Community Engagement to Tackle COVID-19 in the Slums of Mumbai

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Introduction

The COVID-19 pandemic tragically continues to surge in India. The strict lockdown protocols may have stunted the transmission of the disease in some parts of the country, but the coronavirus continues to spread, particularly in cities with large, dense populations and major economic activity. Social distancing is almost impossible to practice in densely populated areas such as slums, where residents live in congested spaces with poor water, sanitation, and hygiene (WASH) facilities and practices, and shared public amenities. Thus, several of India's slums are major hotspots for the virus.[1]

Further, the majority of slum residents are informal day-wage laborers and migrant workers who have lost their livelihoods through the pandemic and the lockdown—and become more vulnerable to the disease because of food insecurity and limited transport options. The extended lockdown and related COVID-19 response measures have adversely impacted other critical health needs and health determining factors. For example, patients with hypertension, cancer, or tuberculosis have been unable to access their medication or treatment.

In other pandemics, such as Ebola in West Africa or SARS in Asia, interventions that adopted a community-centric lens were more successful than others in driving sustainable impact. Studies revealed that crisis preparedness and response is not effective without the participation of vulnerable communities. When involved in the mitigation process, the communities' "confidence, capacities, and coping mechanisms develop in an upward spiral,"[2] and they are more accepting of and amenable to remedial initiatives and approaches. For example, at the height of the Ebola crisis in Sierra Leone, fears and misconceptions existed about Community Care Centers (CCCs)—government facilities set up with UNICEF's support—which led to them not being utilized to capacity. When additional CCCs were set up, the government consulted community leaders and influencers through the entire process of site selection, construction, and management of care, support and nutritional services. A social mobilizer interviewed as part of a related study noted, "Now the scenario has changed. The communities are so mobilized that people want to access CCCs, treat their loved ones early, and get more information on how they can protect their families from Ebola."[3]

Beyond an epidemic context, the World Health Organization's ENGAGE-TB approach similarly aims to integrate community-based tuberculosis (TB) diagnosis, treatment and management into the programs of nongovernmental organizations (NGOs). The approach, initially implemented in the Democratic Republic of the Congo, Ethiopia, Kenya, South Africa, and the United Republic of Tanzania, resulted in an increased utilization of TB care facilities, and increased disease notification rates.

Policymakers in India have recognized the important role of communities as part of a health crisis strategy. The National Health Policy 2017 calls for "close collaboration with local self-government and community-based organizations"[4] as well as "an army of community members trained as first

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[1] Vaishnavi Chandrashekhar and Clara Lewis, "With 42% living in slums, virus casts long shadow across Mumbai," *The Times of India,* May 18, 2020, https://timesofindia.indiatimes.com/city/mumbai/with-42-living-in-slums-virus-casts-long-shadow-across-mumbai/articleshow/75798141.cms

[2] Mikael Linnell, "Community approaches involving the public in crisis management: A literature review," Dec 2013, https://www.researchgate.net/publication/285512375_Community_approaches_involving_the_public_in_crisis_management_A_literature_review

[3] Paul Pronyk, Braeden Rogers, Sylvia Lee, Aarunima Bhatnagar, Yaron Wolman, Roeland Monasch, David Hipgrave, Peter Salama, Adam Kucharski, Mickey Chopra, and on behalf of the UNICEF Sierra Leone Ebola Response Team, "The Effect of Community-Based Prevention and Care on Ebola Transmission in Sierra Leone," *American Journal of Public Health,* Apr 2016, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4816080/.

[4] Ministry of Health and Family Welfare, "National Health Policy 2017," https://www.nhp.gov.in/nhpfiles/national_health_policy_2017.pdf.

responders for accidents and disasters." The Disaster Management Act, 2005, under which the pandemic is being managed in India, also refers to the importance of community engagement.[5]

This rapid study explores how different community engagement models have played out in the context of the COVID-19 crisis in the major slums of Mumbai. We highlight why community involvement in slums is critical to the COVID-19 response and describe activities where communities have been engaged. We then synthesize the prevalent models for community engagement and assess the factors for replicating and scaling them in the slums of Mumbai and beyond, both to tackle the pandemic and to build community resilience for future pandemics or other physical, social, and economic shocks and stresses.[6]

In this report, we hope to inform policymakers, public health officials, funders, and civil society organizations about viable, large-scale community engagement models as an approach to sustainably address the pandemic, other infectious diseases, and wider health needs in slums and other densely populated low-income settlements.

We find that solutions specific to and respectful of the local slum context are more likely to institutionalize durable measures to prevent and control COVID-19. Our stakeholder interviews suggest that conventional top-down approaches will only have limited or short-lived success in tackling the pandemic in India's slums, given their unique structural and demographic make-up. Community engagement approaches can have a broader and more lasting impact if they are part of a carefully planned disease response strategy where some elements of disease control are centralized, and others grounded in localized, community-driven measures.

Disproportionate impact of COVID-19 in the slums of Mumbai

Slums are a universal concept but take on a local character in different nations and their cities. The government of India defines slums[7] as "residential areas where dwellings are in any respect unfit for human habitation by reasons of dilapidation, overcrowding, faulty designs of buildings, narrowness or faulty arrangement of streets, lack of ventilation, light or sanitation facilities, or any combination of these factors which are detrimental to safety and health."[8] Slums are common in India's cities, constituting 24 percent of the urban population (100 million people)[9] nationwide;[10] in Greater Mumbai, they make up a sizeable 42 percent of the population (12.4 million people).[11]

Poor living conditions have made urban slums COVID-19 hotspots. Some estimates suggest that the population density of large slums in Mumbai, such as in Dharavi, is as high as 220,000 people per square kilometer.[12] Access to water and sanitation is a challenge; and as many as 78 percent of toilets in slums lack a reliable water supply.[13] Each year, 30-60 percent of households in Mumbai's non-notified slums[14] (those not registered by the government) suffer from waterborne diseases because they have no access

[5] Disaster Management Division, Ministry of Home Affairs, "The Disaster Management Act, 2005," https://www.ndmindia.nic.in/images/The%20Disaster%20Management%20Act,%202005.pdf.

[6] Rockefeller Foundation, "100 Resilient Cities," https://www.rockefellerfoundation.org/100-resilient-cities/.

[7] Slums are also referred to as *bastis, chawls* or informal settlements

[8] Registrar General & Census Commissioner, India, Ministry of Home Affairs, "Census of India 2011 – Circular No. 8," Jan 1, 2010, https://censusindia.gov.in/2011-Circulars/Circulars/Circular-08.pdf.

[9] Benjamin Parkin and Andrea Rodrigues, "India's biggest slum tests Modi's Coronavirus response," *Financial Times,* Apr 23, 2020, https://www.ft.com/content/5199e04b-d235-49e2-a20c-af7bb8fc53a9.

[10] Registrar General & Census Commissioner, India, Ministry of Home Affairs, "Housing Stock, Amenities & Assets in Slums- Census 2011," https://censusindia.gov.in/2011census/hlo/Slum_table/Slum_table.html.

[11] Yue Zhang, "Building a Slum-Free Mumbai," *Wilson Center,* Mar 3, 2016, https://www.wilsoncenter.org/article/building-slum-free-mumbai.

[12] Press Trust of India, "Dharavi's journey to becoming Mumbai's COVID-19 hotspot," *Economic Times,* May 14, 2020, https://economictimes.indiatimes.com/news/politics-and-nation/dharavis-journey-to-becoming-mumbai-s-covid-19-hotspot/articleshow/75737341.cms?from=mdr.

[13] Shubhagato Dasgupta, Anindita Mukherjee, and Neha Agarwal, "Hand washing to stop coronavirus — 78% of toilets in Mumbai slums lack reliable water supply," *The Print,* Apr 16, 2020, https://theprint.in/opinion/hand-washing-to-stop-coronavirus-78-of-toilets-in-mumbai-slums-lack-reliable-water-supply/402590/.

[14] Settlements not registered under the 1956 Slum Areas Improvement and Clearance Act and therefore not recognized by the government.

to the city's central chlorinated water supply.[15] Moreover, congested slum residences are poorly ventilated and trap heat, so families, averaging 8-10 people, living together indoors for extended periods, are prone to falling sick.[16]

The impact of COVID-19 has therefore been disproportionately felt in India's slums. On April 14, 2020, 31 percent of Mumbai's containment zones—the areas most affected and hence under strict lockdown—were in slums; by May 11, 2020, this number had risen to 57 percent,[17] and by late June, it was closer to 96 percent.[18] A large portion of the slums' residents also suffer from chronic illnesses such as respiratory infections, cancer, diabetes, and cardiovascular diseases, which increase their risk of mortality due to COVID-19.[19] A survey conducted by the Brihanmumbai Municipal Corporation (BMC)[20] at the end of April 2020 found that out of the surveyed 31,000 citizens—mainly in slums—over 4,000 senior citizens had such comorbidities.[21]

[15] Anastasia Papadimitriou, "Mumbai's Slums: The Positives and Negatives," *The World Mind,* Mar 1, 2019, https://www.theworldmind.org/home/2019/3/1/mumbais-slums-the-positives-and-negatives.

