Disaster Response of Urban Local Bodies towards the Urban Poor and Vulnerable in three cities of Maharashtra

under

Learning from COVID-19 - Urban Governance Perspective

Research Study 2021-22

Regional Centre for Urban & Environmental Studies
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Preface

The sudden and unprecedented nature of the COVID-19 pandemic presented a new and dynamic set of challenges to systems of governance. The impact was first felt by institutions of public health, soon government institutions grappled with methods to curb the spread of the virus. In time, the repercussions of government interventions were most acute among sections that experienced social and economic vulnerability. Hence, the three-tiered government made various policy-level provisions to meet the emergent needs of marginalised groups. The local self-governments, Urban Local Bodies in urban areas and Panchayati Raj Institutions in the rural areas, played a crucial role in containment of the spread but also in determining the operational outcomes of the interventions.

Interrogating the efficacy of the 74th Amendment, at a time when institutions were facing such a magnanimous challenge, offers opportunities to reimagine and realign local institutions to equitable urban governance and reliance building. This study, based in Western Maharashtra, aims to evaluate the role played by Urban Local Bodies of Mumbai, Navi Mumbai and Vasai-Virar. The three cities, although geographically adjacent to each other, have seen the development of unique local governments. The municipal corporation of Mumbai, being one of the oldest and financially endowed urban bodies, has certain policies and practices in place to deal with crises. Yet, the diverse and expansive population concentrated in urban informal pockets posed dire challenges to the local institutions. The corporations of Navi Mumbai and Vasai-Virar, albeit younger in their establishment, had to deal with similar challenges at a smaller scale. In addition, the research study has also included the integral role of civil society organisations in tackling the humanitarian crisis. Their long-association with vulnerable and excluded groups allowed them to act as a bridge, of information and relief, between the government and the citizens. In all three cities, several independent and organised groups worked with the state coordinating and ensuring last-mile delivery of several basic services.

The study employed primary and secondary data from key institutional persons as well as voices from the most disenfranchised communities. Following the data collection, an analysis was undertaken to determine the linkages and key nodal points instrumental in effective relief and rehabilitation work. This allowed the presentation of a detailed set of recommendations which can be used as a reference while developing layered Disaster Management Plans for the Urban Local Bodies.

Acknowledgement

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Director

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Contents

List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
AIILSG	All India Institute of Local Self-Government
ANM	Auxiliary Nurse Midwife
APL	Above Poverty Line
APMC	Agricultural Produce Market Committee
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
MCGM	Municipal Corporation of Greater Mumbai (MCGM)
BMWM	Biomedical Waste Management
BOCW–WB	Building and Other Construction Workers Welfare Board
CAA	74th Constitutional Amendment Act
CACR	Citizens Association for Child Rights
CBO	Community Based Organisation
CCC	COVID Care Centres
CDO	Community Development Officer
CHV	Community Health Volunteer
CIDCO	City and Industrial Development Corporation
CJP	Citizens for Justice and Peace
COWIN	COVID Vaccine Intelligence Network
COVID-19	Coronavirus Disease of 2019
CPI (M)	Communist Party of India (Marxist)
CSO	Civil Society Organisation
DCH	Dedicated COVID Hospital
DCHC	Dedicated COVID Health Centre
DCCHC	Dedicated COVID Care Hospital Centre
DDMA	District Disaster Management Authority
FGD	Focus Group Discussion
FSAI	Fire and Safety Association of India
GR	Government Resolution (Directive)
HSBC	Hong Kong and Shanghai Banking Corporation

HUL	Hindustan Unilever Limited
ICMR	Indian Council of Medical Research
ICU	Intensive Care Unit
ILO	International Labour Organisation
IPC	Infection Prevention and Control
IPSA	Institute of Policy Studies and Advocacy
JNS	Jagruk Nagrik Sanstha
MCGM	Municipal Corporation of Greater Mumbai
MDM	Mid-Day Meal (Scheme)
MDWWB	Maharashtra Domestic Workers' Welfare Board
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act, 2005
MHADA	Maharashtra Housing and Area Development Authority
MLA	Member of the Legislative Assembly
MMR	Mumbai Metropolitan Region
MoHFW	Ministry of Health and Family Welfare
MoHUA	Ministry of Housing and Urban Affairs
MP	Member of Parliament
MVC	Municipal Vaccination Centre
NDMA	National Disaster Management Authority
NGO	Non-Government Organisation
NFSA	National Food Security Act, 2013
NMMC	Navi Mumbai Municipal Corporation
NULM	National Urban Livelihoods Mission
ONORC	One Nation One Ration Card (scheme)
PDS	Public Distribution System
PHC	Primary Health Centre
PMGKAY	Pradhan Mantri Garib Kalyan Anna Yojana
PPE	Personal Protective Equipment
RRT	Rapid Response Team
RT PCR	Reverse Transcription Polymerase Chain Reaction (COVID test)
RWA	Residents' Welfare Association

SBM	Swachh Bharat Mission
SBK	Shiv Bhojan Kendra
SDMA	State Disaster Management Authority
SHG	Self Help Group
SNEHA	Society for Nutrition, Education and Health Action
SOP	Standard Operating Procedure
SSP	Slum Sanitation Programme
ST	State Transport
ULB	Urban Local Body
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
VVCMC	Vasai-Virar City Municipal Corporation
WASH	Water, Sanitation and Hygiene
WFC	Worker Facilitation Centre
WHO	World Health Organisation
YUVA	Youth for Unity and Voluntary Action
ZP	Zilla Parishad

List of Images, Maps, Diagrams & Tables

List of Images

List of Maps and Diagrams

List of Tables

Chapter I

Introduction: Governance and the Pandemic

Human vulnerability, risk and exposure play a vital role in converting potentially damaging natural phenomena or human activities into complex disasters and emergencies. The COVID-19 crisis has resulted in a disaster of unprecedented proportions warranting immediate response and relief – to an ongoing health and humanitarian crisis – a complex disaster, with no recent precedent (YUVA, 2020 a). The health emergency has continued with the dreaded anticipation and fear of multiple waves in the future. Alongside, the devastating impact on human lives and livelihoods has resulted in the largest humanitarian crisis in recent history.

In India, the pandemic-induced lockdown that began on 25 March, 2020 was imposed under the Disaster Management Act, 2005. While the nation-wide lockdown was lifted after 68 days on 1 June 2020, the Home Ministry allowed State governments to enforce restrictions or lockdowns to contain the spread of the virus (Hindustan Times, 2020). In the second wave of the pandemic, several states and municipal authorities implemented lockdown and curfew measures beginning from April 2021.

