Exploring Urban Governance & Social Protection in light of COVID-19 in Mumbai

Part-2

Response of Municipal Corporation of Greater Mumbai to COVID-19

Regional Centre for Urban & Environmental Studies (RCUES) of
All India Institute of Local Self Government (AIILSG), Mumbai
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October/2021

This report presents the findings of a study that was undertaken to explore urban governance and social protection in the light of COVID-19 in the city of Mumbai. It is prepared by the Regional Centre for Urban and Environmental Studies (RCUES) of the All India Institute of Local Self Government (AIILSG), Mumbai with funding from UNICEF. The main objective of this endeavor is to understand the role of the municipal administration and elected representative in delivering services to the marginalized during the COVID -19 pandemic. Part One of the report critically reviewed the existing Urban Social Protection Schemes (USPS) in two selected wards of Mumbai and identified the gaps. Based on the same, preliminary recommendations are made. Part Two documents the outreach of Municipal Corporation of Greater Mumbai (MCGM) in managing COVID-19 in Mumbai with a focus on social protection and highlighting any emerging noteworthy initiatives.

The study collected both quantitative as well as qualitative information. Quantitative information from secondary sources was collected from concerned departments at the State and MCGM levels. Qualitative information was collected via Focus Group discussions (FGDs) and Key Informant Interviews (KIIs) from different state and local level officials, elected representative, functionaries of Non-Governmental Organizations (NGOs), Civil Society Organizations (CSOs), and finally beneficiaries as well as non-beneficiaries in the two selected wards. Data collection involved, both, online consultations as well as extensive field visits.

This was followed by a final 'Stakeholder Consultation' which has representations from UNICEF, senior government officials, elected representatives, subject experts and NGO representatives. The main analysis and inferences of this study was shared with them, and insights generated through this entire process were incorporated in the present report.

This is Part Two of the report. It captures the role of MCGM in delivering services to the vulnerable during the pandemic in the areas of – food, maternal and child health, education and water and sanitation. It also documents a noteworthy initiative in managing COVID-19 in Mumbai.

Acknowledgments

This report is the result of tireless efforts from several individuals who guided and shaped it at various points in its development.

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Municipal Corporation of Greater Mumbai:
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NGO's:
APNALAYA Mumbai, YUVA Mumbai, CACR Mumbai, PRAJA Mumbai, SNEHA Mumbai.

Beneficiaries and non-beneficiaries from G\N and M\E wards.

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Abbreviations

AIILSG	-	All India Institute of Local Self Government
AMC	-	Assistant Municipal Commissioner
ASHA	-	Accredited Social Health Activist
AWH	-	Anganwadi Helper
AWW	-	Anganwadi Worker
BPL	-	Below Poverty Line
CDO	-	Community Development Officer
CHV	-	Community Health Volunteer
CO	-	Community Volunteer
CSO	-	Civil Society Organization
CSR	-	Corporate Social Responsibility
CT	-	Community Toilets
ER	-	Elected Representative
FGD	-	Focus Group Discussion
FPS	-	Fair Price Shop
GIS	-	Geographic Information System
GoI	-	Government of India
GoM	-	Government of Maharashtra
GPS	-	Global Positioning System
GR	-	Government Resolutions
IEC	-	Information, Education and Communication
KII	-	Key Informant Interview
LPCD	-	Litres per capita per day
MCGM	-	Municipal Corporation of Greater Mumbai
MCH	-	Mother and Child Health
NGO	-	Non - Governmental Organization
PA	-	Per Annum
PDS	-	Public Distribution System
PT	-	Public Toilets
PW	-	Pregnant Women
RCUES	-	Regional Centre for Urban and Environment Studies
SHG	-	Self-Help Groups
UD	-	Urban Development
ULB	-	Urban Local Body
UNICEF	-	United Nations Children's Fund
USPS	-	Urban Social Protection Scheme
WCD	-	Women and Child Development
WASH	-	Water, Sanitation and Hygiene

Part Two

RESPONSE OF MCGM TO COVID-19

Background

Maharashtra and Mumbai emerged as the epicenter of the COVID -19 pandemic with daily positive cases escalating to thousands during its peaks in both the waves, driving up national figures exponentially. Around April 2020, a high level 'Task Force' was set up by the Chief Minister of the state consisting of experts drawn from various fields. Mumbai's precarious position due to its two contrasting realities – being the financial and commercial capital of the country whilst *also* straddling huge, dense sprawling slums – brought it under focus at national and international levels.

The 'Mumbai Model'

During the initial days of the pandemic, a centralized control room at MCGM headquarters was created to integrate and manage the city wide COVID -19 response. However, as the city started witnessing an alarming upward spiral in COVID-19 infections, major changes in this 'command and control' modality were deemed necessary. This same was dismantled to form 24 decentralized 'War Rooms' in the city's municipal wards, each under the helm of the Assistant Municipal Commissioners (AMCs). AMCs were given relative autonomy to take independent decisions.

Key Informant Interviews (KII) with War Room officials revealed that these 'war rooms' emerged as vibrant centralizing hubs that could consolidate information in real time, direct it to the appropriate levels of decision making and respond quickly. The exact status on the ground could be deciphered on a day-to-day basis and outreach efforts directed in a targeted manner. Single point helpline number with these dedicated response teams supervised the unfolding situation in the city 24/7. The use of data analytics (COVI-Techs, Mobile Apps, and Geographic Information System – (GIS) and Global Positioning System – (GPS)) facilitated the collation of reliable and accurate data, based on which decisions were taken.

