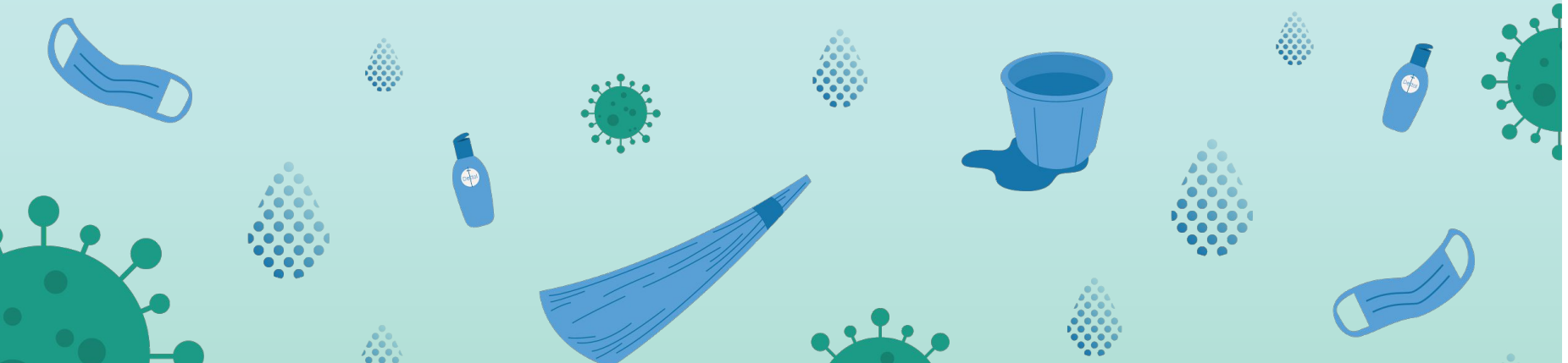
- Vulnerable members at home- do everything possible to ensure wellbeing

Barriers leading to discontinuation:

- Not through any official source- mostly picked up on WhatsApp
- Lack constancy- one off mentions
- Only possible at home- not when out, thus not as effective
- Seen as good to have- not musts and thus quick to be dismissed

2.3 | Supply-side Context

Struggles and hardships of various Frontline workers are not hidden from anyone. In times of such a health emergency in the country, these struggles became multifold and hardships increased. Let's take a look at the responses of various service-delivery personnel who played a major role in combating COVID-19 transmission in both the communities -



Supply-side Context

Service Delivery Response to the Pandemic: Fearful Sentiments

While for families lockdown meant staying indoors and venturing out only to purchase essentials, for the service delivery-side, this did not hold true and lead to some discontentment towards work and authorities -

No lockdown - They had to continue to work through the entire lockdown period, becoming more responsible for maintenance and sanitized services/facilities, being at the thick of things and thus, a sense of putting oneself and their families at risk grew amongst them.

Increased workload - COVID-19 added onto their existing workload - multiple times of cleaning and extra care into sanitization and then maintenance of facilities and services - all for the same incomes as before.

- *Frontline health workers and Arogya sevikas* had to do door-to-door visitations for COVID-19 symptoms check, awareness drives, food packet distribution, etc on top of keeping a check on the women and children they were already taking care of.
- *Sanitation workers and manual scavengers* started getting in more complaints for community toilet cleaning as there was no one to man them. Authorities (BMC and Mandal organisations) provided them with new materials to clean toilets with. They were also given the work of sanitizing the roads and neighbourhoods within chawls twice a week on top of the other things.

"What changed for us? Nothing. We were working only throughout. Rather the work increased. We had to go to families now and also check for covid patients. We got no break."

"The families were home all day so they would have more complains that our pipe got clogged and all. We were doing more work but no more money."

"Apart from taking care of the facilities, we now had to control the crowd as well. These are people who have no toilets at home, and visit here only when it is very urgent. How am I supposed to tell them to wait in queues and maintain distance when they're in urgency? Many come without wearing masks; I do send a few away, but that cannot happen all the time"

Supply-side Context

Service Delivery Response to the Pandemic: Fearful Sentiments

Workload and income issues were only two of the many issues the supply-side workers were facing. One of their other major concerns was the fear of contracting the disease themselves. While they have come to terms with the fact that they are putting themselves at risk, the fear of it reaching their home was much bigger. Being on the frontline, and having a basic knowledge of the risks and modes of transmissions, these supply-side workers took extra precautions to lessen the risk of spreading the disease to their loved ones. Many mentioned adoption of certain measures to do “the best possible they could on their own”.

- *Separate soaps - At public facilities or at home, to minimise the risk of transfer*
- *Gloves - Some of the sanitation workers purchased their own gloves to avoid transmission through touch.*
- *Bathing after work - to avoid transmitting the disease microbes if they had it on them. They have been extra cautious and even wash their work clothes separately from the other clothes.*
- *Washing outside home - Handwashing has been a common practice among the people, but the frequency surely increased after the introduction of COVID-19. Not only most service-delivery personnel, but also people from the demand-side started washing their hands and feet before entering the homes. People started keeping a soap and either their water drum or a separate bucket of water at the entrance to wash hands and feet before entering in.*

"Yes I use to keep soap for them and separate for myself too which I use it for myself. As I need to touch different things so I use my personal soap for my hygiene- i will not get nor spread. No one else cares but i have to."

“The moment I reach home I take a bath. I don't touch anything- straight to the washroom”

I can’t leave this work because it is my only source of income, but I can keep my family protected at least. So I make sure I follow all preventative measure, I always keep a bottle of sanitizer handy and wash hands more often. I have also stopped eating from the roadside.