[16] Sahana Ghosh, "India's lockdown has left millions holed up inside shanties without fans as summer peaks," *Quartz India,* Apr 13, 2020, https://qz.com/india/1836752/indias-coronavirus-lockdown-is-unbearable-for-the-poor-in-summer/.

[17] Kabir Nanda, "Covid's spread in Mumbai's slums is a warning for all cities," *Live Mint,* May 25, 2020, https://www.livemint.com/opinion/online-views/covid-s-spread-in-mumbai-s-slums-is-a-warning-for-all-cities-11590419925759.html.

[18] Shrinivas Deshpande, "96% of containment zones in Mumbai are in slums, chawls," *Hindustan Times,* May 29, 2020, https://www.hindustantimes.com/mumbai-news/96-of-containment-zones-in-mumbai-are-in-slums-chawls/story-K82DeK0wjnTJV7VjWdpQGP.html.

[19] Andrew Gully, "Coronavirus in the city: A Q&A on the catastrophe confronting the urban poor," *The New Humanitarian*, Apr 1, 2020, https://www.thenewhumanitarian.org/interview/2020/04/01/coronavirus-cities-urban-poor.

[20] Mumbai's local government body, with elected representatives, also known as Municipal Corporation of Greater Mumbai (MCGM).

[21] Mehul R Thakkar, "BMC Surveys 31K senior citizens, 4K have comorbidities," *Hindustan Times*, Apr 28, 2020, https://www.hindustantimes.com/mumbai-news/bmc-surveys-31k-senior-citizens-4k-have-comorbidities/story-9ES0WjbBqDsHykagt47IjO.html.

Methodology

This study was conducted during the ongoing and evolving COVID-19 pandemic crisis, specifically in Mumbai slums. We interviewed 45-plus social sector actors, including community leaders, NGOs, philanthropic organizations, government officials, and experts involved in India's COVID-19 response.[22] We also conducted targeted research in secondary sources,[23] including government and other published data, where available and current. In addition, we have drawn on widely read print and online media such as *Live Mint, Hindustan Times, Indian Development Review (IDR), Quartz,* and others, and supplemented reportage with interviews where possible.

We spoke to organizations, local government, and community representatives that work across the larger slum areas of Mumbai (Dharavi, Govandi, Shivaji Nagar, Malvani, and the Kurla belt[24]), as well as in a few non-notified slums (Ambujwadi, Ambedkar Nagar, and Appa Pada). We also interviewed stakeholders involved in supporting the COVID-19 response in urban settlements in China and Kenya to understand how they were engaging with local communities.

Our interviewees were drawn from a representative (but not exhaustive) sample of community engagement efforts in the slums. However, information was largely self-reported by the respective organizations, and we have not undertaken due diligence efforts to verify their accounts. Our interviews with community members were conducted in local languages and have been translated for the purpose of the report. With the changing realities of the pandemic, specific COVID-19 activities may evolve as India unlocks further—although we believe that the principles and practices guiding the community engagement models we identified will largely hold true.

Need for Community Engagement

In every community, there are local actors (e.g., individuals, community groups and bodies, grassroots organizations), relationships, processes, and resources that intersect with health and other public services.[25] Community engagement can mean different things; for the purpose of this study, we define community engagement as external stakeholders (e.g., government, NGOs, funders) working closely and collaboratively with local actors and processes to understand and address the local residents' most pressing needs.

Other research concludes that engaging local communities is generally important to delivering high quality, people-centered healthcare, and to building resilient and inclusive systems for development.[26] Our study surfaced four specific reasons to involve slum communities in preventing the spread of the COVID-19 pandemic.

First, community engagement helps to develop initiatives and solutions that are relevant to the unique **characteristics, assets, and constraints of each slum**. Slums vary significantly in terms of their legal/ notified status, property rights, demographics, economic activities, access to public goods and social services, and culture. For example, vertical slums, like those in the M East ward, have multistoried buildings, whereas horizontally built slums such as Dharavi have densely co-located homes at the ground level. The Rafi Nagar area of Shivaji Nagar (in M East ward) has four public toilets and a few

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[22] The interview guides and interview list for this study are set out in Appendices V-VI.

[23] Additional research beyond the footnoted sources are detailed in Appendix IV.

[24] Some of the wards covered are G North (Dharavi), M East (Govandi, Shivaji Nagar), P North (Malvani), and L (Kurla belt); details are mentioned in Appendix I.

[25] International Federation of Red Cross and Red Crescent Societies, World Health Organization, UNICEF, "Community-based health care, including outreach and campaigns, in the context of the COVID-19 pandemic," May 5, 2020, https://www.who.int/publications/i/item/community-based-health-care-including-outreach-and-campaigns-in-the-context-of-the-covid-19-pandemic.

[26] World Health Organization, "Malaria eradication: benefits, future scenarios and feasibility," May 2020, https://www.who.int/publications/i/item/malaria-eradication-benefits-future-scenarios-feasibility.

community-built makeshift wooden toilets to cater to the sanitation needs of 45,000 people,[27] whereas households in some parts of Dharavi have their own toilets (although often with poor water supply). Also, slums such as those in the M East ward are worse off economically because the residents are predominantly day-wage earners who have lost their livelihoods in this crisis. By comparison, Dharavi holds approximately 1,200 manufacturing units and 8,000 shops,[28] and has not been as adversely impacted economically. That diversity of circumstance is why we found that solutions that require community uptake or behavior change need to be contextualized to each slum, rather than applied with a cookie-cutter approach.

Second, communities are proximate to and can best **identify their diverse and evolving needs** in the face of the pandemic. Slum communities are experiencing multifold needs and deprivations, as emerged through our interviews (see Exhibit 1: Needs of Urban Slum Communities during the COVID-19 Crisis). The voice and support of communities help to map, prioritize, and address needs in the context of each slum.

Exhibit 1: Needs of Slum Communities during the COVID-19 Crisis
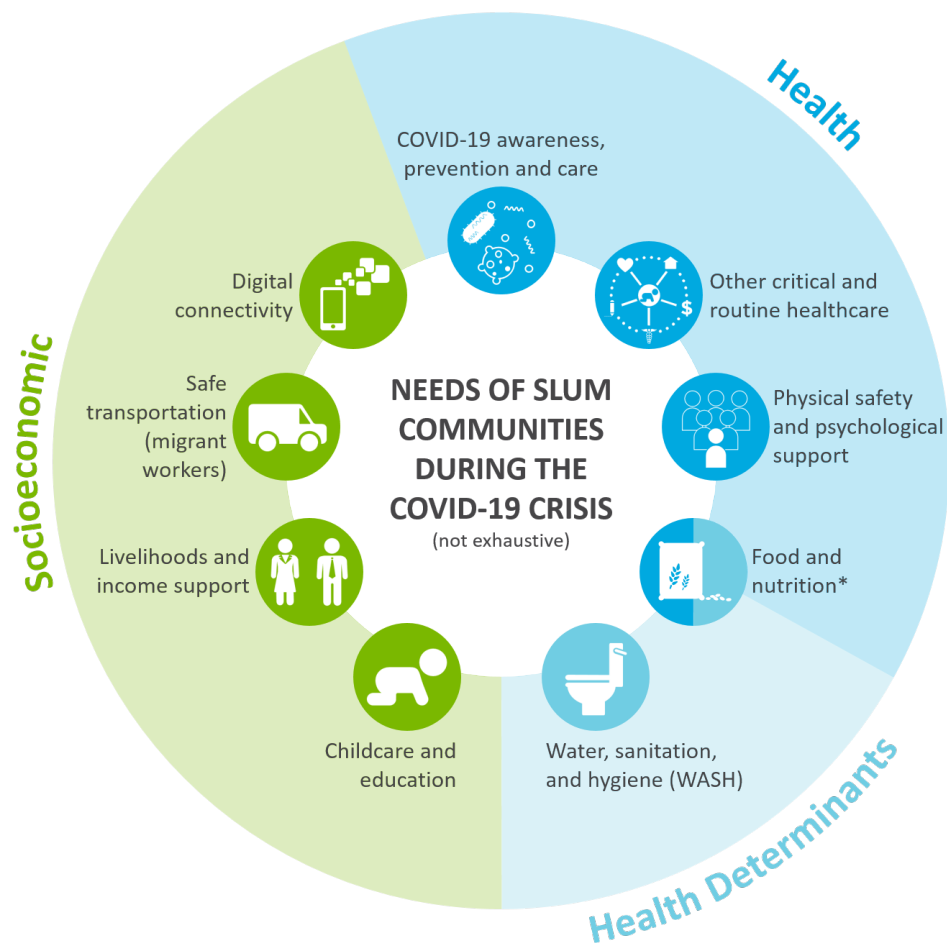
Note: *Food and nutrition is considered a health determinant. Nutrition falls under the Ministry of Women and Child Development, which coordinates with the Ministry of Health and Family Welfare.
Source: The Bridgespan Group

[27] Momali Banerjee and Sarojini Pradhan, "Raising a stink," *India Development Review,* 2020, https://idronline.org/ground-up-stories/raising-a-stink/.
[28] Anastasia Papadimitriou, "Mumbai's Slums: The Positives and Negatives," *The World Mind,* Mar 1, 2019, https://www.theworldmind.org/home/2019/3/1/mumbais-slums-the-positives-and-negatives.