Understandably, at the beginning of the pandemic all of the efforts were targeted towards the medical management of the disease. For instance, dashboards facilitated live tracking of cases and requirement as well as availability of hospital beds[1]. Ambulances were run on Uber software to facilitate quick response time[2]. Regular audits helped the Task Force to take evidence based and targeted decisions aligned to the crisis on the ground. Systematic and regular guidelines issued to all stakeholders vis-à-vis protocols to be followed for triaging patients, issuance of medicines as well as oxygen etc. created a quick, responsive and accountable implementation machinery. A delegated structure of leadership and decision making, closest to ground realities as they unfolded, emerged to be a game changer. This 'Mumbai Model' emerged as a successful one at mitigating the onslaught of the COVID -19 virus and has been feted by the NITI Aayog and the Supreme Court as a 'good practice'. It was also a recipient of an award at the Rise World Summit 2021.

The basic tenets of decentralization, collaboration and quick response based on real time data and monitoring were also applied to the massive **Food Distribution** efforts that were undertaken. These are now discussed.

[1] (Chakrabarti, 2021)

[2] (Smruti Koppikar, 2021)

Figure 1: Visit to G-North Ward War Room

Food Distribution Outreach during COVID-19

Mumbai's squatter settlements emerged to be the most defenseless against the pandemic due to multiple 'marginalization' across board. Restrictions of movement implied loss of livelihoods and accessibility to food. The national lockdown disrupted supply chains, especially in the initial period, resulting in hoarding in some circles but inaccessibility amongst the poor. Realizing that food shortages could be endemic, the MCGM, under the Planning and Poverty Eradication Cell, adopted the same decentralized structure already in operation for pandemic management as described above.

Governance Model: Decentralization, Accountability and Responsiveness

KIIs with the Deputy Municipal Commissioner[3] that a three-tiered structure, with the War Room as the pivot, was created linking up the strategic levels of decision making to the ground. Additional Municipal Commissioners (AMCs) of MCGM granted all approvals for funds as well as permissions for large distribution orders. The AMC (Planning and Urban Poverty Eradication Cell) headed the entire food distribution initiative, providing a platform for one point co-ordination, right from the sourcing of food (cooked as well as dry rations) to its distribution.

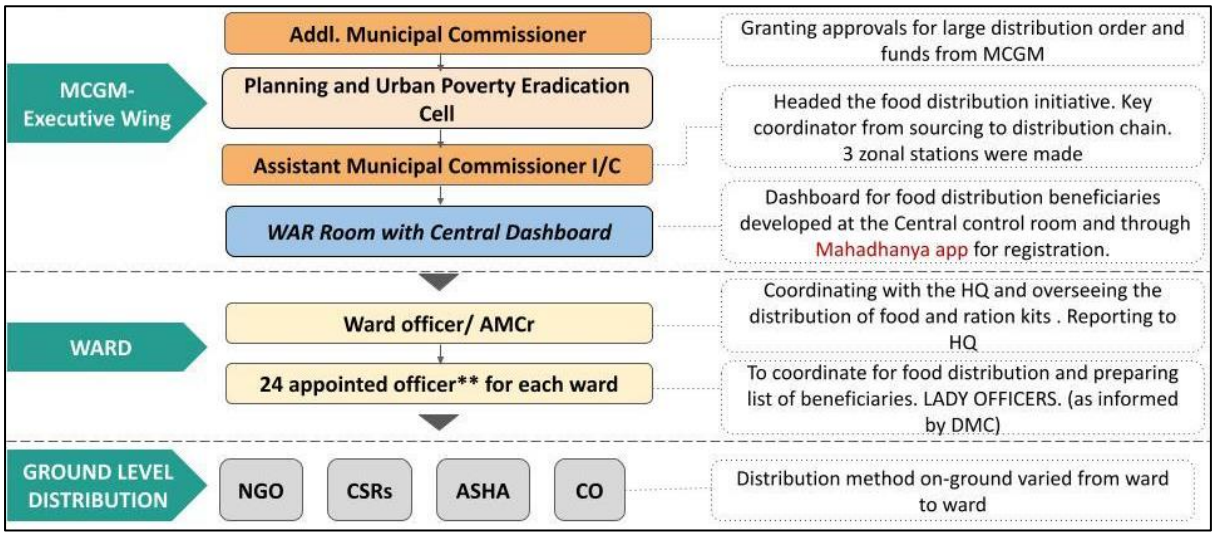
The War Room was a convergence point, through which all information and data was routed. A dashboard developed by Ernst and Young centralized the food requirement, sourcing, distribution, and beneficiary outreach modality. Distribution of dry ration kits was facilitated via the software system using the *Mahadhanya* app. The Ward Office under the AMC played a pivotal role – on the one hand coordinating with the War Room and on the other, with the Headquarters. One officer appointed at each ward level (24 in total) prepared accurate lists based on a systematic collation of requests received via various channels. These ward level food requirements were placed between 6:30 to 9:00 pm each day to facilitate planning and distribution for the next day. Thus, the massive food distribution operation could be operationalized within an integrated framework.