Service Delivery Response to the Pandemic

Based on the data collected, it can be seen that there is a difference in the various drivers for behaviors, social treatment as well as stigmatization of the frontline workers in both the communities.

Drivers for Motivation

Front Line Health Workers and Arogya Sevikas

Sense of being a covid warrior- *'In it to defeat it'* -

With covid, the role of FLWs was extended to identify, test and care for the covid patients along with the doctors. Thus they saw themselves as a part of the team fighting the virus. This imbued a sense of 'I am important' or 'I am a professional' - driving them to give in their best. This was further reinforced by certain nudges from the authorities that gave them a sense of being taken seriously and treated as professionals.

Sanitation Workers and Manual Scavengers

Feeling of being at the bottom of the pit - *'no one cares'* -

Not much has changed for the sanitation workers; no support from authorities or the people. Their work continues as before and moreover they feel that there is not much they can do to protect themselves against covid (factor of the work they do). Thus, there is a lack of motivation to even change things around.
However, there is a realisation that their work puts them at more risk: dealing with medical waste, domestic garbage, fecal matter, etc. Their fear is more in terms of taking the virus home or being out of work. Thus, they seek aids more in the form of assurance - regular or subsidised testing for self and family, job security and salary-over aids in terms of protective gears.

"At the start they gave us nothing. Just a sanitiser bottle but no mask ot kit. We were very scared. But after some time they gave us PPE kits to wear on work just like doctors. So we knew that we have to do it"

"I deal with garbage, how much sanitiser can i use";

"If I am cleaning a sewage then what will a mask save me in that place"

Service Delivery Response to the Pandemic

Based on the data collected, it can be seen that there is a difference in the various drivers for behaviors, social treatment as well as stigmatization of the frontline workers in both the communities.

Institutional Support

Front Line Health Workers and Arogya Sevikas

High engagement with FLWs, through either various initiatives or factor of the nature of their work - making them feel more prepared to fight and deal with Covid

- **Regular Trainings** on how to engage with covid positive cases, understanding of symptoms, best practices around maintaining hygiene.
- **Distribution of preventive gears like** PPE kits, sanitisers to ensure safety for FLWs while out on duty, compulsory to wear it when out on covid duty
- **Regular checks:** Tested for temperature everyday at the hospital before starting their rounds, tested for covid on account of any complain about symptoms, ease of tests for self and family, easy access and regular interactions with medical professionals

"We received training and were taught how to take temperatures from a distance, how to keep ourselves protected from an infected family and not making them feel uncomfortable. We had constant checks in the health centres we worked in."

Sanitation Workers and Manual Scavengers

Low to no engagement, mostly left to their own ways and means to deal with Covid

- **No trainings on how to work around covid,** how to incorporate certain practices in their everyday work to ensure safety- other than the generic messaging of 'wear mask and wash/ sanitise hands'
- **No distribution of any gears for protection**- mentions of self-purchase of gloves and masks to do whatever little one can to ensure some level of safety
- **Refusal for testings:** instances of the MS/TC being refused testing on account of complains of minor symptoms- **'They said when you have some major symptom then come. This could be just allergy'**

"I work for the local CBO here. Although I didn't have anyone to train me for things, there were a number of people from NGOs who came and told me again and again to wear masks, maintain distance, have sour foods and warm water."

Service Delivery Response to the Pandemic

Based on the data collected, it can be seen that there is a difference in the various drivers for behaviors, social treatment as well as stigmatization of the frontline workers in both the communities.

Stigmatization

Front Line Health Workers and Arogya Sevikas

FLWs were seen as someone most susceptible to catching and thus spreading the virus. However distancing in most cases did not mean stigma - while they kept their distance, not many instances of them being discriminated against or shunned. Rather, instance of them being celebrated for their work of relentlessly fighting against the virus or for having emerged victorious after testing positive.

Sanitation Workers and Manual Scavengers

The experiences of the MS/TC were the opposite of what FLWs experienced- they were subjected to forms of discrimination for being lower caste and doing the 'dirty' work even before the covid and thus covid just amplified the same.

"I had tested positive and I was in quarantine facility for 2 weeks. When I was negative and I returned home all my neighbors clapped for me. It felt very good"

"There is anyway a lot of stigma we face because of what we do. People in my locality know i clean toilet and they keep distance. During covid they are more scared of us. If i tell them i clean gutters they will throw me out of the ward"

Varying WASH behaviour: barriers at the different levels

Home Level

- FLWs only visiting homes with reported symptoms or part of the covid chain tracking
- No emphasis on WASH practices other than social distancing, wearing mask and sanitising - most of the information already established or not clearly aligned with their current realities
- WASH an expensive affair

Public Toilet Facility Level

- No protective gears- PPE kit, sanitiser, mask, gloves, soap/ hand wash
- Lacking the authority to demand compliance of best practices by community members- no social distancing, wearing masks, keeping toilet clean
- No disinfectant products provided
- No medical insurance or assurance of tests in case of symptoms surfacing
- Overall lack of motivation

Community Level

- Lack of regular trainings on ways to deal with covid

Fear of

- High stigma attached to the occupation- low motivation and efficacy
- Increased workload, no added monetary incentive
- Differential treatment to different players- medical professionals, FLWs and TC/MS

3 | Strategic Interventions

Level of Interactions

- Family Level
- Public Toilets-Infrastructural Level
- Community Level

Levels of Interaction

Deeply delving into the possible interventions in the WASH sector, the following map is used to bring to focus the different needs and gaps at the various levels within the informal environment they live in according to which possible recommendations have been listed.