Third, **building trust with communities can improve their adoption of and compliance with services.** Unfortunately, in these slums as with elsewhere, there is a social stigma and fear associated with COVID-19.[29] Thus, it is important to build trust with communities, so that individuals feel comfortable disclosing their health symptoms and conditions. Promoting healthy behaviors relies on trust in health systems, and especially in care providers. Community members in Dharavi were initially scared to come forward with health issues; for example, until the BMC partnered with local doctors whom community members knew and trusted. Kiran Dighavkar, the assistant municipal commissioner at BMC, who is leading the COVID-19 response in Dharavi, shares his experience that, "None of this [Dharavi's ability to curb the spread of the virus] would have happened without gaining the community's trust." In another example, isolation centers in slums across Mumbai were concerned about how they could support religious rituals during Ramadan, such as the breaking of fasts at sunset. Local authorities ensured they distributed proper meals at appropriate times.[30] These humane initiatives help to build trust and engage with communities meaningfully.

Fourth, involving communities can enable **solutions to be sustained and scaled.** Many slum communities are naturally resourceful. For example, a community volunteer in Rafi Nagar reached out to several NGOs, including the Society for Nutrition, Education and Health Action (SNEHA), to arrange for sanitary napkins when these were in severe short supply during the lockdown. Similarly, several communities proactively solved for their food shortages during the lockdown by partnering with local kiranas (cornershops) and running food kitchens. These activities supported the related efforts of BMC and partner NGOs when the lockdown got extended and several slum communities found themselves short of food and water. Involving communities in the crisis response—from understanding their needs to delivering solutions—can develop more enduring and locally owned approaches.

Areas of Community Engagement

In India, as in most other countries, the government—at the central, state, and local levels—has driven the COVID-19 healthcare response through command and control leadership. Philanthropy and civil society, including community-based organizations, complement and fill gaps in the government's health system capacity, and address wider socioeconomic needs.

Thus, we found three principal activities where slum communities had opportunities to engage in tackling COVID-19: improving awareness and healthy behaviors; delivering services; and informing governance (see Exhibit 2: Areas of Community Engagement on the next page).

[29] Dhwani Pandya and Bhuma Shrivastava, "Mumbai Races to Keep the Virus From Asia's Most Crowded Slum," *Bloomberg*, Apr 6, 2020, https://www.bloomberg.com/news/articles/2020-04-05/mumbai-races-to-keep-the-virus-from-asia-s-most-crowded-slum.

[30] Dhwani Pandya, "How Dharavi, Asia's densest slum, chased the virus has lessons for others," *The Economic Times,* Jun 14, 2020, https://economictimes.indiatimes.com/news/politics-and-nation/how-asias-densest-slum-chased-the-virus-has-lessons-for-others/articleshow/76367313.cms?from=mdr.

Exhibit 2: Areas of Community Engagement

1 Improving awareness and healthy behaviors

Developing and sharing **locally contextualized information** related to COVID-19, including on WASH and health comorbidities; as well as enabling **health-promoting behaviors**

2 Delivering services

Providing **socioeconomic supports** and assisting in **community-level health screening** and **COVID-19 prevention and control services**

3 Informing governance

Informing **policy and government action** on community needs, health systems, and access to public services and entitlements

Source: The Bridgespan Group

Improving awareness and healthy behaviors

As the BMC realized in Dharavi, community leaders, opinion shapers, and peers are often more trusted by slum residents—particularly during times of crisis—than technical experts or the government. Efforts to spread awareness and change behaviors to prevent and contain the spread of COVID-19, therefore, depend on community involvement. That's why communities are active in creating, contextualizing, translating, or disseminating COVID-19-related information that reinforces the need to wear face masks, regularly wash or sanitize hands, and participate in health screenings. Communities are also disseminating information about essential health and other social services, such as nearby hospitals or health centers, food distribution sites, and safe transportation options.

Consider SNEHA, an NGO that is working with religious leaders in Dharavi, Govandi, and Malvani, to announce over loudspeakers after prayer times about COVID-19 prevention, symptoms, and control. ARMMAN, another NGO, is sending automated voice recordings of COVID-19-related information to mothers in their database and exploring two-way communication through WhatsApp. Our conversations with community leaders suggested that slum communities are more likely to believe and accept information relayed by religious leaders and others with whom they have strong informal ties, rather than external actors, who are of10Moreover, religious influencers have a good pulse on the personal motivations and fears of their fellow community members, and can communicate COVID-19-related messages that more effectively drive adoption and behavior change. "If the community's *Maulana* (religious leader) tells [the community] something, people listen and respect his guidance," shared a community volunteer in Govandi. NGO partners and the government shared with us that these locally grounded strategies (imparted in the local language) lead to better compliance among slum residents in wearing masks and practicing hygiene, and also helps in identifying potential COVID-19 cases based on reported symptoms.

Delivering services

The government delivers the bulk of COVID-19 health services, but the already-stretched public health systems in urban slums have been further strained by the pandemic. Several NGOs and community groups have repurposed their work to support health services, such as COVID-19 screening, contact tracing, and home-based care and management of mild or moderate cases. Consider community health workers in Dharavi who have supported contact tracing, and community-based women's self-help groups that have manufactured personal protective equipment (PPE). Additionally, community groups are participating in addressing socioeconomic needs. For instance, community volunteers are working with NGOs such as CORO India, Praja Foundation, and Apnalaya to package and distribute food ration kits across Mumbai slums. Arun Kumar, CEO of Apnalaya, spoke of the important role of community in

mobilizing COVID-19 response efforts: "The 15 slum clusters [we work in] are divided into 266 lanes, and each lane has 2-3 community leaders who support the smooth communication and organization of operations on the ground." In another example, Swasth Foundation is working with slum communities to identify patients with chronic and acute health conditions and providing in-person consultation, telehealth, and medication services. A representative from Swasth Foundation shared that working closely with community members helps to streamline their delivery of services so that the households in most urgent need are helped before others.

Informing governance

Slum communities are coming together to identify and voice their critical unmet needs—such as better health facilities—to influence and inform local government action and policies during the pandemic. Some of the other needs that slum communities across Mumbai have raised to the local government include food and water for migrant workers who do not have locally addressed ration cards, cash transfers to support their loss of livelihood, routine health services (e.g., immunization, essential medicines), and sanitary napkins.

Communities rely on local leaders with political support and influence to inform government action on these pressing and sometimes life-critical issues; alternatively, they form groups or collectives to amplify their voices. NGOs sometimes facilitate the growth of community collectives by investing in their formation and skill-building. However, the NGOs reduce their involvement over time to typically providing resources to the collectives, thereby allowing the groups to lead their own change efforts. For instance, civic action groups in Shivaji Nagar are partnering with Apnalaya to demand better public food distribution during the lockdown. Community collectives across several slums—with the support of organizations such as CORO India, Youth for Unity and Voluntary Action (YUVA), or Tata Institute of Social Sciences (TISS)—are asking the BMC for better access to water and sanitation. "Our theory of change is to make the communities change makers—we support the agendas decided by the community. I think that is what has allowed us to succeed, albeit it does take time," shared Roshni Nuggehalli, executive director at YUVA. Community members voice that the pandemic has exacerbated their unmet needs such as clean water and waste disposal. In these times, it is more important for them to come together and influence local government to make these facilities accessible.

Community Engagement Models

We identified different models for how slum residents individually and collectively are getting involved during the COVID-19 crisis. The community engagement models describe the roles that these communities are playing in the pandemic response: as **recipients,** as **partners,** and/or as **owners** (see Exhibit 3: Community Engagement Models). These three models are not discrete classifications; rather, the same community might flexibly assume different and multiple positions across the spectrum of roles, depending on the need at hand, the specific COVID-19 activity, the capabilities and resources of the community, and the role of government or partner organizations. In addition, there is a time dimension to these roles: community engagement could shift toward owners as their experience grows over time, or equally shift toward recipients in times of crisis, as is happening during the pandemic and strict lockdown.

Exhibit 3: Community Engagement Models

Increasing community participation

Recipients

Community members **receive essential products and services**, as determined, designed, and provided **by external stakeholders**. There is minimal active participation by the community

Partners

Community members are **closely involved in identifying collective needs, co-creating solutions** with interested stakeholders, and **supporting implementation.** Communities share decision making and accountability with external stakeholders

Owners

Community members **solve their own problems with minimal external support** and resources, as needed. Communities are primary decision makers and hold accountability

Source: The Bridgespan Group

The agency and voice of communities varies across these three models, in terms of how actively the communities are involved in identifying needs, designing and implementing solutions, and where possible, being accountable for results. As the terms suggest, the community's agency and contributions become more enhanced as they transition from recipients to owners. Many times, particularly during a pandemic, the community does not on its own determine its role. The relevance and success of each model depends on the specific circumstances of the situation, and there is no universally held best model. We summarize the three models below, elucidated with examples across Mumbai slums. More detailed profiles of the models are provided in the Appendix.[31]

Communities as Recipients

COVID-19 and the lockdown have challenged the basic needs of otherwise thriving slum communities. Many have lost jobs and, with negligible savings and no social security, have no means to purchase food. The pandemic created an urgent need for external stakeholders to address the basic and critical needs of slum residents such as food, water, healthcare, and other essential services. That's why communities as recipients—when community members are mainly passive recipients of essential services provided by the government or NGOs—was the most common model as the pandemic initially took hold.