Ward officials were empowered to plan and take decisions vis-à-vis food distribution with the informal understanding that larger amounts would require official sanctions. This was decided on a case-to-case basis. Evidently a massive effort, the management and co-ordination of the food operations was facilitated due to quick and transparent reporting structures. Each Ward innovated on its own delivery modality, following the pattern of distribution coordinated with their field level workers, who were conversant with ground realities. Systematic and regular guidelines issued to all stakeholders created

[3] Previously Additional Municipal Commissioner – Planning Department

a vibrant and direct system of communication and response. As each day ground level realities changed frequent change in decisions were required. KIIs with officials and field level functionaries revealed that they were given training in the SOPs to be followed. This implementation structure is presented in Figure 2.

Figure 2: COVID-19 Outreach - Implementation Structure



Source: AMC and other stakeholders, 2021

Targeting and Inclusion

As the pandemic exploded it was evident that the poorest could not meet their food needs. Hence, a prudent strategy was to first cover the most vulnerable – migrant workers, homeless, jobless, disabled, daily wage earners and Transgender. In some wards, municipal schools and marriage halls were converted into shelters for the homeless, thus consolidating the distribution efforts. As distress calls were received on the dedicated helpline with requests for food and supplies, they were verified and sorted according to the area and ward and food distribution planning efforts directed accordingly. NGOs and field level functionaries also drew lists of the most vulnerable. Targeting was facilitated via coordinated efforts from various partners – NGOs, Civil Society Organizations (CSO), Community Health Volunteers (CHV), ASHA/Anganwadi workers (AWW)/Anganwadi Health workers (AWH), COs and Elected Representatives (ERs). These actors were in direct contact with the needy and helped in identifying and forwarding requests to the ward level officials or route it through the War Room. Ward wise lists were prepared each day with convergence with the Public Distribution System (PDS) system to avoid duplication. The War Room Dashboard presented the status on a real time basis. The entire procedure, being online, was audited at every level to assure transparency and appropriate targeting. Alongside, daily database of the ration stock, supplies and storage availability was maintained[4].

This planning, coordination and distribution, facilitated by a decentralized structure of decision making and accountability, assured inclusion of the most vulnerable. The War Room, invigorated due to the crisis brought about by the pandemic, emerged as a 'rapid response' structure, operating largely within a transparent data management system. That the same structure was also used for city-wide

[4] Along with the needy, the frontline workers were also provided with food due to efforts of various NGOs, CSOs and via CSR. Leading hotel chains stepped in for food distribution.

epidemic implied close communication with the headquarters, with strategic leadership, guidelines and directives offered from this level.

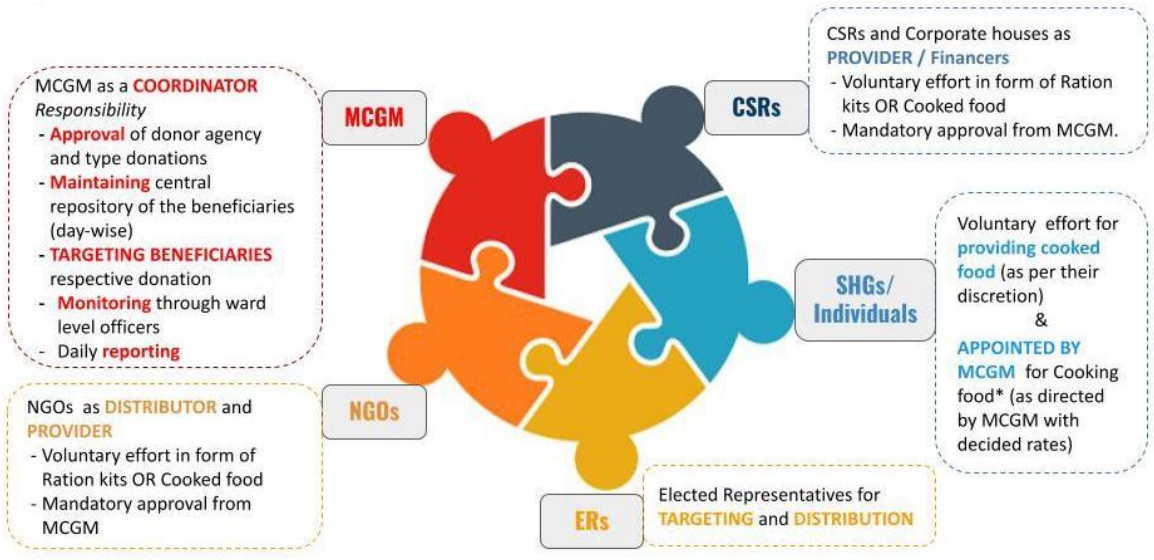
In the initial phases cooked meal (khichdi / pulao / puri-vegetables) was distributed which was changed to dry rations subsequently. Similarly, the rate of Shiv Bhojan Thali of GoM was initially reduced to Rs.5/plate and was later made free. However, autonomy to decide the actual distribution modality at the ground level was vested on the agency doing the same. This allowed for field level adaptations depending on changing situations. NGOs revealed that the decentralized modality was able to simplify processes, was accountable and inclusive. NGOs could rely on the system for accurate and timely information. Deploying their own departmental functionaries, as well as police and partnering with NGOs /CSOs for regular communication with the citizens created a modicum of predictability in the administration's response. This built trust amongst the system and the beneficiaries. Barring some instances of overcrowding and exclusion, the overall food distribution was a synchronized effort.