During the lockdowns and in the months that followed, the success of effective implementation of the national and state decisions under the Disaster Management Act was dependent on its ground level implementation - district administration and local self-government institutions (Rammohan & Alex, 2020). Within the state, there was a decision that the final command in urban municipal corporations would be the Commissioners who were bestowed with the authority to introduce measures to contain the spread of COVID-19. Representatives of local self-governance, have the advantage of having an ear to the ground as they are located closest to the communities that they serve, and so can understand the needs of people across their constituencies while responding effectively to emergent barriers.

Since disaster management theories highlight that risk is a function of hazard and vulnerability, those sections of society that live in poverty and with discrimination are further incapacitated by disasters which threaten their already limited access to resources; thereby curtailing their ability to absorb and finally recover from the effects of a hazard (Acharya, 2020). The pandemic has laid bare the abject deprivation of the urban poor - their lack of access to food, work, wages, healthcare, water and sanitation. Yet, variations in the level of deprivation are contingent among other things on the level of planning and coordination of relief responses between ULBs and the state.

Hence, the pandemic has highlighted the crucially of governance, particularly that of the local government. Simultaneously, it has seen collaborations of state actors with civil society organisations to enable last mile

delivery of relief: during the lockdown, governments announced various relief measures to assist those struggling to survive the challenging times, it was primarily NGOs and CSOs that were actively involved in ensuring this relief reaches those in need (Acharya, 2020), while also making efforts to ensure immediate access to resources for the Urban Local Bodies.

Disaster Management Structure in India

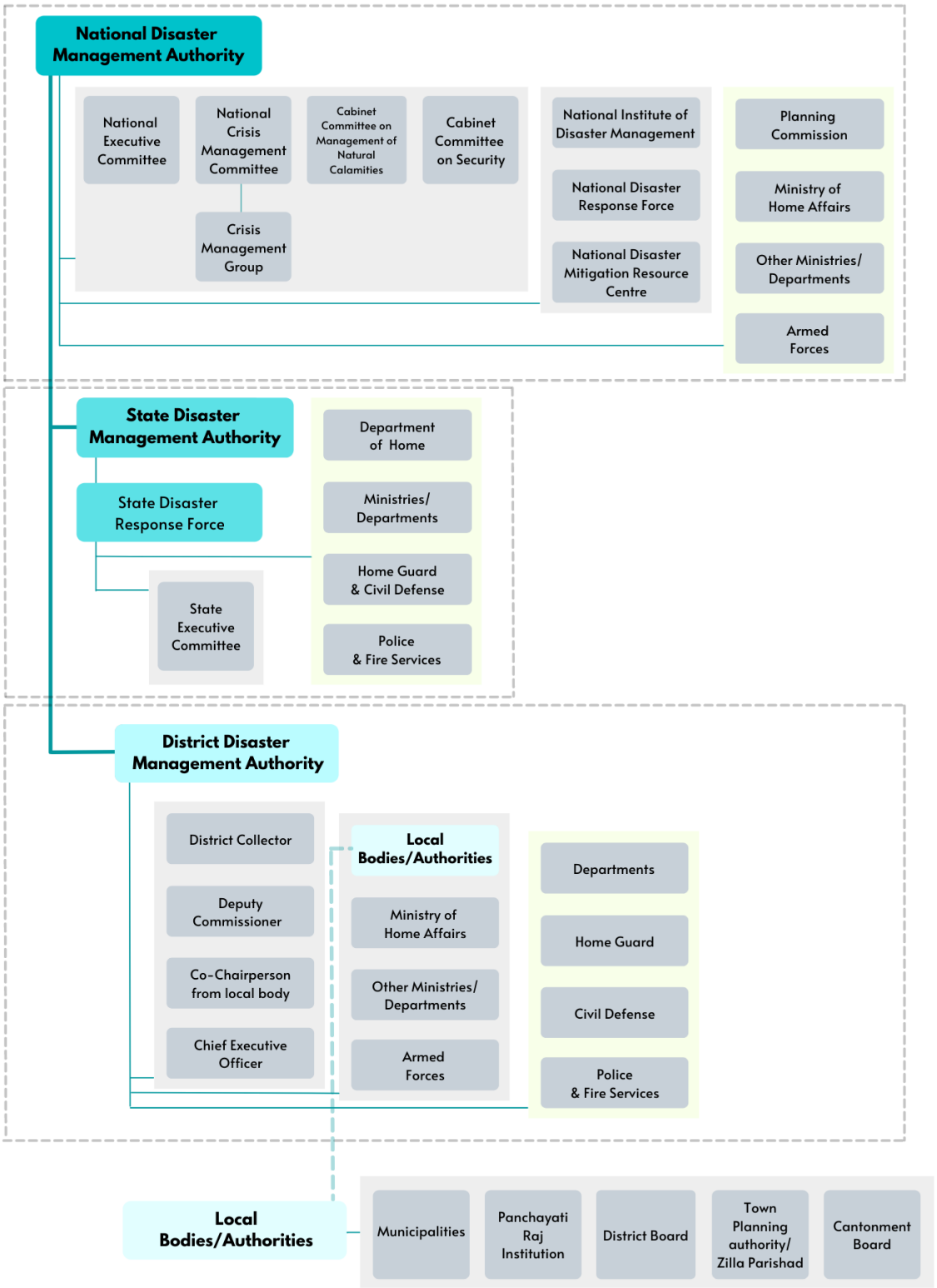

Fig 1.1 Structure of Disaster Management, Source: Author, (Samwal, 2018) & (Das, 2012).

The structure of disaster management is largely divided into 3 levels - National, State and District level. The role of ULBs/local bodies falls under the ambit of the District Disaster Management Authority (DDMA).

The Government of India established the National Disaster Management Authority (NDMA) in 2005, headed by the Prime Minister. The NDMA is the lead agency responsible for the preparation, execution, functions of Disaster Management at the national level. In most cases, it is the state governments that carry out disaster management and the central government plays a supporting role. Following this is the State Disaster Management Authority (SDMA), which is mandated for the preparation of state DM plans, integration of measures for prevention of disasters or mitigation into state development plans, allocation of funds, and establishing Early Warning System. Likewise, the DDMA will act as the planning, coordinating and implementing body for DM at the district level and take all necessary measures for the purposes of DM in accordance with the guidelines laid down by the NDMA and SDMA. The ULBs or local authorities/bodies are deemed to initiate disaster management tasks in urban areas under the jurisdiction of municipal bodies. By definition from the the Disaster Management Act, 2005, the term local authority 'includes panchayati raj institutions, municipalities, a district board, cantonment board, town planning authority or Zila Parishad or any other body or authority, by whatever name called, for the time being invested by law, for rendering essential services or, with the control and management of civic services, within a specified local area' ("The Disaster Management Act, 2005", n.d.).

Urban Governance: The Case of Urban Local Bodies in India

In India, 31 per cent of total population currently lives in urban areas (Census of India, 2011), while among the states, Maharashtra is the forerunner with 45.2 percent being urban residents (Ministry of Housing and Urban Affairs, 2020).