Wash Practices

Family Level

- Wife
- Husband
- Children
- FLWs
- School Teachers

Public Toilet Facility Level

- NGO volunteers
- Toilet Caretakers
- Manual Scavengers

Community Level

- Employers/ colleagues
- Family members
- FLWs
- Nagar Sevak/CBO volunteers
- Vendors

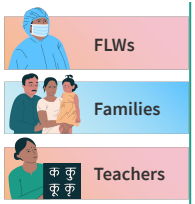
Demand-side	Supply-side
High	High
Moderate	Moderate
Low	Low

Home Level

Focus I: Transforming Home Into a ‘Safer Haven’

Focus II: Bridging the gap between families and system by installing nudges and sustaining motivations

Focus I: Transforming Home Into a 'Safer Haven'



1. 'Kabad se jugaad' - DIY upskilling through digital workshops

Conduct digital workshops for stay at home mothers and other family members in order to help them upskill and become able to create home-based, cheaper solutions for maintenance of best WASH practices. Some emerging themes for such workshops could be reusable masks, gloves, cleaning agents, hand-wash liquids, hand-free hand washing container, soap carriers, mask hangers, etc.

Targeted pain points

- Affordability- high expenditure incurred on masks, sanitisers and other disinfectant products leading to non-compliance
- Lack of knowledge on best practices to adopt with increased mobility outside home
- Changing attitude, belief that covid is not as serious as it is made out to be- reduced government interventions, no fear of punishment leading to discontinuation

Expected Outcome

- Empowered households- to not let affordability be a deterrent to adoption and continuation of best practices
- Constant reinforcement of the fact that covid is serious, around and deadly - and thus one needs to adopt certain practices to safeguard self and family
- Increase compliance- by bringing in credible people to conduct these workshops and by teaching relevant skill sets

Platforms to Leverage

- **Online schooling:**
  - High reach- already prevalent in most households
  - Teachers seen as trustable and credible sources of information
  - Greater compliance
- **Social media:**
  - WhatsApp most prevalent and trusted source of information- forwards seen as tried and tested
  - Mentions of youtube
- **Local TV channels:**
  - Marathi channels more popular than Hindi GECs
  - Entire family watches together

Focus I: Transforming Home Into a 'Safer Haven'

2. Wash Checklists

a. **Hygiene checklist** should be placed at strategic locations such as near the toilet, the kitchen, or near the puja place where the woman visits daily in the morning and are also critical points where she or the family needs to uptake hygiene practices. Food hygiene and home environment hygiene checklists to be placed to ensure hygiene is maintained for both cooked and uncooked food with handwashing before and after food / home-treatment of drinking water, hygiene practices while accessing drinking water / home hygiene and safekeeping - DIY low cost detergents and antiseptics to clean the house.

b. **Stepping in and out checklist** should be placed at the main door/ entry for easy visibility in entering and exiting from home. The checklist details out the items to be carried along while going out to different places- mask, sanitiser, gloves, soap, etc.

Targeted pain points

- Increase in mobility leading to discontinuation of WASH practices at home
- Increasing negligence- on return from work/ outside
- Lack of knowledge on various steps one need to adopt to ensure complete safety
- Too many steps to follow- leading to one not remembering to do it all
- Growing inertia leading to discontinuation

Expected Outcome

- Providing all encompassing checklist of different activities to do, to ensure maintaining home as a safe haven
- Enable families to follow every safety measure- reducing the scope for lapsage or missing out
-

Focus I: Transforming Home Into a 'Safer Haven'

3. Sanitation Stations or 'Sanitizer ATMs' (a one-stop solution)

Sanitiser booths/ vending machines placed at key touchpoints- kirana store, station, public facilities. Along with Sanitisers this could have different nozzles for different products- sanitiser, hand wash, lizol. Families simply have to put in money and collect the product in the container they are carrying. They can withdraw whatever quantity for whatever amount of whichever product they want (like a soda fountain dispenser). This could also have the facility to 'sanitise your mask' through a jet spray mechanism or a 'on the spot sanitiser' feature.

Targeted pain points

- Affordability: branded products seen as expensive leading to rationed use or no use
- One for all members: most of the products are kept at home to be used buy all members at the time of leaving or entering home. No individual sanitiser kit or separate soap for each member

Expected Outcome

- Create physical nudges throughout their journeys OOH - Acting as constant reinforcement/ reminder
- Anytime, anywhere usage-increased usage occasions
- Create covid kits for all family members- instead of 1 for entire family

Focus II: Bridging the gap between families and system by installing nudges and sustaining motivations

1. Door to door visits

Health workers expand their coverage to every household/ or at least household with vulnerable members to engage in conversations around Covid-19 and WASH, and impart knowledge on the best practices. They check on the different products/ aids being used to ensure safety- suggest measures to improve their behavior. They also keep a check on the different products/ aids being used to ensure safety- suggest measures to improve their behavior. The FLWs create awareness around digital workshops and other activities for them to attend. They also distribute new knowledge-around the cases, deaths, developments, and the new practices to uptake.