Partnerships

Evidently such a massive effort was a collaborative one. A partnership between MCGM, NGOs and Corporate Sector was created with each having a specific role and area of operation. MCGM, emerging as a fulcrum, was largely responsible for sanctions/approvals, part funding, targeting, supply and overall coordination and management. The corporate sector stepped in for part funding (Milkar Initiative discussed subsequently) and supply of rations; the NGOs were involved in beneficiary identification and listing, information dissemination, targeting and distribution.

ERs too played a critical role in identifying the needy and distributing food in their constituencies. Cooked food was prepared by Self Help Groups (SHG), Hotels and individuals under the directives and rates of MCGM. This partnership, constituted under no official format or rule, functioned as an informal collective of stakeholders enjoined together with the objective of offering food security and alleviating the suffering of the most vulnerable during an unprecedented crisis facing the city. The partnership Model is represented in Figure 3.

Figure 3: Partnership Model Adopted for Food Outreach



Source: Based on KIIs and FDGs with Stakeholder

Delivery Modality

The entire relief effort can be categorized under two predominant arrangements of delivery: 1) Management and Funding by MCGM; and 2) Management by MCGM, funding by Donor Agencies via CSR. Both the arrangements followed the overall framework outlined above. In the first, as already described in the preceding section, the entire effort was mobilized via MCGM's War rooms. Funds were allocated from the State Disaster Relief Fund (Rs.24 crore), along with MCGM's own and additional Rs.20 crore from donor agencies. The second arrangement, was similar to the first in terms of decision making, planning and coordination, the only difference being funding Donor agencies, notably via CSR. In all, there were 53 community kitchens providing khichdi with 3.5 crore meals distributed (from April 2020 to July 2020), whereas seven lakh food packets were distributed to the homeless (from April 2021 to August 2021)[5]. These food distribution efforts continue on a smaller scale even today especially for the homeless. The staff from the assessment and collection as well as planning departments continue to be involved in this food outreach[6].

Conclusion

In MCGM's food distribution efforts, winning praise from various quarters, a decentralized model of planning, coordination and monitoring at each level of the supply chain was evident. The War room integrated the city-wide efforts and used real time data via digital platforms (dashboards, WhatsApp groups, portals) to inform evidence based and quick decision making. Officials banded around as 'quick response teams', empowered to take autonomous decisions and adapt the delivery mechanisms as per the ground realities. Thus, rather than a fixed, top-down response, each ward had its own distribution modality that best suited the ever-evolving situation in their specific ward. This enabled quick decisions, flexibility and inclusion. The administration turned a collaborator, creating partnerships with NGOs, civil society and private sector, in the 'whole of society' approach, to mobilize food and assure accessibility.

Thus, some critical dimensions of governance – co-ordination and strategic planning within a largely accountable system, a decentralized, autonomous decision-making structure, use of evidence to inform planning, open channels for reliable, accurate and timely communication with stakeholders / public, quick and responsible systems of targeting and inclusion based on updated, real-time data and flexibility and adaptation to the evolving crisis situation – were clearly evident. Crowd management was done with help from the police whereas information dissemination with help from ERs, NGO, ASHA, AWW, AWH, COs etc. The entire effort was monitored in real time. KIIs conducted across both the wards reveal that the vulnerable were reached by the government or its agencies assuring mostly uninterrupted food supplies, although quantity and content may have varied. Evidently, this was a classic model of adopting a 'learning by doing' approach as there was no set precedent.

However, a core aspect of this outreach was its temporal nature. As the pandemic continues to abate, the mobilization efforts of the system indicate the same trajectory too. The focused and massive distribution efforts necessitated due to lockdowns, have ebbed as the municipal administration gradually returns to its normal functioning. Although not completely halted, at present, dry food

[5] Based on information provided during KIIs with Community Development Officer, MCGM and NGO officials and Interview with DMC- SWM.

[6] (Dipti Singh, 2021)

rations are distributed through the Targeted, Public Distribution System (TPDS) Mid-Day Meal and the Anganwadi Centers (AWCs). In some areas Elected Representative (ER) and NGOs continue food distribution (dry as well as cooked) as per availability and need.

The efficiency and outreach demonstrated in the food distribution is not mirrored in the other departmental responses related to maternal and child health, education and WASH. We now turn to these.

Maternal and Child Health

The lockdown measures during the initial days of the pandemic witnessed a massive disruption in the maternal and child health care services. Accessibility to maternity hospitals for pregnant women was severely restricted especially during the heightened waves of the pandemic wherein the authorities were fully diverted in mitigating its spread[7]. Many government and private hospitals were turned into exclusive COVID-19 centers during the initial phase of the pandemic. Panic and uncertainty surrounded pregnant women as fear of 0infection ran high which forbade them from exploring options, even if they existed. FGDs with NGO officials working closely with the target group indicate that although institutional deliveries continued, Pregnant Women (PW) received no reliable information or guidance. Additionally, they faced cancellations of planned hospital visits and deliveries and changes in antenatal, delivery and post-natal care. As all transportation was stopped there was also difficulty faced in reaching the hospitals. Accessibility to allied services – sonography, blood tests etc. were also difficult.