Across district and state borders, the trend of increased urbanisation is commonly influenced by climatic and economic push factors influencing the migration of people from rural to urban areas. In India there is an interesting case, with most people engaging in circular migration, which constitutes temporary and undocumented labour crisscrossing the length and breadth of the country without people permanently settling in the cities where they are employed (Aajeevika Bureau, 2020).

Alongside the growth of the urban, the nation has also witnessed a growth in informal settlements, which house many of the circular migrants. National figures point to approximately 65 million people living in urban slums, while Maharashtra alone accounts for 18.1 per cent of the total slum population of the country (Census of India, 2011). With most migrant workers employed in the informal economy in urban Maharashtra, their impermanence in the city forces them to keep their ties with the village intact, often manifesting in the lack of documentary proof in the city of the temporary residence. This is also one of the reasons that contribute to service deprivations which are commonly observed in cities and towns, manifesting in increased amounts in slum and squatter settlements (YUVA, 2019).

In an attempt to empower local governance and address social inequality at its root, the 1992 amendment to the Constitution aimed to decentralise power and recognised municipalities as the third tier of government. Formally termed the 74th Constitutional Amendment Act (CAA), it is often referred to as "Power to the People" as it ensures peoples' representation in the house through regular elections and by assigning them with specific civic functions. Through this amendment, Urban Local Bodies acquired political, functional and fiscal empowerment and were enlisted with the responsibility on matters of:

1. Urban planning including town planning.
2. Regulation of land use and construction of buildings.
3. Planning for economic and social development.
4. Roads and Bridges.
5. Water supply for domestic, industrial and commercial purposes.
6. Public health, sanitation conservancy and solid waste management.
7. Fire services.
8. Urban forestry, protection of the environment and promotion of ecological aspects.
9. Safeguarding the interests of weaker sections of society, including the handicapped and mentally retarded.
10. Slum improvement and upgradation.
11. Urban poverty alleviation.
12. Provision of urban amenities and facilities such as parks, gardens, playgrounds.
13. Promotion of cultural, educational and aesthetic aspects.
14. Burials and burial grounds, cremation, cremation grounds and electric crematoriums.
15. Cattle ponds; prevention of cruelty to animals.
16. Vital statistics including registration of births and deaths.
17. Public amenities including street lighting, parking lots, bus stops and public conveniences.
18. Regulation of slaughterhouses and tanneries.

(Listed under the Twelfth Schedule (Article 243W, CAA 1992))

While this list does not explicitly mention disaster management, the Model Municipal Law, 2003[1] includes "management of disasters" as a function of ULBs. The pandemic tested local self-governments and pointed to the critical need for robust and autonomous ULBs. In this period, it was observed that the inherent hierarchy of power in governance structures which the 74th amendment stood to dissolve, served as an impediment in the functioning of ULBs which despite all intention were controlled by parastatals and other departments under the pretext the urban development is a state subject (Jha, 2021). Important to note that

[1] The Model Municipal Law, 2003 prepared by Ministry of Urban Development and Poverty Alleviation (the erstwhile undivided Ministry) is an initiative to implement the provisions of the 74th CAA for empowerment of urban local bodies and provide
Legislative framework for implementation of the Urban Reform Agenda. Source <https://mohua.gov.in/upload/uploadfiles/files/URDPFI%20Guidelines%20IIA-IIB(1).pd>

on 14 March 2020 the Maharashtra state government issued a notification under the Epidemics Diseases Act 1987 that gives a municipal commissioner significant powers to take any action deemed necessary to control the pandemic. Interestingly, the Maharashtra State Disaster Management Plan 2016[2] barely mentions the role of ULBs in disasters and there is no mention of pandemic management in the same.

With regard to the complexity in governance, a crucial aspect of urban disaster management in the context of Mumbai has been highlighted by Bhide and Kamble (2020). They note that:

> *According to the National Disaster Management Act of 2005, the key institution to handle crises like floods and pandemics is a District Disaster Management Authority. Clearly the act falls short of imagination for a metropolis like Mumbai that actually comprises two administrative districts – Mumbai City and Mumbai Suburbs. Despite this peculiarity, the Municipal Corporation of Greater Mumbai is the institution responsible for disaster management in both the districts. In 2017, the Bombay High Court dismissed the idea of a single Greater Mumbai Disaster Management Authority with the municipal commissioner as its head and with the two district collectors as members. As a result, Mumbai has two District Disaster Management Authorities, one for the city and one for the suburbs – in addition to the Greater Mumbai Disaster Management Authority formed in 2011 with Municipal Commissioner as chairperson and key officials from the police, the railways and other institutions as members.*

In the current study, a similar situation has been seen in Navi Mumbai Municipal Corporation where parts of it are within the Thane District and some parts are within the Raigad District. Another point they note is that while the National Disaster Management Act has guidelines for relief during epidemics, during the pandemic guidelines were completely set aside. This was seen to have visible impacts on testing strategies, decisions about the nature of food-relief to be provided to groups that were facing hunger due to the lockdown and the sources from where resources could be obtained to avail of such relief (Bhide & Kamble, 2020). Over time, this friction contributed to slowing down the response of the government in curbing the effects of the pandemic.

In this context, this study aims to understand the handling of COVID-19 by three Urban Local Bodies in the Mumbai Metropolitan Region across three critical aspects of disaster response with regard to the urban poor and vulnerable groups.

The three ULBs include:

1. Municipal Corporation of Greater Mumbai (MCGM)
2. Vasai-Virar City Municipal Corporation (VVCMC)
3. Navi Mumbai Municipal Corporation (NMMC)

[2] <https://rfd.maharashtra.gov.in/sites/default/files/DM%20Plan%20final_State.pdf>

Scope of this Study

I. Municipal Corporation of Greater Mumbai (MCGM)

The Municipal Corporation of Greater Mumbai (MCGM) (MCGM) is one of the oldest formed corporations. It includes two districts i.e. Mumbai City and Mumbai Suburban. As the city grew northward, the boundaries of MCGM expanded from island city to western and eastern suburban regions. The MCGM consists of 24 Wards in total, with 9 wards in the island city towards South and 15 wards towards western suburbs and eastern suburbs in the North. These wards cater to a population of over 12.4 million as per the 2011 census, and are deemed to be growing exponentially ("Mumbai (Greater Mumbai) City Population Census 2011-2022 | Maharashtra", n. d.). The census also states that around 42% of the city's population reside in informal settlements (ibid.).