For instance, in the desperate initial weeks of the lockdown in March 2020, BMC supplied 24,000 packets of dry rations and 19,000 food packages to containment zones in Dharavi every day.[32] NGOs also stepped in to help. For example, Swasth Foundation and Praja Foundation are providing dry ration kits in the slums, with community volunteers helping with packaging and distribution. Project Mumbai and

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[31] Examples and profiles of community engagement models detailed in Appendices II and III.
[32] Sanjana Bhalerao, "Episode 922: The controversial India-China statements, Dharavi's COVID-19 model, encounters in J&K," *3 Things (podcast), The Indian Express*, Jun 22, 2020 https://indianexpress.com/audio/3-things/the-controversial-india-china-statements-dharavis-covid-19-model-encounters-in-jk/6470088/.

SNEHA are offering mental health and crisis helplines, respectively. ARMMAN is conducting free virtual outpatient treatments for mothers and children, and TISS is offering telemedicine consultation.

Our study suggests that, within this model, slum communities are not always entirely passive even if an external stakeholder is the primary driver of the activity. In select cases, communities may provide input on their needs through surveys and the like, and/or volunteer support to improve the reach of essential services to all residents. For instance, Aajeevika Bureau interviewed employees of small businesses who live in slums and had lost their livelihoods, so they could design programs that provide them with financial help or loan access. But in this model, it primarily falls upon the government, funders, or NGO partners to assess community needs, design and implement solutions, and be accountable for results. While the Recipients model works for emergency relief, our interviewees were unanimous that this approach is neither sustainable nor empowering for communities to continue beyond the lockdown. "Large NGOs have consciously started reducing relief efforts for dry rations and cooked meals. We have been able to make great progress with help from communities, but the dependence of slum communities on NGOs for essential needs is not sustainable in the long term," said Shishir Joshi, the CEO of Project Mumbai.

Communities as Partners

The Partners model is underscored by strong collaboration between the community and the external stakeholder(s), which may include governments, NGOs, donors, or other invested parties. The community plays an active role in identifying its needs, co-creating solutions, and contributing to implementation. The collaborative work of SNEHA and community action groups (CAGs) in the slums of Dharavi, Govandi, and Malvani to coordinate COVID-19 response efforts exemplifies the Partners model. SNEHA has been supporting health activities in these slums since 1999. Over the years, SNEHA has created and trained a cadre of community volunteers, the CAGs, who serve as a link between the community and public health services, and encourage community members to improve their health-seeking behavior. During the pandemic, SNEHA and the CAG volunteers are working together to support the communities' needs. CAGs are also playing a critical role in the food ration drive arranged by SNEHA, by identifying families with the most acute needs and coordinating distribution of rations. Similarly, these CAGs have also supported the food distribution drives of local government authorities by managing crowds and identifying eligible beneficiaries.

In addition, the BMC is being supported by these CAGs in Malvani to identify positive COVID-19 cases, because it is challenging to track and locate all infected cases in densely populated slums with migrating populations. The CAGs also assist those infected so they can self-isolate and receive treatment, while ensuring their confidentiality to prevent any social stigma. They provide SNEHA's staff with regular updates on pregnant women who test positive for COVID-19, so SNEHA can counsel and support them.

Our conversations with both SNEHA and CAG members suggest that their partnering is working effectively largely for two reasons. First, the active role and input of the CAGs has enabled SNEHA to draft COVID-19 awareness, control, and prevention messages in local languages that are easy to understand, contextualized, and acceptable to the communities. One CAG member noted that often health awareness messages are complicated and technical, which makes them difficult for communities to understand or to take action. Second, CAGs have enlisted the help of hyper-local community actors like rickshaw drivers and faith leaders to deliver these messages in an understandable way from sources that are trusted by families. (We describe this community partnership model in more detail in Appendix III (B).)

We heard from stakeholders that this model has been difficult to implement during the COVID-19 lockdown, because mobility restrictions limited community interactions and external supplies. However, organizations such as SNEHA, which have preexisting, strong, and trusted relationships within slums as well as local government support, have still been able to leverage community input and partnerships to

address the community's pressing COVID-19 needs in a timely and effective manner. "Due to the lockdown, SNEHA's staff have not been able to come, so volunteers in the community are stepping forward to support awareness generation and ration distribution," shared a community volunteer in Malvani. Further, it was SNEHA's assistance in the formation and training of these community cadres over the years that facilitated effective partnering for the pandemic response.

Communities as Owners

In this model, community members identify their own needs, design and implement solutions largely independently, and seek external support only where there are gaps in local resources or expertise. Members of Malvani Yuva Parishad—a youth collective in a non-notified slum called Ambujawadi— operate autonomously on a day-to-day basis to address the needs of their communities. During the pandemic, the youth collective is mobilizing resources to address the most urgent needs of its neighborhood. Another woman's collective in Ambujawadi focuses on identifying and addressing needs pertinent to women in the slum.

The need for resources from external stakeholders has understandably increased during the pandemic. Still, collectives such as Malvani Yuva Parishad have proved effective in catering to unmet community needs—for example, by manufacturing masks, operating community kitchens, providing psychological peer support, and seeking better public services from the government. We also learned of similar collectives in Appa Pada and Ambedkar Nagar slums that have been able to convince the government to provide access to clean water, sanitation, and waste disposal services by writing letters and sending tweets to local businesses and government authorities for these essential, health-determining services. (We describe these efforts in more detail in Appendix III (A).)

Many of those collectives were nurtured by YUVA well before the COVID-19 crisis. YUVA has been facilitating the formation, and building the capacity, of people's collectives – including the two mentioned—in the non-notified slum communities of Mumbai since 1984. YUVA trains community collectives over the first six to eight months of their establishment on skills such as critical thinking, conflict management, negotiation, knowledge of citizen's rights, and entitlement benefits through workshops, training sessions, street plays, and film screenings. Once the collective is operational, it defines and executes its own agenda, and YUVA helps with resources and funds in case of need. Over time, these collectives function independently and solicit external help, only as and when needed. The women's collective, for instance, identified the need for sanitary napkins in Ambujawadi during the lockdown, and reached out to multiple grassroots NGOs to obtain and distribute them to women throughout the community.

This is important because our conversations with the collectives and YUVA suggested that while some collectives have remained dynamic and effective during the pandemic, others have been rendered dysfunctional because of the socioeconomic and health-related stresses on its members. Collective members attribute their ability to mobilize resources and lead COVID-19 response initiatives to the training and other capacity-building exercises that YUVA provided.

However, the Owners model is not common in slums even in normal times, and the multifaceted pressures imposed by the pandemic have made it all the more difficult for this approach to thrive. Moreover, organizations such as YUVA and the Society for the Promotion of Area Resource Centers (SPARC), which endorse and invest in these models, state that the power dynamic between those with resources and the communities they work in often may not allow for communities to be empowered and self-reliant if external stakeholders feel a loss of control or do not fully trust the communities.

Where functional, the Owners model supports community resilience—its capacity to bounce back from external shocks and stresses. Some of the factors that enable its success include strong peer networks, high social capital, and trusted influencers in the community, such as respected leaders, organized collectives, and a culture of mutual aid. Building these structures in resource-poor settings

such as slums takes effort and investment by all stakeholders involved and over many years, our interviewees point out. YUVA, SPARC, and Aajeevika Bureau note that slums that lack social cohesiveness and community groups—especially several of the non-notified, temporary settlements—are struggling to combat the pandemic.

Lessons Learned

Our rapid study of the COVID-19 response in the Mumbai slums focuses on the areas and role of community engagement. We learned several lessons that could be applied to inform policy and action for crisis response in resource-poor settings, to strengthen primary health systems in urban slums, and more generally, to build local slum communities' resilience to shocks such as the pandemic. As seen in Dharavi, where over 2,500 total cases had been recorded but only 142 active cases remain as of July 23, 2020,[33] the coronavirus has, as of that date, been reasonably well-controlled due a collaborative and coordinated effort across government, local NGOs, and the communities.[34]

Our study reveals the high degrees of dynamism and flexibility in the roles played by Mumbai's slum communities as well as other partners supporting the government in the COVID-19 response. The pandemic and lockdown context, where community needs are changing at a rapid pace and stakeholders are continually evolving their strategies to manage the situation, compounds the complexity of community engagement models. We see that communities across slums and other stakeholders have nimbly repurposed their programs to serve a range of urgent needs, are innovating to provide localized solutions, collaborating extensively to improve efficacy, and correcting course as needs evolve.