Targeted pain points

- Lack of government interface- leading to the perception that government does not care, or it is not big enough for the government to care about
- Lack of knowledge on best practices to adopt with the change in their realities- increased mobility out of home
- Changing attitudes: declining seriousness around covid with sudden absence of any fear, enforcement, nudge

Expected Outcome

- Acting as the bridge between the authorities and the families to create a sense of seriousness around covid and need for compliance
- Create awareness around WASH practices as a way to safeguard self and family against covid
- Act as regular check on adherence to safety and WASH measures
- Mobilise people to participate in digital workshops, trainings programs, visit testing camps

Focus II: Bridging the gap between families and system by installing nudges and sustaining motivations

2. Targeted messaging

a. Extend the idea of a **'responsible man'** to **'one who ensures his own safety to keep his family safe'.** Impart messages related to OOH best practices to ensure safety on how to live with Covid-19, do's and don'ts, and how to not take it home. Platforms like WhatsApp, Workplaces, Public transport could be used to spread these messages.

b. Creating the sense that a **'a responsible mother'** needs to anchor the responsibility of ensuring that best practices are adopted and everyone is in compliance with the rules set. Communicate ways to keep the home safe - what products to use, how to clean the house, etc. Platforms like WhatsApp, the FLWs, mass media could be used to spread these messages.

c. Use **the child as a nudge** to push for certain practices to be picked at home. To make them push their families by asking and keeping check on practices - wear and wash masks, maintain social distancing, wash hands properly with soap, etc. Online classes can become a medium to check this.

Targeted pain points

- Varying risk perceptions: the risk perception around covid impacts the adoption and continuation of certain practices- however lack of united front in this regard, factor of:
  - Mobility: Members with high mobility/ going out to work showcase low risk perception (mostly men) while stay at home members (mostly woman) are still more fearful of it
  - Access to social Media: source of many conspiracy theories around Covid being a sham (men and women)
  - Access to mass media: information limited to just wearing mask and cleaning hands (kids and women)

Expected Outcome

- Target each member of the family with communication that would be easy to reach them, easy for them to comprehend, most relevant to them and their role in the household and thus more receptive to adoption

Public Toilet Facilities Level

Focus I: Infrastructural Interventions for the Public facility

- COVID-19 Safety Map
- Hands-free Tools
- Sanitation Facilities for high-risk Population
- Branded Toilet Facilities

Focus II: Enhancing Self-efficacy for Service Delivery Personnel

- Sanitation Warriors or “DETTOL Warriors”
- Privilege Card

Focus I: Infrastructural Interventions for the Public facility

1. COVID safety map

Install a map of the facility, highlighting the different tools and aids installed at different physical points in the facility. These will be numbered to create an ideal journey that an individual should take within the facility - this journey and every step in this journey would mean one has done everything to ensure safety for self and others.

Carrying a small container to use as mug → sanitiser at entry → standing on the marked circles to maintain social distancing → using foot pedal to open doors → using one's own mug for washing → using water to clean the toilet post use → using pedal to open the door again → using tippy taps/ automatic taps to wash hands → use hand wash/ soap carried from home.

Targeted pain points

- Fear of touching surfaces at public facilities- leading to many families washing hands on returning
- Changing attitudes: declining seriousness around covid with sudden absence of any fear, enforcement, nudge

Expected Outcome

- Reducing risk of surface contact at public places
- Increase uptake of WASH practices at the facility
- Normalize the routine into daily behaviour

Focus I: Infrastructural Interventions for the Public facility

2. Hands-free tools

Handsfree tools can be installed at the public facilities in order to reduce touch-points within the facility and manage the fear of transmission of disease through touch. These tools can be used as -

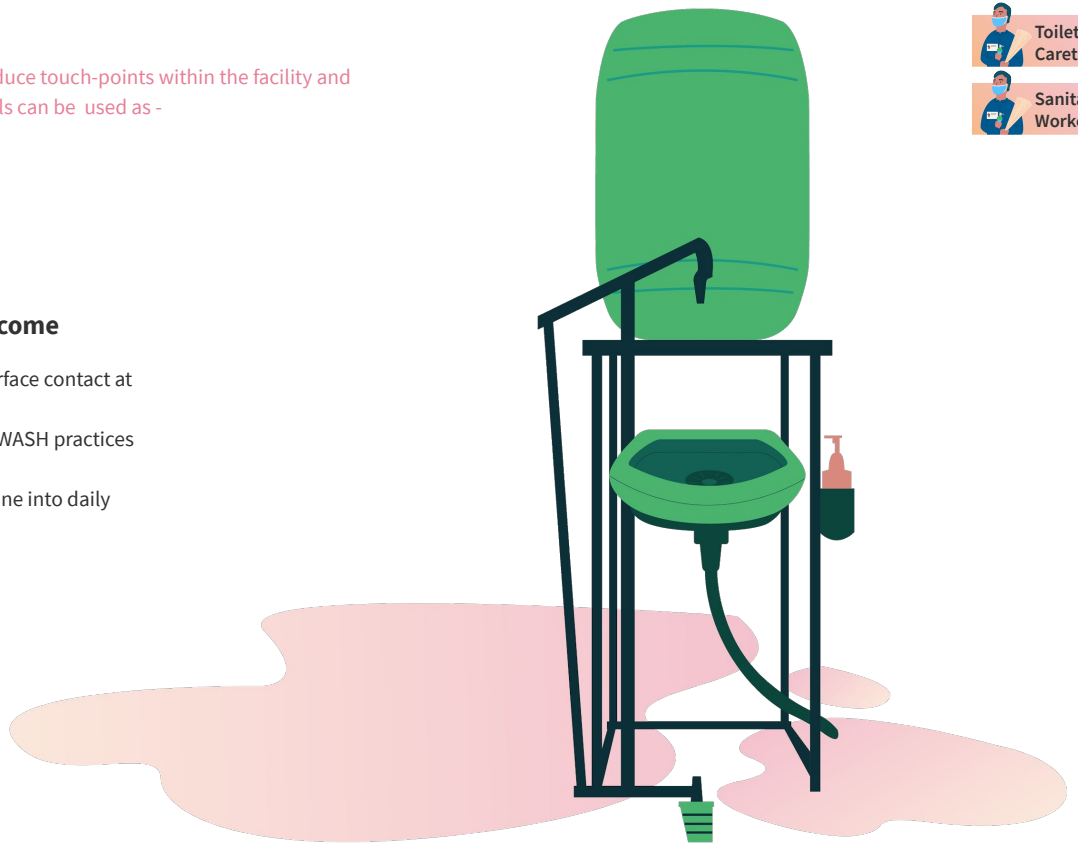
- Foot-pedal dispenser for sanitizer and liquid soap,
- Automatic taps/ tippy taps for hand-washing,
- Foot pedal to open and close doors,
- Shoe sanitiser sprays, etc