The pandemic embodied several challenges particularly for the urban poor, as numerous gaps in infrastructure, healthcare and sanitation persisted. To curb the spread of COVID-19 virus, the policy of Containment Zones adopted by the MCGM revealed various contrasts in its implementation. Although the policy was intended to lower the epidemic exposure, the implementation of Containment Zones in dense informal settlements did not affect internal contact rates (Tandel et al. 2021). This was because the residents continued to access the shared limited services, such as public toilets and water taps, and also due to indoor crowding. According to the data from MCGM's Preparatory Studies[3], R ward has the highest number of population followed by K ward, M ward and P ward. This is due to the presence of dense informal settlements that splinter across these wards. A study reveals that, there were a high number of containment zones in wards with a high number of informal settlements (Tandel et al. 2021). Dharavi being a huge hotspot during the pandemic received large attention from the ULB. However, the situation worsened in the northern wards and P North ward emerged as a highly affected area with a double positive case rate (Kumar 2020).

For this study, P North ward is investigated in detail owing to the ward's high vulnerability during the pandemic along with the presence of a high number of urban poor settlements. In June 2020, P North ward had emerged as a hotspot with the second highest number of active cases; within a span of a few days, P North reported the highest case growth rate in Mumbai at 5.9% (Deshpande 2020). Around 70% of these cases were from *bastis* like Konkani Pada, Santosh Nagar and Appa Pada.

II. Vasai-Virar City Municipal Corporation (VVCMC)

The Palghar district consists of 8 talukas, which include Vasai Taluka with 125 villages, 2 towns and 5 cities. The Vasai-Virar City Municipal Corporation (VVCMC) and Chandrapada Census Town are the two towns that come under the Vasai Taluka. The Vasai-Virar City comes under the Vasai-Virar City Municipal Corporation, with 50 villages and a population of 1,222,390 as per census 2011, with a growth rate of 317% (Cox, Renn, and Abley 2011). According to the census 2011 the total number of slums in the VVCMC amounts to 2.92% i.e. 8,158 households with around 35,691 population. Further, Nalasopara region has a population of 184,664 houses and just under half a million people (Census, 2011), which accounts for 38% of the population of Vasai-Virar (Jose, 2017). This is due to the presence of large-scale industries which amongst other factors

[3] Data from MCGM's Preparatory Studies, for the Revision of Mumbai's 20 Year Development Plan, 2013.

contributed to growth of informal settlements in the region. It is estimated that this region houses over five lakh population in informal settlements namely Santosh Bhawan, Bilalpada, Dhanivbaug, Shriram Nagar, Jadhavpada, Valaipada, Waliv etc. Most of them are inhabited by migrants working as industrial workers, construction workers, daily wage workers, hawkers and domestic workers. The situation in this region exacerbated during the lockdown due to shut down industrial workshops and construction sites.

During both first and second lockdown this region had become a major hotspot of COVID due to several issues ranging from poor public infrastructure, lack of healthcare services, issues in following social distancing norms etc. (Sharma 2020). Besides, several governance and management issues surfaced during the COVID pandemic due to the nature of governance that persists in the region. For this study, the entire municipal territory has been investigated through gaps in governance during a disaster event, with a focus on urban poor communities in the region.

III. Navi Mumbai Municipal Corporation (NMMC)

On the map of India, Navi Mumbai stands out as one of the few planned cities in the country. Stretching across the Thane and Raigad districts, it was envisioned with the objective of reducing the burden on the adjacent city of Mumbai. According to the Census of 2011, the total population of NMMC is 11, 19,477. The city has a floating population of approximately 2, 50,000 persons (YUVA, 2017).

The city was planned and developed by City and Industrial Development Corporation (CIDCO) to meet the burgeoning infrastructural needs of a modern metropolis. Urban planners saw Navi Mumbai as an alternative city, with greater planning in terms of economic and residential options, and hence imagined that it would become an alternative to residents and migrants of the city of Mumbai. The plan anticipated to reduce homelessness in Bombay, provide residents of slums a better life and absorb migration from the countryside (Ananthakrishnan, 1998). The new city was designed such that it has a number of nodes/townships which accommodate industrial and commercial activities as well as offer secure and affordable housing to workers (YUVA & IPSA, 2020).

While the Navi Mumbai region was previously managed by CIDCO, the Navi Mumbai Municipal Corporation (NMMC), established on 1st January 1992, now functions across 8 zones (Belapur, Nerul, Vashi, Turbhe, Koparhairane, Ghansoli, Airoli and Digha) and is divided into 111 electoral wards.

Yet rapid development and a burgeoning population in the new city have presented challenges of urban development similar to other cities in the country. Despite housing being a priority in its conception, Navi Mumbai has 48 notified slums with 41,805 households (AIILSG, 2016). Estimates about the non-notified slums are more than double of these. Most of the residents of these households live on the brink of insecurity, as they are employed in the informal economy and face the regular threat of forced evictions at their residence. Moreover, since the NMMC is yet to unveil its first Development Plan, over 29 years after its establishment, the model of development, and how envisages to include or exclude the urban poor is yet to be seen.

For this study, one ward, i.e. Belapur, was considered due to the high incidence of COVID-19 cases during the second wave (Mumbai Live Team, n.d.). With a population of 1, 43,091 (Census 2011), the ward is also an administrative headquarters, and houses several important government buildings including the new NMMC head office.

Districts	MC	Urban governance - ward division	Population of MC (Census 2011)	Percentage residents in informal settlement (Census 2011)
Mumbai City and Mumbai Suburban	MCGM	24 administrative wards 236 electoral wards	12.4 million	42%
Thane and Raigad	NMMC	8 zones 111 electoral wards	11,19,477	18.48%
Palghar	VVCMC	9 administrative wards 115 electoral wards	12,22,390	2.92%

Table 1.1: Administrative and Demographic distribution of the MCGM, NMMC and VVMC

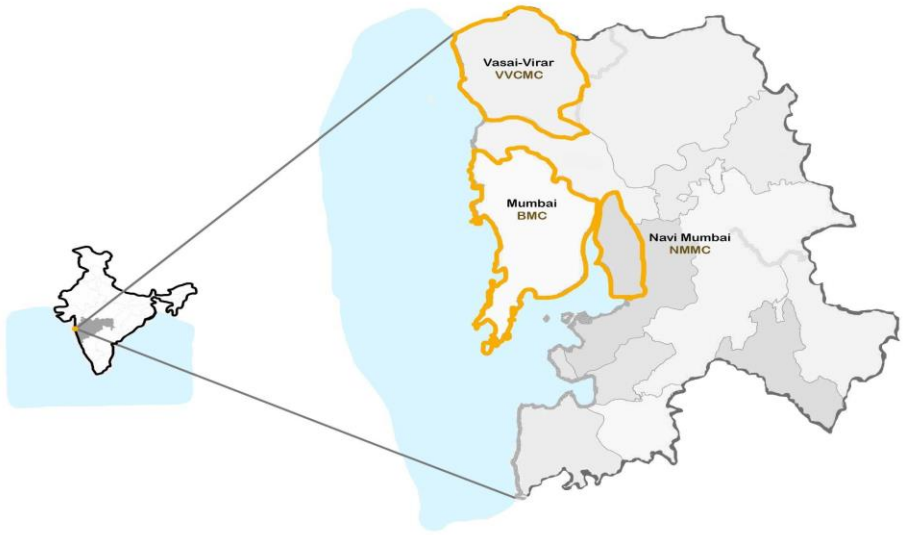

Fig 1.2: Location map showing the Mumbai Metropolitan Region boundary and administrative boundaries of 3 Municipal Corporations that form part of this study. Source: Author.