Similarly, schedules for check-ups, distributing folic acid and calcium tablets as well as immunization of infants were disrupted as all AWCs were closed. Tracking of high-risk pregnancies was stopped. ASHA, AWW, AWH were directed to COVID-19 duties. Resultantly, the plethora of services for maternal and childcare greatly suffered. The normal functioning in Health Posts (HPs) came to a standstill as its ground level staff was also diverted to COVID-19 duty, especially during the waves. These frequent interruptions in field level functioning have created backlogs, especially of immunization schedules. Although some efforts were initiated to reach PWLM (Pregnant women lactating mother) via mobile apps, beneficiaries had restricted access to mobile phones at home which did not assure timely information dissemination. Field level workers were also viewed as carriers of the virus, especially during the peaks, which also impacted cooperation from the beneficiaries. Some efforts at counselling, arranging for referrals and visits by field workers resumed intermittently during the lull between the waves.

During these disruptions, unlike food distribution noted in the preceding section, there was an absence of a systematic and coordinated system that could respond to the specific needs and challenges faced by women and children. On the contrary, all existing modalities were halted. In an atmosphere of panic, PW had unreliable information and very restricted accessibility to the system. Reliance was more on NGO functionaries or informal contacts for guidance and direction. There was no dedicated system or structure created to handhold this target group.

As the second wave abates, resumption in some services has been noted post July 2021, wherein most of the focus is on clearing the backlog and updating the systems. Field level workers note that the processes have streamlined presently, and concentrated efforts are being diverted towards Maternal

[7] (Kavitha Iyer, 2020)

and Child Health (MCH). PW are being assisted by the HPs in their vicinity and guided towards the government maternity homes and in critical cases to larger, well-equipped ones. Dedicated hospitals for COVID-19 positive PW have been set up. Requests for information as well as beds is routed via the War Room. More concentrated efforts are either planned or under way – i.e., appointment of a private agency for allied services, campaigns to recruit eligible women with help of ERs and field level staff under social security schemes, drop down services for PW in city hospitals for referral and treatment and ambulance services. However, KIIs with beneficiaries revealed that they are completely unaware of these, as no information has yet reached them.

In both the wards selected for this project, NGOs steeped in to mediate the outreach, by undertaking door to door surveys via their field level volunteers, information dissemination, handholding, even arranging for transport and beds in times of emergency and conducting mobile van immunization drives. Although not having a formal role, they nevertheless augmented the outreach efforts in their work areas. During the pandemic, ERs too stepped in, on a case-to-case basis, to assist PW, guide them to maternity hospitals, arrange for transportation and extend monetary support if needed. They facilitated accessibility to necessary services by coordinating with HPs, government functionaries, and maternity homes in their own wards.

In conclusion, it is evident that support for PWLM in the initial phase was lacking. The war rooms were completely focused on the pandemic and all efforts were directed towards containing the viral spread. The already deficient health system was overloaded with COVID-19 cases. In this situation the social security net geared towards MCH was absent. As the situation eased up, the same started coming back on the decision-making agendas. Presently, the schemes specifically targeted at MCH are resuming and gradually returning to their pre-COVID-19 levels.

Education

There is a broad agreement that education was one of the worst affected and the least prioritized sector during the pandemic. In response to COVID-19 schools across India were closed with a total shift to online education. As the city struggled with spiraling infections, lockdown and containment zones implied restricted mobility for children. The municipal administration diverted into containing the spread of the virus, largely left the schools and educational institutions to its own devices in the initial phases. There were intermittent directives from the Central and the State government to guide and support the distance/home-based modality of learning for children. However, this sudden change in methodology of education had a direct and intense impact on the children.

Some intermittent outreach efforts were visible in the form of training teachers in the use of technology, launching online channels and digital content and uploading educational material online. NGOs and CSOs collaborated with the municipal authorities in conducting special learning workshops, distribution of laptops, tablets, projectors and learning kits and increasing accessibility by distribution internet data packs. WhatsApp, YouTube, Telegram, Zoom and Google Meet, emerged to be preferred tools used by students and teachers. Whilst this support to ensure continued remote learning were creditable, the drastic change in instruction was plagued with difficulties.

Students from underprivileged sections struggled with accessibility and adaptation issues. Digital channels were not smoothly accessible to this cohort with low level of technical infrastructure in slums, interruptions in internet connectivity, non-availability of android mobile phones/laptops for all children in family and inability to pay for fast internet connections. Teacher as well as students were not aware of the full range of features that could be used for remote learning. With lesser hours spent

in online classes, students were expected to self-study. Inability of parents to guide their children due to low education levels coupled with irregular learning materials, increased learning gaps. The online instructional modality was not always suited to the realities of crowded slum hutments which hardly offered a facilitative climate for learning and exploration.

KIIs with the latter, revealed that siblings took turns in attending classes as only one android mobile phone was rotated amongst them, resulting in missed classes. Lacking face to face interactions and classroom discipline, children also easily got distracted oftentimes spending time playing video games. Instructions in some subjects/concepts were difficult to impart without face-to-face interactions. Systematic assessments and tracking progress were impeded during this time and with no examinations students' interest in learning plummeted. NGOs estimate that due to non-accessibility to mobile phones, inability to keep up with remote learning, or migration to hometowns, dropout rates have likely increased manifold. Beyond just learning shortfalls, there is wide agreement that with school closures and the resulting isolation, fear of the virus, loss of livelihoods and in some cases escalations in domestic violence have had a direct impact on the mental health of children.