Policymakers, as well as stakeholders who work in slums and other densely populated low-income settlements, might benefit from understanding these overarching themes on engaging communities, especially during times of an epidemic or other crises or disasters:

The socioeconomic characteristics of a slum influence its community engagement. The legal, political, and physical characteristics of a slum, as well as the social capital of its residents, determine a community's vulnerability to the pandemic and the extent of its engagement in the response and recovery. Notified slums such as Dharavi house largely permanent settlements, where many residents own their homes and have strong formal and informal networks within the community. These factors have played an important role in mobilizing the community's efforts during the crisis. "Slum residents have their own formal and informal networks which they build over time and lean on in times of need," says a community volunteer in Rafi Nagar. The BMC and NGOs such as SNEHA are partnering with the cadre of community volunteers and leaders in Dharavi to assist the residents with essential public services, socioeconomic supports, and COVID-19 health supports. Also, Dharavi's relatively better infrastructure—in terms of WASH and health facilities—and its political capital enabled its communities to come together on issues beyond their basic survival needs to address promoting healthy behaviors and creating hygienic quarantine facilities for COVID-19 patients and suspected cases. We found that several non-notified slums in Mumbai such as Ambujawadi and Ambedkar Nagar with poorer infrastructure and limited economic means have depended on external support for basic sustenance as well as for disease management. The Recipients model is common and persists in these areas.

Community roles often shift during shocks such as pandemics. In the COVID-19 pandemic, economically thriving and engaged slum communities, such as parts of Dharavi, have become recipients of food and basic services as well as psycho-social supports such as mental health and crisis counselling. On the other hand, some slum leaders and residents in Dharavi are taking proactive and lead roles in

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[33] "Mumbai: 6 new Covid-19 cases found in Dharavi; tally rises to 2,513," *Times of India*, July 23, 2020, https://timesofindia.indiatimes.com/city/mumbai/6-new-covid-19-cases-found-in-dharavi-tally-rises-to-2513/articleshow/77129687.cms.

[34] Purva Chitnis, "Success of Your Efforts: Uddhav Thackeray on Dharavi's COVID Fightback," *NDTV*, Jul 11, 2020, https://www.ndtv.com/india-news/coronavirus-success-of-your-efforts-says-uddhav-thackeray-on-dharavis-covid-19-fightback-2261137.

supporting BMC with health screening, contact tracing, and sharing COVID-19 prevention measures in the community. This suggests a high degree of flux in community roles and engagement models during crises—where erstwhile strong communities may slip into becoming recipients, or alternatively step up to innovate and lead local response initiatives. For example, Aajeevika Bureau provides food relief with YUVA to slum communities in Khairani Road, but in Tilak Nagar, community volunteers are collaborating directly with local grocery stores for food distribution in nearby slums. To be sure, we recognize that, given the still-rising incidence of COVID-19 and the precarious living conditions of these slums, community conditions and engagement could easily slide in either direction as needs, resources, and circumstances change.

Roles of stakeholders continuously adapt as community needs evolve. As mentioned, the three community engagement models prevalent in the Mumbai slums during the pandemic are not independent or discrete approaches. Depending on factors such as slum characteristics (as noted above), the specific COVID-19 response activity, and support from external stakeholders, different models can coexist within and across slums, and different external actors serve, partner with, or enable communities, as appropriate. "The initial issues [due to the lockdown restrictions] in [M East ward] have been loss of livelihood, poor access to food, and lack of non-COVID-19 healthcare services. So we provided for and partnered with those communities to solve these issues. These issues, however, might change over time, and our response to them will as well," said Amita Bhide, dean, School of Habitat Studies from TISS. In the M East ward slums, TISS is both partnering with local slum communities for better sanitation facilities, and supporting community leaders who are operating their own food supply response. TISS is also serving slum communities in Govandi and Shivaji Nagar with telemedicine and mental health helplines. TISS therefore exemplifies the different roles an NGO can play across the community engagement models within and across slums, depending on the needs and context of these communities. TISS' responsiveness to slums in need highlights the evolving nature of community engagement and demonstrates how to adopt a flexible yet agile approach to working with communities on COVID-19 efforts.

Communities, even in crisis, are keen to script and own their development. Our interviews of community volunteers and leaders, and NGOs working in the Mumbai slums were unequivocal that communities wish to retain or regain their autonomy, and most importantly, their dignity and self-reliance for survival and development. Community coordinators said that they were "proud" of their ability to address the needs of their fellow residents. "Food is of course a problem, but residents with savings have stepped forward to feed their neighbors. Another problem is that people are struggling to find jobs, so we are seeking a classified jobs board which could tell us where jobs might be available," said a community volunteer in Shivaji Nagar. In the Partners and Owners models, we also see some slum leaders and community collectives take proactive and lead roles in advocating with local government for essential amenities, COVID-19 awareness and behavior change activities, and delivering some basic services. NGOs also mentioned that while government is the central agency in the COVID-19 health response, partnering with communities has enabled more effective relief, response, and recovery.

Social capital, cohesiveness, and capacity building enable greater community engagement. We found the Owners and Partners models primarily in slums with strong peer-to-peer bonds, community cohesiveness, and social ties—underscoring the importance of social capital for community engagement. For example, despite their poor economic and human development indicators, slums such as those in the M East Ward that have strong social networks and previously formed collectives have partnered with NGOs as well as led and owned aspects of the COVID-19 response, such as when they set up local community kitchens and distributed sanitary napkins early in the pandemic. NGOs such as SNEHA and YUVA that have spent time building trust and relationships in slums are able to partner with and enable communities for the response initiatives. These NGOs attest to the importance of investing in capacity building of community groups. SNEHA, YUVA, and SPARC have historically focused on forming community collectives and building their skills and capabilities by training them on such topics as community mobilization and citizens' rights to enable them to lead their development agenda and

independently design and implement community solutions. These collectives have emerged as strong change makers during the pandemic, when it has become challenging for external parties to enter slums because of mobility restrictions and other lockdown measures. A community coordinator in Govandi said that she independently reached out to about 15 NGOs in early May with a categorized list of the community's needs that included food items, sanitary napkins, and essential medicines, so that they could mobilize resources as soon as possible.

We hope that these lessons are instructive to stakeholders working or aspiring to work with slum communities. This rapid study, conducted during the pandemic, highlights a few points that can help guide community engagement for the COVID-19 response and beyond. First, a deep understanding of the slum's historic and current context as well as its community characteristics—geographic/physical, legal, economic, and socio-cultural—are instructive when developing response strategies and implementation approaches. Second, approaches that are flexible can better adapt to a slum community's evolving capabilities. Roles can shift significantly during crises; deploying different community engagement models for different needs and response activities might be needed, both within and across slums. Third, communities generally have a mindset of dignity and self-reliance that should be respected. Investing in building skills and peer networks is one way to be sensitive to that mentality. Fourth, empowering and enabling slums to own their development agenda, providing external assistance and resources only as required, can enable recovery and build resilience.

Conclusion

COVID-19 has presented us with daunting and unprecedented challenges, and slums have been disproportionately impacted. The immediate, animating response is dominated by external stakeholders providing slum communities with basics such as food, water, sanitation, and essential healthcare. Hence, at the outset, the Recipients model emerged as the most prevalent model in tackling the pandemic in the slums, especially during the stringent lockdown period.

As economic activities gradually resume, slum populations will need to regain agency over their futures. In the immediate term, engaging and partnering with them in promoting healthy behaviors including preventative and promotive care (e.g., wearing face masks and washing hands), and regular health screening for COVID-19 or other disease symptoms, is critical. While behavior change has historically been arduous and time consuming, the pandemic presents an opportunity to rally the communities' efforts toward healthier behaviors through awareness building, peer-driven change, and locally grounded initiatives. As our study shows, external stakeholders could serve, partner, and enable the slum communities for this change.

In the medium to longer term, inclusive development requires slum communities to be resilient and script their own progress. In the Owners model, communities develop and drive their agendas, and funders, NGOs, and governments support and strengthen their efforts. To be feasible, this model requires reimagining and investing in more humane physical spaces and infrastructure that can deliver, at a minimum, essential public and social services in health, water, sanitation, and education in the slums. It also calls for more participatory governance that is equitable for slum dwellers. While the pandemic has cast a spotlight on the yawning gaps in these services, our study shows that it has simultaneously sparked community partnership and leadership in voicing and addressing these gaps, for example, by seeking better WASH and accessible health facilities and services from the local government.

Multifaceted as these challenges are, if these basic infrastructure as well as community engagement approaches are strengthened as the pandemic eases, Indian slums may bounce back stronger. Unlike past "interventions," an inclusive and respectful approach to participatory development will empower slum dwellers and likely lead to lasting, positive change.

About the Authors

Pritha Venkatachalam is a partner and Niloufer Memon is a manager in Bridgespan's Mumbai office.