A. Aim of the study

To understand the management of the COVID-19 pandemic by Urban Local Bodies across three critical aspects of disaster response i.e. relief response, healthcare infrastructure and vaccination, with regard to the urban poor and socially vulnerable groups.

B. Objectives

1 Identify the key measures, scope and delivery mechanisms taken for immediate response by the local government system in the face of the pandemic and the humanitarian crisis, focusing on 3 key aspects: i. Relief ii. Vaccination iii. Healthcare infrastructure for homeless, migrants and vulnerable communities, while also assessing the role of non-government actors in enabling the accessibility of the above-mentioned aspects.

2 Understanding major barriers, as also best practices, in disaster response with a focus on the issue of access to basic services.

3 Proposing recommendations for strengthening the role of local government in managing disasters, with particular emphasis on reaching out to urban poor and socially vulnerable.

C. Research Questions

1 What was the role of ULB's in the management of the COVID-19 Pandemic, in tandem with the Centre and State Government, as also Non-government actors?

2 How were different aspects of disaster relief (Food, Healthcare and Vaccination) provided to the urban poor and vulnerable communities by the local government institutions and functionaries?

D. Methodology

This study adopted a qualitative research design, primarily collecting information through interviews and focus-group discussions. This was supplemented with statistical data from the reports published by government agencies, and secondary sources which provided an on-ground perspective, including reports previously published by YUVA.

The qualitative data was collected through in-depth interviews with state and non-government actors and Focus Group Discussions with residents. The interview schedules have been attached in Annexure A.

The findings are based on an analysis of in-depth qualitative interviews with key stakeholders, including:

1. Ward officials
2. Block level authorities
3. Elected representative s
4. Primary Health Centre, Health Post and Anganwadi workers involved in screening, testing

5. NGO workers involved in relief, vaccination and rehabilitation
6. Community-based organisations, activists and volunteers involved in relief and vaccination (youth, women's groups, etc.)
7. Front Line workers and Healthcare Staff at government hospitals and health posts

The validity of these responses has been confirmed by the triangulation of data through FGDs which were conducted with residents of slums in each selected ward across the three ULBs in the MMR. The participants in the FGDs included migrant workers (street vendors, construction workers, domestic workers, daily wage workers) and socially vulnerable persons (elderly, disabled, widows, children, and homeless). This perspective was essential for the study, as the residents of slums often live in the shadow of the city plagued by informality, in occupation and residence, which is often the reason for their disenfranchisement as citizens of the city. With some of these settlements emerging as COVID hotspots, the beneficiaries and non-beneficiaries of relief and government services offered a clear reflection on the efficiency and timeliness of the efforts in reaching vulnerable groups during a disaster. Finally, these settlements proved easier to access as YUVA has engaged with the residents in the past for work on basic services and social protection, and then later during the relief-work in the first and second waves of the pandemic. In total, 21 in depth interviews and 5 FGDs have been conducted in Mumbai, Vasai-Virar, and Navi Mumbai.

Municipal Corporation	Focus Ward	Interviews[4]	Focus Group Discussions
Municipal Corporation of Greater Mumbai (MCGM)	P (North)	State Actors: 3 Non-government Actors: 2	1. Ambujwadi
Vasai-Virar City Municipal Corporation	Entire VVCMC	State Actors: 2 Non-government Actors: 8	1. Dhaniv Baug, Nalasopara (E) 2. Gangripada, Nalasopara (E)
Navi Mumbai Municipal Corporation	Belapur	State Actors: 2 Non-government Actors: 4	1. Tata Nagar, Belapur 2. Female Domestic Workers, Belapur

Table 1.2: Sample of the Study

For the purpose of the report, the names of the interviewees (state and non-government actors) have been included, with due permission from each participant. The participants in the FGDs have been anonymised in keeping with their request for privacy.

[4] Details of interviewees have been attached in Annexure B.

The qualitative data once collected was transcribed and then coded into major themes - including roles of stakeholders, response, decision making, collaborations, real time information and data sharing on the situation. A network analysis will also be conducted on the qualitative data gathered from the interviews to understand the linkages and key nodal points instrumental in effective relief and rehabilitation work.

Selection of Location

To understand effective approaches for delivery of relief and rehabilitation during complex disasters in slums, this study was conducted in the three cities - Mumbai, Vasai-Virar and Navi Mumbai. The cities were selected as they represent Municipal Corporations with differing trajectories and functioning born out of their historicity, geographical and demographic constitution, budgetary robustness and structure of governance.

While the context and practices of each ward differ slightly within and across cities, some common rules and governance mechanisms apply to administration at the local level. Hence for the purpose of this study, it was initially decided that one electoral ward would be selected in each of the cities since it was considered that the findings and recommendations would have transferable implications for other wards within the same municipal limits. However, as the study began to be implemented this approach held true for MCGM (P/North Ward) and NMMC (Belapur Ward). In Vasai-Virar, the entire constituency that fell under the purview of the Municipal Corporation was considered.

Chapter II

Measures, Scope and Delivery Mechanisms of Relief by ULBs & Non-government Actors

This chapter outlines the good practices of each ULB, and the civil society in that municipal corporation, in responding to the pandemic. It specifically looks into relief measures such as the provision of cooked food and ration, transport, shelters, healthcare, water and sanitation. It also proceeds to outline the vaccination drive, taken up from 2021. The role of state (ULB) and non-government actors (civil society organisations and independent activists) have been delineated.

While the state often considers the universe, in the sense of the population, non-government actors played an important role in ensuring a bottom-up approach of pandemic management and ensuring last mile delivery access to people. Yet there were several forms of collaboration in the provision of essential services, bringing up issues to the media, ensuring healthcare facilities for all, and several others. These have been included, too.

A. Scope of Relief Offered by the State and Central Governments

The COVID-19 pandemic has put the three-tier system of Indian governance to the test. As the virus spread from region to region, across urban and rural belts, the government had to address myopic challenges at the local level, but also intervene through policy and action, adopting a macroscopic lens. Also, since the effects were not limited to systems of health, it was necessary to address each dimension (health, education, food, water, etc.) independently, so as to address specific challenges, while keeping in mind the inter-relatedness of these dimensions and how they affected the vulnerabilities of populations at risk.