Although government directives insisted on training teachers and holding weekly monitoring and review meetings, the actual reality on ground differed as shared in KIIs with administrative officials and NGOs. No systematic training was given, the same left to the discretion of the headmasters and school authorities. Teachers often had additional COVID-19 duties. School Management Committees (SMCs), in any case largely defunct, could also not emerge as external supervisors to assure quality and accountability.

Clearly, education remained an undervalued sector in the municipal administration's outreach as affordability, accessibility and quality of learning greatly suffered.

Water, Sanitation and Hygiene

The predominant preventive measure in COVID-19 was hand washing and social distancing. Both these prospects were extremely difficult in the high-density slums. The strict lockdown measures had a direct impact on the availability as well as accessibility to water and sanitation as the already overburdened services were brought under further stress. Overall water supply reduced, tanker supply halted, and other informal water supply arrangements were unapproachable due to lack of mobility. At the same time demand for water increased manifold due to COVID-19 Standard Operating Procedures (SOPs) under the COVID-19. The initial phases, many slums struggled with severe water scarcity, infrequent supply, quality deterioration and crowding for water collection.

Crowding at communal sources of water (tankers and public taps) was widespread. Monthly expenditure on water increased. In any case, even in normal times slum had struggled with water scarcity (only 29 lpcd)[8]. All members of the family, now restricted to their tiny hutments due to lockdown, inadvertently increased pressure on the overall water requirements. Residents took to infrequent bathing to conserve water for cooking or other family members. Sanitation mirrored a similar scenario. As more residents were homebound, in some areas, a single Community or Public Toilet (CT/PT) catered to hundreds of users and rapidly fell to a state of disrepair. This was exacerbated due to infrequent cleaning operations.

[8] (CPD, Pani Haq Samiti & Center for Promoting Democracy, 2020)

As slums started getting identified as COVID-19 clusters, especially in the first wave, attention of the municipal administration shifted to these sprawling localities. In a situation of severe scarcity of toilet blocks, with overwhelming loads per seat even during normal times, the ongoing pandemic posed special problems. Slum dwellers were unable to maintain social distancing, there was a complete absence of running water, soap and disinfectants and a very negligible number of toilet blocks had sewerage connections. To mitigate this situation, a number of steps were taken by the authorities, albeit not in the coherent manner as seen in the food distribution initiative already discussed.

Initiatives under WASH

Cleaning operation of toilet blocks in each ward and containment zones was increased manifold by revising the schedules of the sanitation workers. Coordination with the War Room identified city zones in which COVID-19 cases were spiraling, based on which cleaning operations were directed and augmented. A quick reconnaissance of slum areas experiencing heavy footfalls facilitated the provision of mobile toilets. Foot operated sanitizing machines were installed outside many CTs to assure hand washing. In some places incinerators and sanitary pad vending machines were installed to address menstrual hygiene needs of women. Although, public toilet user fees were waived off, for the third party managing the toilet complex this became financially unviable.

'Flush the Virus' campaign witnessed partnership between multiple stakeholders, like the NGOs, Corporate houses and international funding agencies. NGOs made concentrated efforts to mobilize Community Based Organizations (CBOs) to spread awareness about COVID-19 amongst their constituencies. Distribution of cleaning solutions (bleaching liquids, phenyl, sanitizers, hand wash, soaps) to CBOs, toilet operators and cleaner and installation of foot operating sanitizing machines was undertaken. Parallely, corporate houses were also partnering with MCGM for flagging off multi-media and multi-channel awareness campaigns around sanitation and public health as well as in raising money for sanitation supplies. The aforementioned 'Flush the Virus' campaign spearheaded by UNICEF witnessed massive efforts in drawing attention towards maintaining cleanliness in CT/PTs and government schools. Similarly, training was provided to sanitation workers for the SOPs to be followed during cleaning operations. Residents, taking a lead, devised an informal system of dedicated toilet seats in CT / PT for those infected, so that cleaning and SOPs could be maintained and viral spread mitigated.

During KIIs, some NGOs maintained that Dharavi in G (N) ward got a disproportionate attention from decision makers as it come under intense media scrutiny, even though situation in other sprawling slums was also as precarious. Testing and tracking was more concentrated in this slum, as an imminent crisis was expected. KIIs with residents of M (E) w0ard revealed that efforts at cleaning, awareness building and augmentation in services was noted during the peak of the waves but then waned as situation started normalizing.

This ebb and flow in outreach pointed towards the temporal nature of the pandemic and the shifting priorities of the administration thereof. NGOs claim that as planning for long term and sustainable options for water and sanitation in Mumbai's slums continue at the strategic level, the on-ground situation is largely back to pre-COVID-19 levels. As the heightened focus on WASH activities gradually abates, slums once again return to the original situation of severe scarcity and overcrowding.

Whilst there were certainly city-wide efforts in the area of WASH, these were not within a unified and dedicated system as evidenced it the Food Outreach. Herein, as already noted in the preceding section, a decentralized war room system created a consolidated and responsive system, capable of

integrating city wide data on real time basis and quickly channeling distribution to fill the gaps within a collaborative framework in an efficient and largely accountable manner. In the case of water supply and sanitation, efforts were more sporadic, prioritizing the high-risk slum zones at times at the expense of other slum areas that may have escaped sustained interventions. These clusters witnessed intermittent outreach, more concentrated during peaks but waving soon after.