Targeted pain points

- Fear of touching surfaces at public facilities- leading to many families washing hands on returning
- Changing attitudes: declining seriousness around covid with sudden absence of any fear, enforcement, nudge

Expected Outcome

- Reducing risk of surface contact at public places
- Increase uptake of WASH practices at the facility
- Normalize the routine into daily behaviour



Focus I: Infrastructural Interventions for the Public facility

3. Separate sanitation infrastructure for high-risk population

A few toilets stalls, at least 2 out of 10, should be reserved only for the elderly, children, and for people with pre-existing conditions or comorbidities. These units could be ones that are cleaned more often and have a separate provision of no-contact hand washing/sanitizing facilities.

Targeted pain points

- Lack of focused care for high risk/ vulnerable members- no special attention given to them

Expected Outcome

- Extra layer of protection for the vulnerable
- Added reminder for people with comorbidities to keep a check on their health and keep safe- a constant reminder of the same
- Creating a sense of responsibility- not just for self but for those at high risk

4. Branded toilet facilities

Brand the entire space with posters, billboards, logo of a brand that is trusted and enjoys strong equity in the WASH space - DETTOL, HARPIC, LIZOL, SAVLON, LIFEBUOY (like branded metro stations). These facilities could also be equipped with some products from these brands - soaps, hand wash, cleaning brushes, etc. Branding would enhance people's trust in the facility and attract them to use the facility and WASH products more often.

Targeted pain points

- Lack of trust on government facilities- seen as necessary evil
- Lack of aids and tools at the facility to cue safety or proactiveness on governments part to create safe space

Expected Outcome

- Evokes a sense of safety and trust- a brand more trusted than government for its efficacy and effectiveness
- Gives a feeling of 'something been done' for their safety and well-being- upgradation of the public facility

Focus II: Enhancing Self-efficacy for Service Delivery Personnel

1. Sanitation warriors or 'Dettol Warriors'

Capacity building and enhancing self-efficacy can be done primarily by acknowledging the importance of the service delivery personnel and their fields of work. A branded uniform that identifies these essential workers as 'warriors' can make them feel wanted and visible. Branding could be of Dettol and the imagery around it is already that of a protecting agent against germs. 'Dettol Warriors' will give them confidence that they are someone who is protecting the society from the disease causing viruses, and thus will align well.
An added provision of a safety tool kit and badge of honour identifying their role in the infrastructure. In order to increase authority and ownership amongst the caretakers, competitions can be organised on World Toilet Day and the best maintained toilets can be rewarded for their performances.

Targeted pain points

- Manual scavengers and Toilet cleaners feel the brunt of it the most. They get no special treatment, no aids or trainings to protect themselves or to better manage the facilities.
- People are aware that the sanitation workers and toilet cleaners are the ones working at the frontlines, they are also considered most at risk and thus face discrimination and hostility in their societies.
- There is a lack of motivation due to increased workload due to the pandemic while no real increase in salaries.
- Unofficial service personnel like the manual scavengers and locally-hired sanitation workers lack proper protective gears while working in the riskiest places.

Expected Outcome

- Make them feel acknowledged and recognised for their work- driving motivation
- Create seriousness in them around the work they do contributing to a much larger cause of saving lives
- Also create seriousness in the community around their role and covid warriors

Focus II: Enhancing Self-efficacy for Service Delivery Personnel

2. Privilege Card

An ID document with a unique serial number that connects the sanitation workers to the community management system could be generated. A 'privilege card' will give them guaranteed access to regular medical checkups for them and their families. It will also provide them with priority testing and subsidised medical care for themselves as well as their families. This will give them a sense that their work is acknowledged and that they are recognized as part of the community.

Targeted pain points

- Fear of the spread of disease for self and to family
- Neglected by healthcare system- asked to return later, not tested easily
- Fear of loss of pay/ salary in case of falling sick

Expected Outcome

- Make them feel acknowledged and recognised for their work- driving motivation
- Create seriousness in them around the work they do contributing to a much larger cause of saving lives
- Also create seriousness in the community around their role and covid warriors

Community Level

Focus I: Bridging Knowledge Gap
- 'WHAT-WHEN-HOW' (WWH) workshops conducted by Nagar Sevaks or Ward Representatives

Focus II: Community Engagement and Participation
- Women-led Community Forums
- Women Auditors for WASH facilities
- WASH at home - Ward/Pocket-based annual or biannual competitions

Focus III: Infrastructural Interventions for the Community
- Community Hideouts or COVID-19 Safe Zones
- Digital Town Hall or Digital Sabha - Convergence and Reinstating Trust
- COVID-19 Warriors Conclave

Focus I: Bridging Knowledge Gap

1. 'What-When-How' (WWH) Workshops conducted by Nagar Sevaks/Ward Representatives

Using the information collected by the Aarogya health centres established at various checkpoints in the slums, **nagar sevaks or arogya sevikas (FLWs) can extend their work into conducting weekly workshops for community members - pocket-wise, targeting 20 households at a time - to spread awareness about necessary preventative measures.** These workshops may aim to cover the WHATs - WHENs - HOWs about uptake of necessary preventative behaviors.