Before understanding the role of urban local bodies in addressing the pandemic through policy and programme, it is necessary to first step back and take a look at national and state government interventions during this time. This provides the backdrop to the situation in which each ULB was functioning.

1.1 Ration & Cooked Meals

From the beginning of the pandemic, vulnerable persons across the country expressed that hunger was equally or more likely to kill them than the coronavirus. They reached out to government authorities and other humanitarian actors to prioritise food distribution. Soon, the Central Government sanctioned relief through the PMGKAY with different benefits for ration card holders in each wave. Under the scheme, all card holders received their usual entitlement with an additional 5 kg of grain (rice and wheat) per head and some other supplies, usually some form of dal ranging from 1-2 kg and/or sugar. Similarly APL families were entitled to 5 kg of rice and wheat at INR 12 and INR 8 per kilogram per person, during the first wave. The

government also understood the struggles of migrant workers without a ration card; hence, non-ration card holders were invited under the AtmaNirbhar Bharat Abhiyaan, to receive 5-10 kg of free ration per family member on providing their Aadhaar Card as a proof. However, this scheme was implemented only in 2020, and was minimally utilised because of low levels of awareness (among the citizens and ration shop owners).

In the next waves, however, entitlements were dropped for APL households. Yet a new development in 2021, was the stepping up of State Governments to provide food relief; one example is the case of the government of Maharashtra providing one month's free ration to card holders in between April and June 2021. (YUVA & UNICEF, 2021)

With regard to cooked food relief, the government extended the services and expanded the scope of the Shiv Bhojan Thali scheme, introduced in January 2020. The Shiv Bhojan Kendras provide pre-cooked thalis at reasonable rates at railway stations, bus stands, public hospitals, and other accessible locations. Unlike the PDS, citizens required no prior registration and could avail of meals at any centre on production of any government-issued identification. These centres continued to serve meals during lockdown aimed at ensuring food security for the urban poor. The cost of the meal, which was initially INR 10 was reduced to INR 5 per thali; for a short period in 2021 the thali was offered at no cost. On 30 June 2021, there were reportedly 1,315 active SBKs, some of which even served packaged meals to adhere to the requirements of social distancing while also making it possible to reach populations like the elderly and disabled, who could not travel to the centre (YUVA & UNICEF, 2021).

1.2 Transport

Initially when migrants from states across India started travelling on foot, the state recognised the need for transportation relief. On June 9, the Court directed central and state governments to support stranded migrants. For which around May 2020, 11,379 state transport (ST) buses were released that carried about 1, 41,798 migrant workers up to the border of Maharashtra (Laskar 2020). Subsequently, after receiving huge demands, buses and Shramik special trains were permitted by the central government subject to coordination within different states. On the basis of migration patterns as per census 2011 data, the authorities identified and sought to open up rail transport between Maharashtra and Gujarat to Uttar Pradesh and Bihar (Iyer and Dutt 2020).

Image 2.1: Migrant workers queue up for a seat in a bus (Source: Maha PECOnet)

1.3 Healthcare

The word "triage" in medical terms refers to sorting injured or sick patients according to their need for emergency medical attention. It is usually used when there are more patients and less resources available for the treatment. During the pandemic, Municipal Corporations adopted the similar triage model to avoid panic and crowding at healthcare facilities. The triage model of COVID-19 management was categorised as follows: i. DCH (Dedicated COVID Hospital) ii. DCHC (Dedicated COVID Health Centre) iii. CCC (COVID Care Centres) which were CCC1 and CCC2. Based on the seriousness of the patient's symptoms, travel history and age they were sent to above mentioned centres.

In addition 24x7 war rooms were set up in each ward, where government staff worked on shifts, under the guidance of a medical officer. Each war room had a dedicated helpline, where citizens could call in for different types of assistance. Additionally, staff received a detailed list from the ICMR every morning, based on which they would call the patients to categorise them based on degree of symptoms, and in cases where they realised home-isolation was proving difficult they made efforts to find hospital beds or institutional quarantine after checking the dashboard. The war rooms received calls not only for beds, but also for tests, ambulances and from people who are developing symptoms but have not yet been tested (Mahale, 2021).

Healthcare Infrastructure	*Particulars*	MCGM (P-North)	VVCMC	NMMC
Urban Primary Health Centres	*Where patients can approach the doctors for a regular check-up*	11 UPHCs in P North ward	21 UPHCs across VVCMC	23 UPHC across NMMC
COVID Care Centres (CCCs)	*For suspected and confirmed patients with mild COVID-19 symptoms*	14 CCCs in P North ward	1 CCC across VVCMC	17 across NMMC

Dedicated COVID Health Centres (DCHCs)	*For suspected and confirmed patients with moderate COVID-19 symptoms*	2 DCHCs in P North ward	1 DCHC across VVCMC	DCHC+DCH = 40 across NMMC
Dedicated COVID Hospital (DCH)	*For suspected and confirmed patients with severe COVID-19 symptoms*	1 DCH in Malad in P North ward	3 DCH across VVCMC	

Table 2.1: Distribution of Medical Facilities in MCGM, VVCMC & NMMC during the first wave.

Source: For MCGM https://stopcoronavirus.mcgm.gov.in/; for VVCMC: https://palghar.gov.in/public-utility-category/covid/; for NMMC: https://www.nmmchealthfacilities.com/HospitalInfo/showhospitalist

1.4 Water, Sanitation and Hygiene (WASH)

The immediate reaction of central, state and local mechanisms focussed on providing food and healthcare relief. Likewise most non-government actors like mandals, NGOs, volunteers, unions- also inclined towards immediate relief. But as lockdown extended the existing problems on Water, Sanitation and Hygiene in bastis surfaced. The urban poor communities lack access to these basic requirements, for instance, most bastis depend on informal water supplied through tankers. During the COVID-19 lockdown, these informal water suppliers became unavailable, thereby making access to water supply and sanitation extremely difficult. Moreover, norms on hygiene and sanitation induced at the state or ULB level could not materialise in bastis as they have existing gaps on waste management, toilet accessibility, etc. Through interviews and secondary research it was evident that there was no or less focus on issues related to WASH. The respondents also shared that the situation worsened during peak summer summer season due to lack of water availability and during monsoon when the storm water drains overflowed carrying garbage into houses in bastis.

2. Vaccination

COVID-19 vaccination began on 16 January 2021. During the first stage of vaccination only public health workers were inoculated, followed by frontline workers, senior citizens above 60 years and citizens in the age group of 45 to 59 years with comorbidities.