Added to this was the peculiar characteristics of water and sanitation. Water supply, largely depended on rain fed storage systems of the city, could be augmented only to a marginal degree. Operating within huge deficits even in normal times, a drastic increase in water availability was not possible. Similarly, in the high-density slums severe shortages of community or public toilets were endemic even in normal times, leading to a highly deteriorated sanitation infrastructure. Thus, huge city-wide deficits in water supply and sanitation could not be drastically scaled up only during pandemic times. WASH clearly suffered from supply side constraints with outreach being temporal and cyclic in nature.

What now follows is the Noteworthy Initiative – “Milkar” – partnership between the MCGM, NGOs Corporate Houses and citizens.

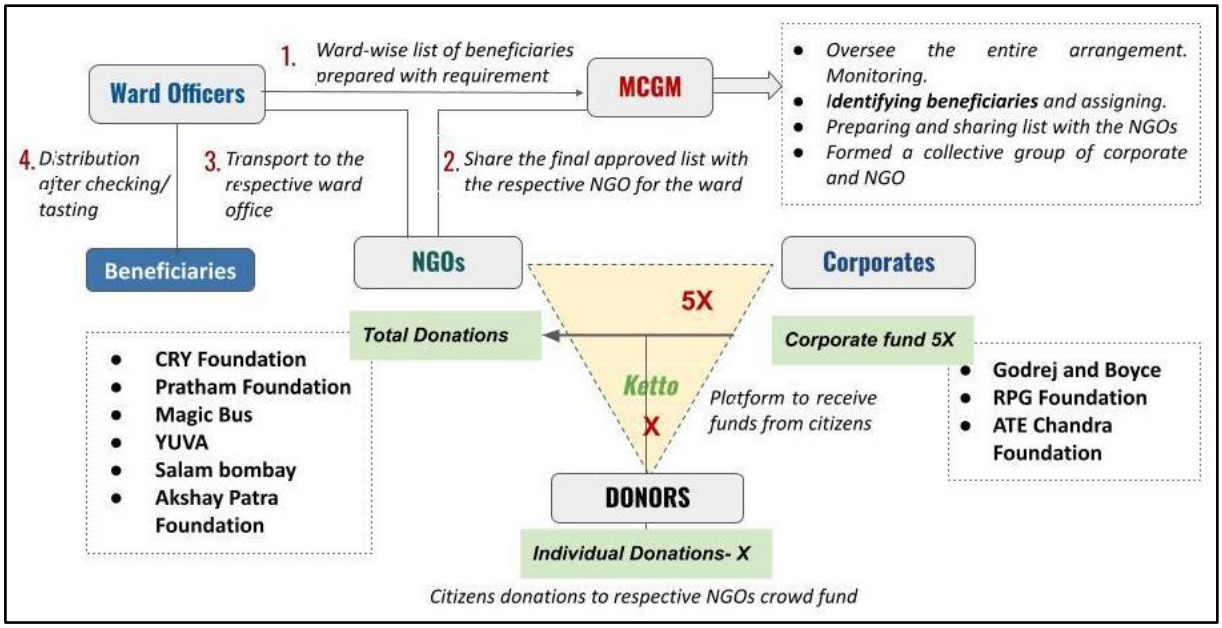
Noteworthy Practice - Milkar Initiative

'Milkar' emerges as a noteworthy initiative during COVID-19. Launched on September 2020 by the Planning and Urban Poverty Eradication Cell of MCGM, it denoted the coming together of disparate agencies and individuals with the single aim of helping the vulnerable who had been severely impacted by the COVID-19 pandemic. It sought to engage city residents in the food distribution effort, thus the moniker – "Milkar – Together for Mumbai". Under this initiative, a standard 'dry ration kit' at the cost of Rs.800 per kit containing 12 kgs of food grains was distributed as a one-time relief for the poor[9].

Firmly placed within a partnership model, it had MCGM at the helm overseeing the entire operation which entailed collating huge number of appeals and calls for food, identifying and listing beneficiaries, Liaisoning with Corporate Houses, NGOs and CSOs and directing relief efforts at appropriate city locations. The Corporate Houses mainly acted as a conduit for funding by matching each rupee raised by NGOs and CSOs with five rupees from their end. NGOs/CSOs emerged as mediators between those needing help at the grass root levels and the administration. This partnership created smooth linkage between beneficiaries, funds and food distribution. Figure 4 captures this vibrant collaborative effort.

Judicious use of online platforms like Ketto for fundraising assured its wide reach to common people desirous to be a part of this initiative. Mahadhanya app was used to collate information about need, stock availability, and sourcing of food grains. Everyday requirement of food grains was also entered on this app by respective ward officials for easy collation. Dashboard developed by E&Y, as already mentioned, collated real time data about the total number of kits to be distributed throughout the city and thus distribution could be directed towards that end in a quick and efficient manner. WhatsApp groups amongst ward officials ensured internal communication and was widely used. In all, 28,539 kits were distributed (from March 2020-September 2020) under this initiative[10]

Figure 4: Partnerships in Milkar Initiatives with MCGM



[9] As discussed by community volunteer, YUVA

[10] KII with CDO MCGM. Data received from office of the Chief CDO

Other Initiatives

A number of announcements continued to be made along the trajectory of the pandemic as it waxed and waned. Some of these translated into preliminary efforts on ground, whereas others awaited clarity. At present, since COVID-19 is in an endemic stage, initiatives continue to be announced. A list of some of these is presented in Table 1.