- **WHATs** - What are the measures to be uptaken - use of masks, sanitizers, handwashing practices, filtering/boiling of water, cleaning/sanitizing homes, sanitizing store-bought products, etc.
- **WHENs** - Bridging knowledge gap about surface contacts and the necessity to sanitize or wash hands every time one touches some public surface (taps, doors, seats in the buses, etc)
- **HOWs** - Imparting necessary information about how to use and dispose the masks - proper handling and possible contamination, ways to wash it to reuse them, and the ways and places to dispose them off to avoid possible transmission of diseases.

As Arogya sevikas' door-to-door screening was a success in tracing symptomatic cases of COVID-19, these workshops can help in a similar way, by maintaining a perception of risk among the communities and normalising use of protective behaviors within their routines.

Targeted pain points

- There is a lack of knowledge on how to ensure safety outside of home.
- People have an improper understanding about the use of necessary preventative measures within home and public spaces. This leads people to discontinue preventative behaviors due to inconvenience.
- There is a gap in information that has brought in a confusion with respect to rising number of cases nationwide. Perception of risk is usually correlated with their proximity to rising positive cases.

Expected Outcome

- Maintained perception of risk that would lead people to be more careful and follow necessary preventative measures.
- Awareness about proper use and disposal of masks and understanding of risks associated with the workarounds they come up with.
- Knowledge about important touchpoints and various surfaces that they come in contact with.
- Understanding importance and proper usage of sanitizer and handwashing behaviors for the same.

Focus II: Community Engagement and Participation

1. Women-led Community Forums

This intervention involves informing women and pushing them into spreading awareness among the community themselves. Particularly when it comes to technical knowledge, it has been seen that women tend to involve themselves in decision making processes at homes and communities. 'Bachat-gat' is a popular savings group with an SHG-concept for women from poor households in Maharashtra. A community forum can be established using the same platform engaging respectable women influencers from the group - each group taking charge of families of women who are part of the group.

This forum can be used to discuss and disseminate relevant information about the pandemic - current realities (information gathered from the Arogya health centres), risks associated with the pandemic and ease of lockdown and sustainable preventative measures and workarounds for managing these risks. Women representatives from these groups can also be pushed to act as social nudges for their neighbourhoods, making people in their vicinity aware of possible risks and bridge the gap in their understanding of possible preventative behaviors for a better uptake and routinize them in their lives.

Targeted pain points

- There is a gap in knowledge and understanding with respect to ensuring safety within and outside of home.
- Women tend to have access to limited information as compared to the men who have control over technology used to access information - news, mobile-whatsapp groups/Youtube channels, etc.
- People have an improper understanding about the use of necessary preventative measures within home and community spaces that becomes over-burdening over time leading them to discontinue behaviors that may not normalise into their routines.

Expected Outcome

- A bachat-gat group or Mahila Ayojan where women come together to hold council meetings and discuss important messaging around pandemic and necessary steps to be taken within the community.
- Build capacity for women to take charge for their families and at large their communities and make them a social nudge for uptake of preventative behaviors.
- Proper knowledge about transmission and understanding towards preventative measures like mask wearing, hand washing, maintenance of distance at public places, etc would help in incorporation of these measures into their daily routines.

Focus II: Community Engagement and Participation

2. Women Auditors for WASH facilities

Building on the difference of ownership and responsibility between private and public, community-led agencies must be formed to monitor and audit and basically take control and responsibility of the community infrastructure. Trichy-based-ODF-model can be followed: **SHE (Sanitation and hygiene education) teams can be formed that are lead by women to maintain and educate others about dangers of ODF, unhygienic sanitation, regular cleanliness of toilet-spaces and maintenance of the facilities. These teams can be given bank accounts to maintain records and could be regularly audited.** Revenue from operation of toilets close to commercial areas can be used to maintain free and low cost toilets in areas vulnerable to open defecation within the wards (especially in case of M East ward where there are less number of community toilets and more cases of ODF due to improper maintenance of MHADA as well as SSP toilets in vicinity of the Deonar dumping area).

A**uditing may involve a checklist for the WASH facilities - regular cleaning, maintenance of sanitation, taking care and note of preventative measures (mask wearing, availability and maintenance of soaps and infrastructural facilities, social distancing, etc) for checking possible transmission of the diseases, etc.** For enhancing participation of the community, different families in the neighbourhood can be given responsibility for maintaining facilities for a month's time. At the end of each month, SHE auditors can check the maintenance through their checklists and reward the families that maintained facilities in the best way.

Targeted pain points

- Lack of community ownership of facilities and infrastructure leads to increase of burden on the supply-side personnels that in turn brings a decrease in maintenance of facilities.
- There is a stark difference between the private and public spaces - there is a sense of responsibility that is associated with maintenance and cleanliness of private spaces, but nothing of sorts with the community infrastructure.
- Lack of motivation and authority among community members to take control of the WASH facilities for maintenance of hygiene and sanitation.

Expected Outcome

- Community ownership and authority by personalising the public infrastructures and facilities.
- Increased sense of responsibility towards maintenance of public infrastructures, their sanitation and hygiene for a healthy community.
- Increased awareness about the risks associated with use of under-maintained public services and facilities.