Acknowledgments

Appendices

I. Overview of Wards with Large Slums in Mumbai

		① DHARAVI	② GOVANDI	③ MALVANI
	Notable slum			
	Geography (Ward)	G/N (Dadar)	M/E (Mankhurd)	P/N (Malad)
	Notified by SRA Mumbai[2]	Yes	Yes	Yes
Population & density	Slum population (% of ward[6]*)	10L[3] (60%)	5L[4] (85%)	4L[5] (75%)
	Population density (per sq. km)[7]*	67K	25K	21K
Access to health	No. of government hospitals[8]*	0	1	3
	No. of government dispensaries[8]*	10	9	11
Economy	Industry	Leather, textiles, pottery, recycling[9]	Service jobs, rag pickers, daily wage earners[10]	Service jobs, tailoring, business[10]
COVID-19 case load	Positive cases from slums[1^]	246	170	497
	Total positive cases[1*†]	5,550	3,481	5,695
	Active cases[1*†]	1,319	673	2,044
	Deaths[1*†‡] (Mortality Rate[1#])	402 (7.2%)	278 (7.9%)	223 (3.9%)
	Doubling days[1*†]	66	79	38
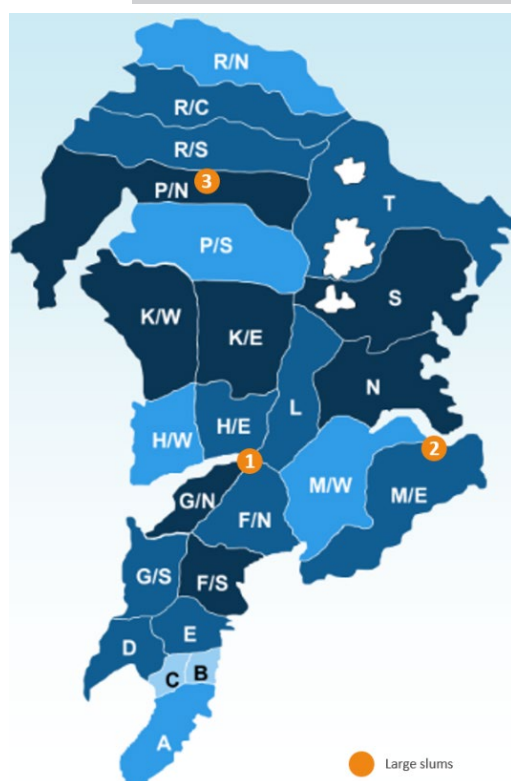
Note: Information on slums across Mumbai is sparse and rapidly changing. We have compiled this data by synthesizing multiple sources, particularly for population and density. Data on slum population as a percentage of the ward, population density, access to health metrics, and COVID-19 case load metrics (excl. positive cases from slums) are at the ward level. *At the ward level, of which the slum is a part. ^Between Jun 3 – Jul 11, 2020; †As on Jul 11, 2020; ‡ Deaths = Total positive cases – active – discharged; #Mortality rate = Deaths/Total positive cases

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2. Slum Rehabilitation Authority, "List of Slum Cluster," 2015, https://sra.gov.in/upload/Listofslumcluster2015.pdf.
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4. Fight Foundation Hunger, "Assessment of Nutrition and Mortality within the Slum Pockets of Govandi – Mumbai," 2015, https://www.actionagainsthunger.in/sites/default/files/images/special-page/SMART_Survey_i.pdf.
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6. Brihanmumbai Municipal Corporation, "Census 2011 FAQ and Answers,"
https://portal.mcgm.gov.in/irj/go/km/docs/documents/MCGM%20Department%20List/Public%20Health%20Department/Docs/Census%20FAQ%20%26%20Answer.pdf.

7. Bridgespan analysis; population of ward as per Brihanmumbai Municipal Corporation, "Census 2011 FAQ and Answers,"
https://portal.mcgm.gov.in/irj/go/km/docs/documents/MCGM%20Department%20List/Public%20Health%20Department/Docs/Census%20FAQ%20%26%20Answer.pdf; area of ward as per Brihanmumbai Municipal Corporation, "Mumbai City Map,"
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https://www.praja.org/praja_docs/praja_downloads/Report%20on%20The%20STATE%20of%20HEALTH%20in%20MUMBAI.pdf.

9. Yardley Jim, "Dharavi: Self-created special economic zone for the poor," *Deccan Herald*, Jan 2, 2012,
https://www.deccanherald.com/content/216254/dharavi-self-created-special-economic.html.

10. All India Institute of Local Self Government, "Action Research for Inclusive Development of Selective Locations in the City of Mumbai (Part – 1)," 2013, https://mdd.maharashtra.gov.in/site/upload/pdf/minority_part_I_final_report.pdf.

II.   Examples of Community Engagement Models

Recipients	Partners	Owners
Community receives services from external stakeholders	Community and external stakeholders work together	Community leads, with as-needed support from external stakeholders

Recipients

- Distribute food/dry rations

- Disseminates COVID-19 information
- Conducts free virtual OPDs* for mothers and children

- Provides hygiene supplies through grassroots NGOs
- Offers mental health helplines

- Offers a crisis helpline for gender based violence
- Manages a counselling and treatment center for sexually abused women at KEM hospital

- Provides telemedicine consultation for community
- Sends educational activities to children in the community through WhatsApp

*OPDs: paediatric outpatient departments
Note: Descriptions sourced from organization websites and interviews.
Source: The Bridgespan Group

Partners

- Community identified need for transport facilities for migrants, the organization facilitated options

- Civic action groups partner with the organization to build awareness

- Communities and the organization partner to influence government action for better sanitation facilities
- Women's groups partner with the organizations to manufacture masks

- Religious leaders, auto drivers spread awareness in partnership with the organization

- Communities highlight need for better sanitation facilities and partner with the organization to influence government action

Owners

- Community members collaborate with local 'kiranas' to provide food relief
  - Aajeevika Bureau supports them by meeting the cost of rations

- Community members run community kitchens and distribute sanitary napkins
  - TISS supports them with supplies like rice, *dal* (pulses) and spices
  - BMC mobilized donations of sanitary napkins from corporates and provided transport support

- Community collectives identify and solve for diverse needs (e.g., food relief, access to water and toilets)
  - YUVA builds capacity for and empowers these groups to lead change efforts

III.   Community Engagement Model Profiles

A. Communities as Owners

Supported by Youth for Unity and Voluntary Action (YUVA)

Slums covered

YUVA works in the non-notified slums of Mumbai, including Ambujwadi, Ambedkar Nagar, and Appa Pada. These slums are not legally registered, and have previously not had legal access to government facilities and entitlements such as water, sanitation, and metered electricity. Residents in Ambujwadi and Ambedkar Nagar share toilet facilities with thousands of other residents and have no or limited access to the city's water supply. The inadequate and shared WASH infrastructure has contributed to the increasing COVID-19 caseload in these communities.[35]

Community engagement model

YUVA has facilitated the formation and built the capacity of people's collectives, including women's and youth collectives, in these non-notified slum communities since 1984. The organization trains collectives over the first six to eight months on skills such as critical thinking, conflict management, negotiation, knowledge of citizen's rights, and entitlement benefits through workshops, training sessions, street plays, and film screenings. Once the collective is active and functional, it defines and executes its own agenda, and YUVA helps with resources and funds in case of need.[36]

COVID-19 activities

Improving awareness and healthy behaviors

- Youth collectives in Ambedkar Nagar have led workshops and door-to-door awareness campaigns on the nature of the coronavirus and COVID-19 prevention measures.

Delivering services

- *Malvani Yuva Parishad* (Malvani Youth Council)*, a youth collective in Ambujawadi, started the #FightAgainstHunger initiative, raising funds and gathering support from NGOs. They distributed 10,000 packets of *upma* (semolina) and *poha* (flattened rice), and 1,500 packets of pasta, to families adversely affected by the crisis.
- In Ambedkar Nagar, a group of youth reached out to YUVA and five other organizations to secure food supplies for the 5,000 families residing there.

Informing governance

- In Appa Pada and Ambedkar Nagar, communities have focused on influencing governments to provide access to clean water, sanitation, and waste disposal services by writing letters and tweets to local businesses and authorities. This resulted in BMC disposing 10 tons of waste—which had been piling up for several months—in a single day, and weekly cleaning and sanitization, including of community toilets. Local governments have also set up dedicated helplines to resolve grievances faster.

Lessons learned

Non-notified slums face severe infrastructure issues and are arguably among the most disadvantaged communities in terms of access to basic public goods and services. In the face of COVID-19, well-

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[35] Sudhir Suryawanshi, "Community toilets main reason behind the rise of corona virus cases in Mumbai: BMC," *The New Indian Express,* May 3, 2020, https://www.newindianexpress.com/cities/mumbai/2020/may/03/community-toilet-main-reason-behind-the-rise-of-coronavirus-cases-in-mumbai-bmc-2138756.html.
[36] Information sourced from interviews and YUVA's website, https://yuvaindia.org/.

established and trusted community collectives in these slums are leading from the front in identifying and delivering needs faced by residents, including by influencing local government action and by mobilizing additional resources. YUVA supported the formation of these people-owned structures and invested in them over decades to build their capacities, skills, and knowledge. The resilience and initiative of the youth and women's collectives in these slums have been central to the rapid and locally contextualized COVID-19 response.