The second phase of vaccination began on May 1, 2021, to be extended to the age group of 18 to 45 years. The vaccination drives were held at private hospitals and makeshift infrastructure like schools and grounds, too. The booking was done on the cowin.gov.in app with Aadhar card linked to it. These slot booking made it difficult for communities which were not able to access the application and technology, creating a digital divide. The first two stages of vaccination created havoc on the sites by people who would stand in long queues and still were not able to benefit. From September 2021 onwards, with COVAXIN receiving approval from the WHO, there was a greater availability of vaccines, easing out the drive. Gradually vaccination camps were set up by civil society groups, resident's welfare associations, offices, as efforts to make them accessible to all. From January 2022, onwards vaccination for children from age 15-18 began. Many secondary schools

set up vaccination camps inside school premises for students. Along with this vaccination drive for administration of booster doses have also begun.

B. Scope of Relief Offered by the ULBs and Non-government Actors

I. Municipal Corporation of Greater Mumbai (MCGM)

The intervention and approach used by the MCGM were based on a containment strategy and the guidelines on COVID 19 prepared by the Ministry of Health and Family Welfare (MoHFW) (Khaparde, S. et.al. 2021). Initially, in March 2020, MCGM handled the pandemic at the ward level. The strategies for pandemic management were monitored regularly by MoHFW and the required suggestions and recommendations were made to the MCGM and ward officers.

The plan largely focussed on healthcare which involved testing people with a recent travel history, providing direct care to COVID patients and establishing quarantine facilities. Later, strategies on relief - shelter, ration and helpline facilities for migrant workers were developed. When the city-wide lockdown was announced in the last week of March 2020, the MCGM along with its ward officers prepared a list for disaster relief which included cooked meals, shelter homes and ration services. War rooms were created in every ward with a helpline number to support people with healthcare and relief-related issues. The MCGM's approach was to create a citizen-centric model in order to bridge gaps between the authorities and citizens.

The MCGM's model of COVID-19 management, particularly in high-density informal settlements, was appreciated globally. This highly decentralised system aimed at tackling COVID from the grassroots. A community engagement model, which later came to be known as the "Mumbai' Dharavi COVID-19 model", stood on the shoulders of a doctor, a community health worker and local volunteer who used the door-to-door approach as key to controlling the spread of the virus. Since some of the emergent containment zones were the densely packed informal settlements like Dhararavi, which included Worli Koliwada, Malvani and Asalpha, the MCGM's COVID-19 response adopted "Chasing the Virus'' strategy which was effective with its 4 Ts : Tracing, Tracking, Testing and Treating in high risk clusters (Alexander and Bhatia 2020). Thus instead of anticipating the spread, the teams were alert and acting to pick up the cases as they emerged.

1. Relief

1.1 Ration & Cooked meals

Relief provided by the State mechanisms

The food relief in MCGM was provided through the office of the Community Development Officer (CDO). During the initial phase, there were around 5 locations identified at ward level for meal distribution, yet as the lockdown was prolonged these locations ranged between 100 and 824 locations on any given day. The

organisation of pre-cooked meal preparation and distribution was decentralised. MCGM appointed Nodal officers and Deputy Collectors for each area and requests for relief came through the nodal officer. At the grass root level, the elected representative based on the electoral ward requirements would request CDOs for packets on a daily basis.

For food, MCGM assigned tenders to restaurants to provide pre-cooked, packed meals from their kitchens as per requirement. The preparation of lunch would last from 10am to 2pm; and at around 3 pm the packages were distributed to designated wards. In the P/N ward the packages would come from Goregaon and Dadar, and as many as 1500 packages were distributed per day to homeless and communities in slums. Another mode of cooked food relief arranged by the MCGM was through the Shiv Bhojan Kendras, detailed earlier.

During the first lockdown the state authorities extended free ration supplies for one-month to homeless and poor communities across the state. Additionally, the MCGM's Additional Municipal Commissioner in coordination with the Rationing Controller's Office, and charities created plans to work out the implementation modalities of the relief for persons who did not possess ration cards.

Relief provided by Non-government actors:

While the central government ordered free ration only for those who had ration cards, migrant labourers who work on daily wages and contract basis experienced loss of livelihood. Cooked meals, too, did not always reach these workers. The invisible nature of their places of stay acted as a barrier to receive relief. Yet the need for food was glaring, and so several independent and collaborative ventures were born at this time steered by the civil society.

During this time communities started coming together and formed local self-help groups, who then sought help from different NGOs for food relief. In P/N ward, Panchsheel Katta was a self-help group started by a few friends from the neighbourhood of Ambujwadi. They began with distribution of food to the homeless and slowly expanded their network with the help of NGOs; finally, they report to have distributed around 3500 ration kits. Other youth groups, like Malvani Yuva Parishad (Malvani Youth Council), from Ambujwadi, had their own approach. Using social media, they started the #FightAgainstHunger initiative, to raise funds and gather support from NGOs.Over the period of a few months, they distributed 10,000 packets of upma (semolina) and poha (flattened rice), and 1,500 packets of pasta, to families in P/North adversely affected by the crisis (Venkatachalam and Memon, 2020).

Individuals, too, raised funds to make sure that people got enough food to survive the lockdown. Faiyaz Shaik, an independent volunteer from Malvani Mumbai set up a Community Kitchen in Ambujwadi during the second lockdown (PTI 2021). As he previously ran a school in Malvani, he initiated partnerships with NGOs to distribute ration to the students and their families. Given the previous association, the ease in accessibility and data management was experienced.

Image 2.2: Minaj Nadab, single mother and auto driver, delivers cooked food parcels to UP-bound bus transporting migrant workers (Source: Maha PECOnet)

Besides this there were several collaborative ventures within the precincts of the MMR to provide food relief to people. Milkar for Mumbai was one such coalition that aimed to bring together MCGM, NGOs, citizens and corporate partners to ensure that the ongoing city-wide food relief distribution efforts are data-led, aligned and focused, reaching the most vulnerable groups in time. One of the key tools formulated with a transparent online database which revealed real-time and authentic information of families who require food assistance, mapped across 24 wards of the city. This allowed individuals to make donations by selecting a ward and the corresponding NGOs working. Moreover, corporate partners promised a 5x multiplier to every individual donation made, thereby rapidly increasing the scope of relief (CSR Mandate, 2020).

Another collaborative initiative, born out of the pandemic, was the Jeevan Rath which operated through the first wave, and was later formalised under the aegis of the Maha PECOnet 2.0. This was a venture convened by UNICEF Maharashtra, to bring the distributed efforts NGOs and CBOs under one roof, for better coordination and more effective reach. In early 2020, Jeevan Rath literally translating to a 'Relief on Wheels' stationed vehicles along the highways, at a few strategic locations like the toll nakas, to distribute cooked meals twice a day and water and fruits such as bananas, apples and pears throughout the day to migrant workers as they made their way home or found themselves stranded in the city. The collaboration claims to have reached over 1.2 lakh migrants and have fed 31,065 travellers with cooked food while providing ration kits to 19,410 households.