Focus II: Community Engagement and Participation


Local Communities

3. WASH at Home - Ward-based / Pocket-based Annual or Biannual Competitions

Community sanitation and hygiene is a necessary requisite to maintain a sanitized and disease free environment. This would involve regular cleaning and sanitizing homes and the neighbourhood lanes, proper disposal of wastes, following WASH mandates at home - washing, cleaning, filtering, maintaining distance and use of protective items - masks, sanitizers, handwash, etc. These behaviors, although necessary, could be time consuming and quite heavy to carry out for a longer period of time without proper motivation except for their individual perception of risks and fear of the disease.

To promote and motivate people to take up the necessary measures of cleaning and washing within home premises, the wards can organize an annual or twice-a-year competition that checks WASH practices and behaviors at household levels. Using the WASH checklists (page 42) for home hygiene and community behaviours, households are marked and the best among them can be applauded or rewarded in community gatherings. In a similar way, such competitions can also promote segregation of waste such as 'healthy lane', 'healthy house' where the community influencers can act as judges.

Targeted pain points

- With irregular communication and a lot of misinformation around, there is a gap in the basic understanding behind how must one protect themselves within their homes.
- Practices that are more time consuming and out of routine for the people become over-burdening over time leading them to discontinue those behaviors.
- There is a lack of motivation towards the uptake and maintenance of particular necessary WASH behaviors within the homes due to unaffordable products and time consuming work which leads to eventual discontinuation of the behaviors.

Expected Outcome

- Promote necessary WASH behaviors and practices for maintenance of hygiene within home and neighbourhood.
- Motivate families to take up sanitation and hygiene practices and maintain community hygiene.
- Normalize specific WASH practices to be incorporated into their routines (could be based on the checklists - hygiene and protective behavior - *Family-level*)

Focus III: Infrastructural Interventions for the Community

1. Community Hideouts or 'COVID-safe Zones'

COVID-19 safe-zones can be created within the community where members of the family often visit. Hotspots like the local chaiwala/paanwala near market spaces, religious institutions - temples, mosques, dargahs, churches, etc. These hotspots can have sanitising showers/disinfectant cabins, operated and monitored by a trained personnel to follow safe behaviours.
This space can be populated with all the relevant information around covid and WASH behaviors. Volunteers from within the communities, or NGO workers can interact with the community members and spread awareness about the various services and facilities available for them. These can be safe-spaces where the religious leaders or community influencers can act as a lever that provides them with information about the necessity of uptake of WASH behaviors and convince people to normalise these behaviors into their usual routines.

Targeted pain points

- Increased frustration with lockdown leading to violation of social distancing mandates and other preventative behavior norms.
- Illiteracy and lack of understanding with respect to disease transmission and recovery without a treatment available lead to lowering of risk perception and hence discontinuation of protective measures.
- There is a sense of exclusion that the people feel because of the illegality of land ownership and neglect they had faced from the authorities due to the same, which has created trust issues towards the local authorities and government bodies.

Expected Outcome

- Monitoring of social gatherings in a controlled environment over risking the spread of disease
- Allowing people a safer escape-route to let-go of their frustration due to lockdown.
- Using these spots to create awareness around the need and importance of WASH practices
- These 'safe-zones' can also have COVID-19 warriors who volunteer to spread right and updated information in regards to the ward/community.

Focus IV: Enabling Digital Service Delivery Capabilities

1. Digital townhall / Digital Sabha – Convergence and Reinstating Trust

A weekly/ fortnightly **digital dial-in that allows community members to interact with key stakeholders and BMC ward-officers in order to seek support, guidance and redressal of grievances**. The families can send in their questions/ grievances in advance, keeping in mind who the next stakeholder addressing them is- top 5-10 of these questions will be answered in the Sabha along with giving out information on any developments in the COVID-19 scenarios. These sabhas will **reinforce the importance of WASH** practices in the context of Covid and the ways to ensure it.
An extension of the same could be almost an event of the sorts that communities look forward to - where one do much more than just give out informations. One could use mediums like songs/ jingles, audio plays, getting celebrities/ C**MO to address, getting covid survivors to tell their stories** and so on.

Targeted pain points

- Lack of trust in government and local authorities
- Misinformation spreads because of lack of formal channels of clarifying news and updates to policy
- Feeling of exclusion 'no one cares about us'- government has left us to mend for ourselves
- Feeling of exclusion leading to non-compliance of WASH practices
- Fear of physical contact- acting as barrier to seek help, visit facilities for support

Expected Outcome

- Create a sense of 'we are all in this' together
- Building trust in authorities and official messaging - bringing to the level of 'us' to interact
- Create an engaging platform
- Building long term community wellness that goes beyond just the pandemic and can be leveraged to communicate around other aspect of health and wellbeing