B. Communities as Partners

Supported by Society for Nutrition and Health Action (SNEHA)

Slums covered

SNEHA has been working in Dharavi, Malvani, and Govandi, some of the largest and densest slums of Mumbai, since 1999. Each slum is distinct and heterogeneous, across factors such as socioeconomic fabric, cultural dynamics, and prevalent sources of employment. For example, Dharavi has a vibrant economy driven by leather and textiles,[37] while Govandi and Malvani are dominated by daily-wage earners and those in service jobs.[38]

Community engagement model

SNEHA has created a cadre of community volunteers known as community action groups (CAGs). The CAGs are a link between the community and public health services; they encourage community members to improve their health-seeking behavior. For example, the volunteers identify pregnant women in the community and refer them to SNEHA or public health systems for antenatal care, and also ensure they take iron/folic acid tablets regularly. SNEHA provides technical and leadership training to the CAGs, and empowers them to identify needs and take action, such as approaching health posts and local authorities to demand for services and support. While CAGs work autonomously under normal conditions, SNEHA and CAG volunteers have worked mostly in partnership to support the communities' needs in the pandemic. SNEHA deployed some initiatives directly, such as its crisis helpline for gender-based violence and a one-stop center for counselling and treatment of sexually abused women at KEM Hospital.[39]

COVID-19 activities

Improving awareness and healthy behaviors

- CAGs have been trained remotely to disseminate information on risks of, and prevention measures for, COVID-19. They are equipped with communications materials about preventative and health-seeking behaviors. CAGs disseminate this information through WhatsApp and phone calls to slum residents.
- In Malvani, SNEHA and CAG volunteers have approached religious leaders, such as the *Maulanas* of local mosques, to make announcements asking people to adhere to COVID-19 prevention measures. Comprehensive messages are broadcast as part of public announcements during religious gatherings in local languages such as Urdu.
- As part of an "Awareness on Wheels" initiative across slums, volunteers are spreading COVID-19 related information in the community through loudspeakers fitted on auto rickshaws. In areas where these rickshaws cannot reach, volunteers use public announcement systems to play the recordings.

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[37] Yardley Jim, "Dharavi: Self-created special economic zone for the poor," *Deccan Herald*, Jan 2, 2012, https://www.deccanherald.com/content/216254/dharavi-self-created-special-economic.html.

[38] All India Institute of Local Self Government, "Action Research for Inclusive Development of Selective Locations in the City of Mumbai (Part – 1)," 2013, https://mdd.maharashtra.gov.in/site/upload/pdf/minority_part_I_final_report.pdf

[39] Information sourced from interviews and SNEHA's website, https://snehamumbai.org/.

- Between April and June 2020, over 29,000 calls had been made to beneficiaries, and 20 local Masjids had made close to 600 announcements. In addition to this outreach, rickshaws with loudspeakers disseminated messages for 20 hours over two days, reaching almost 16,000 households in the area.

Delivering services

- CAGs have played a critical role in a ration drive arranged by SNEHA, by identifying families with the most acute needs and coordinating distribution. They have also supported the food distribution drives of local authorities by managing crowds and identifying eligible beneficiaries.
- CAGs have assisted municipal health staff in tracing locations of positive COVID-19 cases in these densely populated communities. They verify whether patients have been sent for treatment or not, and update staff on which families have been sent to quarantine facilities and which have refused.
- Particularly in Malvani, CAGs have referred residents to nearby health facilities for routine services such as child delivery, vaccination, and checkups for other illnesses that have been exacerbated by the pandemic.

Lessons learned

Based on the heterogeneous needs of the different slums, SNEHA has drawn on its years of work and partnerships with these communities to collaboratively tackle COVID-19. The CAGs have provided the pulse of each community's needs, and are partnering with SNEHA to develop and roll out localized solutions, including providing essential health and food services, and building awareness of COVID-19. In addition, SNEHA is providing specialized services such as a crisis helpline and supports for abused women.

C. Communities as Partners and Owners

Supported by Tata Institute of Social Sciences (TISS)

Slums covered

The M East Ward, home to over 800,000 citizens,[40] is one of the poorest in Mumbai. It has the lowest human development index (0.05) and a life expectancy of just 39 years.[41] TISS's "Transforming M-Ward" project, which started in 2011, works with vulnerable settlements in multiple slums of the ward, such as Govandi, Shivaji Nagar, Bainganwadi, and Cheeta Camp. The city's largest dumping ground[42] is in the vicinity of these slums and has likely led to the high incidence of drug resistant tuberculosis among its residents.

Community engagement model

The Transforming M-Ward project began with an in-depth socioeconomic survey of the slums in the ward. TISS set up the M-Ward Convener forum as a platform for community leaders and project staff to jointly formulate agendas and set goals, and has also supported the formation and formalization of many community-based organizations (CBOs) in the ward. The forum and CBOs play an influential role in setting and driving the communities' agendas.[43]

TISS engages with communities in a variety of ways. In the context of COVID-19, community leaders are leading various emergency relief efforts, such as setting up community food kitchens and delivering sanitary napkins to women in need, with TISS providing resources. In other instances, TISS is partnering with communities to approach governments for better access to water and sanitation. TISS has also

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[40] Registrar General & Census Commissioner, India, Ministry of Home Affairs, "Census 2011"
[41] Ministry of Housing and Urban Affairs, "Mumbai Human Development Report 2009," http://mohua.gov.in/upload/uploadfiles/files/6Mumbai%20HDR%20Complete.pdf.
[42] Jyoti Shelar, "M East ward records highest COVID-19 fatality rate," *The Hindu*, May 14, 2020, https://www.thehindu.com/news/cities/mumbai/m-east-ward-records-highest-covid-19-fatality-rate/article31578172.ece.
[43] Information sourced from interviews and the TISS website, https://www.tiss.edu/view/11/projects/transforming-m-ward/.

provided direct services like telemedicine consultation and educational activities for children through WhatsApp.

COVID-19 activities

Delivering services

- Recognizing the limited cooking space available in slum households, community members set up five community food kitchens that were able to feed ~6,000 families per day during the lockdown. From identifying locations best suited to distribute rations to managing operations on a rotational basis, volunteers took complete charge. TISS has supported the initiative by supplying rice, *dal* (pulses), and spices.[44]
- When a female volunteer heard concerns in the community about lack of access to sanitary napkins during the lockdown, she collaborated with TISS and the BMC to address this. BMC assisted in sourcing the sanitary napkins through corporate donations and arranged for transport facilities for distribution to slums across Mumbai. Volunteers took charge of the distribution process and supplied over 100,000 sanitary napkins over two days with some support from the project.

Informing governance

- Five or six settlements in M Ward face extreme water supply challenges and inadequate sanitation infrastructure. In these settlements, communities are collaborating with TISS to approach the local government for better access to water. TISS leverages its networks with local governments to ensure that the needs of the communities are communicated effectively. These efforts have increased in light of COVID-19 given the critical need for hygiene and clean and regular water. Their persistent efforts have led to communities receiving water from municipal tankers every other day. Through a similar initiative, water availability was increased by an hour in Annabhau Sathe Nagar. Efforts to influence the government are ongoing in slum areas such as Transit Camp, Bhim Nagar, Cheeta Camp, and Maharashtra Nagar for mobile toilets and water drums.

Lessons learned

This example speaks to the flexibility and dynamism being exhibited by communities, local governments, and other external stakeholders in taking on varying roles depending on the nature and urgency of the need. Similar to the previous profiles, well-established community networks with local leaders, grassroots organizations, and community forums are enabling a coordinated and grounded COVID-19 response. These communities, in partnership with organizations such as TISS, are also playing a central role in informing government action on essential rights and services, such as access to water.

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[44] Information sourced from interviews and TISS' Urban Resources Knowledges (URK) blog, https://theblogurk.wordpress.com/.

IV.   Additional References

In addition to interviews, we conducted targeted research to inform our findings. Additional reference sources beyond those listed in the footnotes of the report are provided below.

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V. Interview Guides

A. Experts

Understanding the impact of COVID-19 in urban slums:

- How are slum dwellers impacted by the **COVID-19 crisis**?
  - What particular areas are **disproportionately impacted** (e.g., higher mortality due to lack of preventive, testing and treatment measures)?
- What **interventions** have been implemented to tackle COVID-19 in slum communities?

Exploring the role of community engagement in tackling COVID-19:

- What are the **different types of community engagement models** that have been implemented in slums? What differentiates different models and which ones work better than others?
- How should we think about **framing/archetyping community engagement models** in the preparedness and response to the pandemic?
  - **External stakeholder-led**: NGO-led, government-led, and hybrid
  - **Community-led (i.e., designed and implemented)**: assessing need, providing input/ feedback on intervention design, designing interventions, implementing interventions
- Are there **organizations** that you have come across that are effectively implementing community engagement models in their interventions?
- What is unique in the way you are engaging communities that **enables results and progress**?