Table 1: List of Initiatives and Announcements during COVID-19

S. N	Initiative	Thematic Sector	Department (MCGM)	Continuous effort/ time bound/	Funded by	Remarks/ Description
1	**Yoga and counselling for MCGM employees and COVID-19 patients**	Health	All department	Continuous	Free of cost. Goodwill practice by the Yoga institute	Voluntary effort by organization
2	**Free drop-off facility ambulance**	Health	Public health	Need basis	PHD-MCGM	Started pilot basis in two hospitals - functional in all now
3	**Mobile school centers**	Education	-	Time bound	Union of teachers	Self-organize group. Initiated in some wards
4	**Dharavi containment strategy**	COVID-19 response	Health-sanitation	Time bound	-	-
5	**School adoption scheme By MCGM**	Education	Education-MCGM	Time bound-targeted	-	This effort resulted into better results of class IX-X
6	**Use of BEST buses during lockdown to transport cooked food**	Food	Planning-MCGM	Need basis	BEST-MCGM	Collaboration with BEST to transport cooked food in defined area,

						prepared by MCGM
7	**Low-cost automatic sanitizing system in CT**	WASH	Sanitation	Pilot based - started in 4 community toilets	MCGM and CSR	Extension planned in more 10 CTs and 10 PTs
8	**Incentive of Rs.1,000 and life Insurance of 50 lakhs upon death of ASHA workers**	Health	Centre - Ministry of Health	Functional till March 2021 - not renewed	Part of COVID-19 relief package	-
9	**Financial support to kids who lost one /both parents under BSY**	Child	Women and Child	-	-	-

Conclusion

The present COVID-19 challenge, unprecedented in recent history, has caused tremendous disruptions in the global economy besides massive loss of lives and livelihoods. The pandemic and mitigation efforts of governments have exposed the fault lines in their administration and delivery systems. Mumbai, the financial and commercial capital of India too struggled with a massive onslaught of spiraling cases in both the waves, thereby driving up the national caseloads substantially.

MCGM's overall response in mitigating and containing the spread of the virus has been lauded as a good practice all over the world. It's decentralized, war room structure created a system of quick, coherent and reliable decision making that was largely accountable and transparent. In an emergency of this proportion, the system was invigorated to respond in a unified and effective manner as its absence would have created catastrophic conditions. MCGM's food distribution stood out as a noteworthy initiative. In this, a number of factors contributed - the delegated structure giving relative autonomy to the ward offices, appointment of specific officials to spearhead and mobilize city wide interventions, quick system of identifying and targeting the most vulnerable, and lastly partnering with NGOs and CSOs, as well as the corporate sector.

Additionally, strong systems of tracking, supervision and monitoring on a day-to-day basis, as well as regular audits, created an open system that provide the prospect of course correction whenever needed. Vibrant communication channels to share relevant information, guidelines and SOPs as well as the civic administration's outreach assured that reliable and accurate data was available to all stakeholders. Put together, MCGM could largely design and implement a 'rapid response' system that offered mitigation against potential food shortages to the most vulnerable. Indeed, in both the waves of COVID-19, MCGM was quick, creative, effective and largely inclusive in its food outreach.

However, the same could not be said for its other initiatives. For instance, accessibility of PWLM and children was severely restricted due to closure of AWCs and schools and diversion of field level functionaries to COVID-19 duties. Efforts to include MCH could be initiated only after considerable delay. Some resumption in services was noted only after the second wave started receding. Presently, the focus is on clearing the backlogs and updating systems.

The education sector, completely disrupted due to the impact of the pandemic, depicted a grave picture. Social protection in these areas was relegated to the background as disjointed and intermittent efforts could not mitigate the hardships of the vulnerable. Students from underprivileged sections struggled with accessibility and adaptation issues. The low level of internet connectivity in slums, non-availability of android phones, inability of parents to guide their wards, coupled with irregular study material and academic assessments increased learning gaps.

In the area of water and sanitation, MCGM's strategy of lowering exposure by isolating high prevalence pockets as 'containment zones' posed a problem in the slums of Mumbai. Indoor and outdoor crowding was unavoidable due to a variety of factors - extreme high density, hutment size, communal nature and severe inadequacy in basic services. Although a number of initiatives were flagged off with partnerships between international funding agencies, NGOs, Corporate Houses and CBOs – supply side constraints restricted their reach and impact. Some NGOs maintained that larger slums captured all the efforts at the expense of other slums as they were under intense media scrutiny. The acute supply side constraints also restricted upscaling of water supply or sanitation infrastructure.

In conclusion, an unprecedented pandemic of this magnitude invigorated the system to unify and respond in a calibrated and accountable manner as far as the food distribution efforts were concerned. However, in the areas of MCH, education and water and sanitation, the social security system was unprepared and indicated many gaps in accessibility as well as inclusion. Going forward, it is clear that the vulnerability of cities to shocks such as Covid 19 has increased. It is therefore imperative to focus attention on strengthening preparedness and creating partnerships between public and private stakeholders to build resilient systems that are able to mitigate against the high socio-economic and human costs that such shocks entail.

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