Focus IV: Enabling Digital Service Delivery Capabilities

2. COVID warriors connect

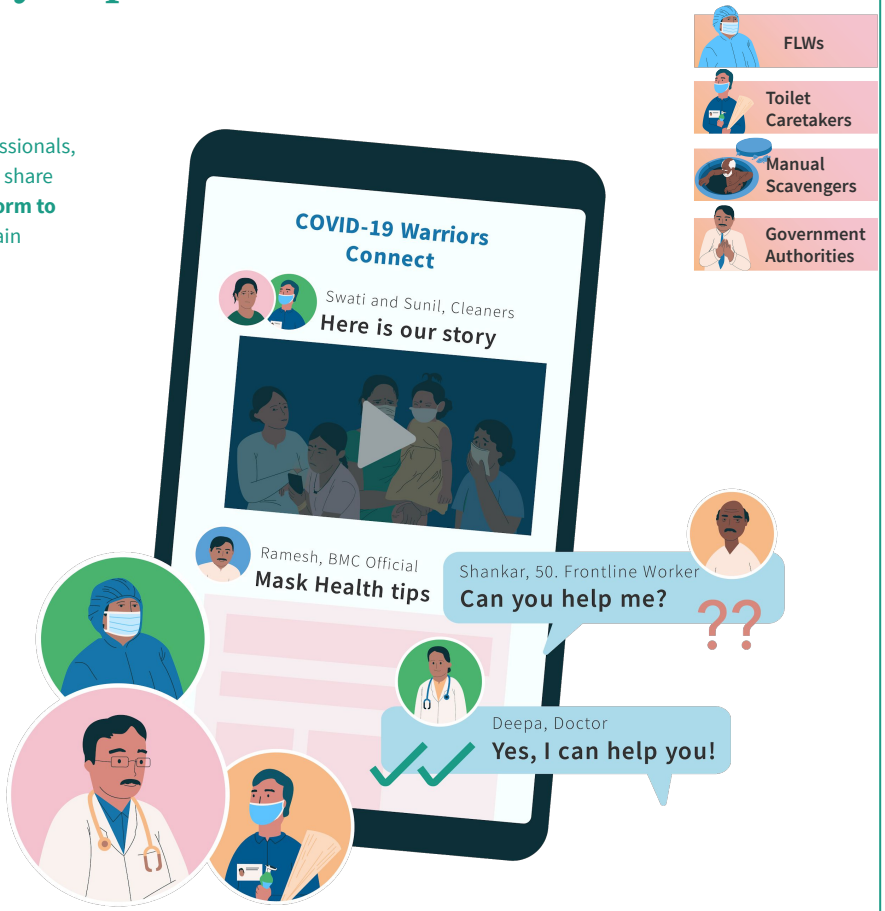
A professional social network of sorts which brings together all the players together- medical professionals, FLWs and Manual Scavenger/ toilet managers. One can use this as a general social media platform to share light and fun stuff along with sharing experiences with fighting with covid. This could also be **a platform to seek free and quick advice from doctors**- FLWs and MS/TC can post videos or messages about certain symptoms felt, or any problems faced. Other can write their suggestions or advice on the same

Targeted pain points

- Feeling detached and disconnected from network; unseen by public
- Differential treatment met- to medical professionals, FLWs and Manual scavengers
- Lack of mechanism to escalate maintenance issues, grievances etc.
- Lack of education on best practices, hygiene, self-care.
- Lack of platform to share experiences- success and failure stories

Expected Outcome

- A single platform bringing all different players together- making them feel as a part of one/ a unified army fighting against the common cause
- Rise in status quo of the players at the bottom- being out at the same pedestal as others
- A robust responsive framework where issues are resolved within hours instead of weeks of raising a complaint- making them feel special for being a part of the essential services
- Pick up micro innovations developed by different individuals in their daily work



4 | Annexure

- Stakeholders Consulted for the Project
- Bibliography

Stakeholders Consulted for the Project

To get an idea of on-the-ground realities of people's lives in both Dharavi and M-East Ward, as well as to understand the quality and condition of infrastructural resources available to them, WASH experts from various backgrounds and a number of NGOs working in these areas were consulted.

Water, Sanitation and Hygiene Experts

Mr. Anand Jagtap
Ex. Officer on Special Duty, MCGM. Currently a PhD student at TISS, Mumbai.

Dr. Prof. Sneha Palnitkar
CEO & Member Secretary of Waste Management Research Centre at All India Institute of Local Self-Government

Dr. Megha Phansalkar
Principal Advisor, Projects AIILSG; Advisor, Centre for Urban Innovations; Steering Committee member at WSSCC in South Asia; and Founder, Tisser Rural Handicrafts.

Mr. Pramod Dabrase
Development professional - Environmental Scientist, policy maker, researcher, trainer, consultant, social entrepreneur. Founder CSEDI, Nature Culture, and Humlog.

Mr. Kiran Dighavkar
Assistant Municipal Commissioner, G/North ward, Dharavi & Nodal Officer Swachha Bharat Abhiyan.

Dr. Tanaji
Assistant Medical Officer for M East Ward, MCGM.

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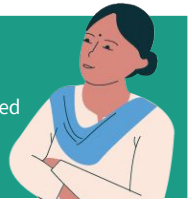
Representatives from NGOs

Anagha Waingankar, Associate Program Director at SNEHA
SNEHA works across many programs and seeks to improve the health and nutrition of women and children, living in the most vulnerable urban informal settlements

Dayanand Jadhav, Executive President of Triratna Prerana Mandal (TPM)
TPM works across areas like Environment, Enterprise, Solid Waste Management, Sanitation and Hygiene, Sports, Women and Child Development.

Poornima Nair, Director-Health & Disability, Apnalaya
Apnalaya employs a highly strategic and prevention-oriented 'Integrated Community Development' approach seeking to attend to the interconnected aspects of urban poverty like Health, Education and Livelihood; presently focusing on 31 clusters of M-East Ward, Mumbai (Shivaji Nagar, Govandi).



Supriya Sonar, Programme Manager - RIGHT TO PEE campaign Activist, CORO India.
CORO INDIA works towards a society based on equality and justice by empowering leaders in the most marginalised communities to steer collective action for social change.

Dr. Lata Ghanshamnani, Health Care Professional, Director Ace Healthcare Services, and Co Founder, Rnisarg Foundation
Doctors from different medical backgrounds work towards waste Management in the urban sector. Rnisarg innovated Wet Waste Composting system for space crunched apartments in various cities.

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The project has used the following sources of literature for background research and insights into the field. These have been listed here for reference:

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