Testing scalability of the model

- What key aspects should we consider when testing the scalability of these models—across urban slums in India and beyond?
  - What are aspects to consider understanding **a slum context** (e.g., formalization of slum, demographics—population and density, poverty indicator, drainage systems and access to WASH, economic potential, local governance and NGO support, health facilities, culture)?
  - What are **conditions that need to be met** when scaling interventions (e.g., homogenous, permanent slum with close community ties)?
- **How** do you think these interventions can be scaled beyond the current geographies including to other countries (e.g., additional funding, training other NGOs or the government, handing over to the community)?
  - What **resources** are required to ensure scalability and sustainability of interventions?
- What are **key success factors and challenges** in ensuring the effectiveness when scaling interventions?
- What are the **opportunities** for improvement/expansion when scaling?
  - Do you think these interventions can be expanded to areas **beyond COVID-19** (e.g., other infectious diseases, primary care)?

B. Implementers

Understanding your organization's COVID-19 work in urban slums and exploring the role of community engagement in tackling COVID-19:

- Which geographies do you currently work in?
  - What are **characteristics of these urban slums** (e.g., formalization of slum, demographics—population and density, poverty indicator, drainage systems and access to WASH, economic potential, local governance and NGO support, health facilities, culture)?
- What are the COVID-19 related health **challenges** that your organization is working to support or address (e.g., prevention, screening, control and management; health systems supported;

food/nutrition needs; mental health and other health conditions) in urban slums—and through what interventions?
- o Why did you decide to work on these particular challenges?
- o What COVID-19 **specific interventions** is your organization implementing to address these challenges?
- o Are there any other actors (e.g., government, other NGOs) working to address these issues?
- What elements of community engagement do your interventions involve?
  - o Did you have a community engagement model **pre-COVID**? If so, how did that trust and engagement help during the pandemic? If not, how did you launch this model for COVID response?
  - o What aspects of previous ways of community engagement **need to change** to work for COVID-19?
  - o How do you **engage the slum community** in the interventions (e.g., identifying needs, designing interventions, implementing interventions, providing input/feedback on interventions)?
  - o What is the role of **different stakeholders** in community engagement (e.g., local government, funders, grassroots organizations, local citizens, others)?
- What **resources** are required to implement these interventions?
  - o How many **staff** do you have on the ground?
  - o Are you working with **any partners** to deliver these interventions (e.g., government, NGOs, private sector players, researchers, etc.)?
  - o How much **money** do you spend on implementing these interventions?
- What has been the **progress/results to date** of these interventions?
  - o How many **people are you reaching** through your COVID-19 interventions?
  - o How do you measure the **success** of interventions?
- What have been the **key learnings** from these interventions?
  - o What is unique in the way you are engaging communities that **enables results and progress**?
  - o What has **worked well** in the implementation of these interventions?
  - o What are the **challenges** in effectively implementing these interventions (i.e., what worked less well)?
  - o What are the **opportunities** for improving this intervention?
    - ▪ What are **key gaps** in terms of the overall COVID-19 response in these slums that can benefit from more support/strengthening?
    - ▪ Do you think these interventions can be expanded to areas **beyond COVID-19 and in the future** (e.g., other infectious diseases, primary care)?

Testing scalability of the model

- Have you **scaled the geographic scope** of the interventions over time—or do you plan to?
  - o What are key aspects to consider when scaling these models?
  - o What are **conditions that need to be met** when scaling interventions (e.g., homogenous, permanent slum with close community ties)?
- **How** do you think these interventions can be scaled beyond your current geographies including to other countries (e.g., additional funding, training other NGOs or the government, handing over to the community)?

C. Community members

Understanding the impact of COVID-19 in urban slums:

- What is your current **understanding of COVID-19**? How has this changed over time?
- What has been yours and your community's **experience of the COVID-19 pandemic**?
- How has the **lockdown** impacted your sustenance and socioeconomic status?

- What is the community's perception of the **support** they have received from governments, NGOs or other external stakeholders?

Exploring the role of community engagement in tackling COVID-19:

- As a community, do you feel **empowered** to implement solutions where you see problems and seek support where required?
    - What support have you **sought** from various stakeholders to mitigate/overcome the negative impacts of the pandemic and lockdown?
    - What support have you **received**?
- How have you or your communities been **engaged by external stakeholders** in the COVID-19 response?
    - Which **government stakeholders or NGOs** have engaged with you?
    - Do you provide **input** on your needs, help **design or implement** solutions?
    - How was this **pre-COVID-19** and how has this changed during COVID-19?
- How would you like to be **engaged** as Mumbai eases out of lockdown?
    - What kind of **products or services** do you believe will strengthen your community's health and socioeconomic status?
    - How do you think you could procure these products and services? Who should be responsible for providing them?

VI. List of Interviewees

Sr. no.	Name	Designation	Organization
1	**Maansi Parpiani**	Senior Consultant, Knowledge and Dissemination	Aajeevika Bureau
2	**Raghav Mehrotra**	Development Executive	Aajeevika Bureau
3	**Chang Liu**	Managing Director for Singapore, Mainland China, and Hong Kong	Access Health International
4	**Tina Ja**	Chief People Officer	Access Health International
5	**Sandeep Singhal**	Managing Director, Nexus Venture Partners	ACT Fund
6	**Mohit Bhatnagar**	Managing Director, Sequoia	ACT Fund
7	**Arun Kumar**	Chief Executive Officer	Apnalaya
8	**Arun**	Community Volunteer, Shivaji Nagar	Contact from Apnalaya
9	**Nasreen**	Community Volunteer, Govandi	Contact from Apnalaya
10	**Swati Saxena**	Director, Resource Mobilization, Communication and New Initiatives	ARMMAN
11	**Carlyle Pereira**	Chief Program Officer	ARMMAN
12	**Gayatri Nair Lobo**	Chief Operating Officer	ATE Chandra Foundation
13	**Hari Menon**	Country Director, India	Bill & Melinda Gates Foundation
14	**Kiran Dighavkar**	Assistant Municipal Commissioner	Brihanmumbai Municipal Corporation
15	**Luis Miranda**	Chairman	CORO India
16	**Sujata Khandekar**	Founding Director	CORO India
17	**Supriya Jaan**	Program Manager	CORO India
18	**Vidya Kumaraswamy**	Program Manager	CORO India
19	**Dr Nerges Mistry**	Director	Foundation for Medical Research (FMR)
20	**Gayatri Divecha**	Associate Vice President and Head, Corporate Social Responsibility	Godrej Industries and Associate Companies
21	**Ziaa Lalkaka**	Head, Corporate Social Responsibility	HT Parekh Foundation
22	**Shobha Shelar Kadam**	Child Development Project Officer, Dharavi	Integrated Child Development Services, Maharashtra
23	**Dr. Saurabh Dalal**	Consultant, Medical Preparedness and Biological Disasters	National Disaster Management Authority
24	**Shreya Deb**	Director, Investments	Omidyar Network
25	**Milind Mhaske**	Director	Praja Foundation
26	**Shishir Joshi**	Chief Executive Officer	Project Mumbai
27	**Vanessa D'Souza**	Chief Executive Officer	Society for Nutrition, Education and Health (SNEHA)
28	**Sushma Shende**	Program Director, Child Health and Nutrition	Society for Nutrition, Education and Health (SNEHA)
29	**Rubina Khan**	Community Volunteer, Malvani	Contact from Society for Nutrition, Education and Health (SNEHA)
30	**Isrid Khan**	Community Volunteer, Malvani	Contact from Society for Nutrition, Education and Health (SNEHA)
31	**Updesh**	Community Volunteer, Mankhurd	Contact from Society for Nutrition, Education and Health (SNEHA)
32	**Sheela Patel**	Director	Society for the Promotion of Area Resource Centers (SPARC)
33	**Sundeep Kapila**	Co-Founder and Chief Executive Officer	Swasth Foundation

Sr. no.	Name	Designation	Organization
34	**Amita Bhide**	Dean, School of Habitat Studies	Tata Institute of Social Sciences (TISS)
35	**Sabah Khan**	Coordinator, Transforming M Ward Project	Tata Institute of Social Sciences (TISS)
36	**Jan Schwier**	Partner	The Bridgespan Group
37	**Rohit Menezes**	Partner	The Bridgespan Group
38	**Willa Seldon**	Partner	The Bridgespan Group
39	**Dr. Soumya Swaminathan**	Chief Scientist	WHO Geneva
40	**Zubin Shroff**	Technical Officer	WHO Geneva
41	**Geetanjali Lamba**	Young Professional, Health Systems Research	WHO Geneva
42	**Dr. Asiya Odugleh-Kolev**	Technical Officer	WHO Geneva
43	**Dr. Saurabh Dalal**	Consultant, Medical Preparedness and Biological Disasters	WHO India
44	**Dr. Sayantan Banerjee**	Technical Officer	WHO SEARO
45	**Rajesh Singh**	Chief Executive Officer	WISH Foundation
46	**Dr. Nachiket Mor**	Health Expert	-
47	**Roshni Nuggehalli**	Executive Director	Youth for Unity and Voluntary Action (YUVA)