Khaanachahiye.com, too, started by handing over a cooked meal, a snack, a bottle of water and, in some cases, soap or hand sanitiser and a face mask to passengers boarding Shramik trains out of the city. While

the group began with providing these facilities on 6-7 train routes in early May 2020, it soon extended to about 75 trains by the end of the month. Liaisons with the police and railways ensured that their volunteers were stationed at entry points to make sure every passenger boarding the trains received food assistance. They also set up similar cooked food supply chains along the highways and in labour camps of the city (Iyer, 2020).

Image 2.3: Distribution of Food Parcels to passengers on Shramik Trains (Source: YUVA)

Similarly, YUVA ran an online campaign called 'Together We Can', which appealed to individuals to donate for COVID relief (Deshpande 2020). In order to extend the outreach to most vulnerable groups, a surveying and coupon system was opted- where volunteers conducted surveys in each *basti* and distributed coupons to families. Through this, food ration packets were distributed in communities in Malad and in *bastis* across Mumbai, Navi Mumbai and Vasai Virar.

At the same time, some religious groups like Jamaat-E-Islami Hind distributed food packets and groceries to the poor and daily wage workers in several Wards, including informal settlements in Malad, P North ward. Likewise, organisations like Citizens for Justice and Peace (CJP) in partnership with welfare societies, foundations and local organisations working with transgenders, elderly and orphans were able to increase their last mile connectivity (CJP, n.d.). As a delivery mechanism, they used trucks to deliver ration in *bastis* across Mumbai which includes Malvani, P North ward. These local partnerships enabled their outreach to extremely vulnerable groups like sex workers, orphans, destitute, homeless, hand-cart pullers, taxi and auto rickshaw drivers. Despite the gratitude that people in the slums felt for the support they received, they didn't fail to note that as opposed to dry rations, the cooked meal often made them dependent on the person who provided the food/. Since assistance was received on a daily basis, the period was instead defined by uncertainty and a lack of self-sustenance.

1.2. Transport & Shelter

Relief provided by the State mechanisms

The MCGM prepared a list of shelter homes that would cater to the homeless and migrants of the city. To support migrants stranded along highways, the central government permitted the use of state Disaster Response Fund to build shelters and support such pre-existing structures. Following this, the MCGM identified newly constructed buildings in their jurisdictions which are unoccupied so that they can be assigned temporary adaptive re-use for stranded migrants (Singh 2020). 30 makeshift infrastructures were assigned as shelter homes. These shelter homes served cooked meals and had beds, and ranged in capacity from 40 to 800 beds. The largest shelter in M/E ward had a capacity of 1600 beds, housed in a vacant MHADA building. While initially they were managed by MCGM itself, later bids were invited from local NGOs to run these shelter homes. As of April 2020, only 853 homeless had benefited from these shelters (Ashar, 2020) to trace the stranded migrants the ward level officials started data collection and the MCGM approached NGOs to support food rationing.

The migrant exodus got traction when from May 1 the Indian Railways started Shramik Special trains. According to railway officials, Maharashtra and Mumbai saw a majority of exodus with long queues, waiting for hours at railway stations, stampedes, and insane rush to catch these long-distance trains. From Mumbai and MMR itself, the railways and state-run buses sent 18 lakh plus migrants to various parts of the country (Rao, 2021)

In order to ensure smooth functioning of government works, particularly the COVID response, the MCGM ensured continuity of functioning of the local trains for essential workers during the pandemic. When this was opened to the general public in 2021, the railway authorities demanded a compulsory 2-dose vaccination certificate as proof for safe travel on local trains.

Relief provided by Non-government actors

While travel and shelter needs were largely met by the government, different civil society organisations and individuals provided critical help to stranded migrants as well as auxiliary services. From small ventures which included law school students and alumni chartering a flight for migrant workers from Mumbai to Ranchi (Ravi, 2020), to organisations like the Stranded Workers Action Network, an informal group of volunteers who coalesced to connect relief to workers stranded across India due to the COVID-19 lockdown, which is said to have supported around 45,000 workers through ration and financial assistance for their travels (Sofi, 2021).

Another interesting support mechanism was the Crisis Management Centre (CMC) run by Jeevan Rath. 18×7 helpline was set up during the first wave which tracked, provided support and ensured that the migrants had reached home safely. The helpline has tracked over 70,000 migrant labourers and ensured their safe journey.

By providing end-to-end relief support through partner NGOs, it also provided moral support to migrants reminding them that they were not alone and help was just a call away. Additionally, the network also provided, last-mile connectivity through taxis and other private vehicles were arranged from remote areas, in the city or to their destination villages. They also gave cash transfers to migrant workers, guaranteeing them some financial support, if the need arose (Rise Infinity Foundation, 2020).

1.3. Healthcare

Relief provided by the State mechanisms

At the beginning of lockdown, Kasturba Hospital for Infectious Diseases in Mumbai functioned as the main centre for screening and testing for citizens with international travel history. Further, people showing symptoms like fever, cold and cough, were sent to 8 MCGM hospitals and 11 private hospitals for testing. At the DCH, there were screening and testing facilities, while the hospitals were also equipped with beds, oxygen and ventilator facilities, in case of emergency treatment. During the first phase of lockdown, there were 14 hospitals dedicated to severe treatment of patients, though most of these were located in the southern region of Mumbai.

As the duration of lockdown increased and the number of patients increased, the DCHC started to function. These health centres provided basic treatment for mild symptoms patients. Every ward had at least one dedicated COVID health centre, these health centres were further connected to CCCs which were public infrastructure like schools, community centres and hotels transformed into isolation centres for symptomatic and asymptomatic/close contact patients were to be quarantined until the test results were received. The CCC1 functioned as an isolation centre for patients with mild symptoms and were tested positive while CCC2 functioned as an isolation centre for high-risk contacts who were unable to isolate themselves at home. These facilities had bed capacities ranging from 200-5000 (Jumbo CCCs) and were equipped with beds with oxygen cylinders, and ambulances for emergencies. These centres were also provided food from MCGM's community kitchen. "The decentralised management of COVID-19 and the decentralised system of MCGM's administration divided the roles and responsibility and helped tackle COVID-19 at the last mile level," said the medical officer of P/N ward.

During the second wave, there was a rapid rise in cases. At this point, in addition to the triage model, the MCGM also set up COVID war rooms, similar to disaster management control rooms yet decentralised in their functions. Every ward had dedicated war rooms to help and assign beds to the required patients as per the severity in their designated wards. They also helped in the 4 T's of COVID-19 management (Tracing, Tracking, Testing and Treating).

The decentralised system of public health care sector of MCGM functions in following layers: the Public Health Officer is the main head of this branch; this sector further looks at 24 wards which are governed by the medical officer of health under ward level management of health has 3 sections: 1. Periphery hospitals 2. Dispensaries and 3. Health posts. In case of P/N ward there are in all 14 health posts under the supervision of the Assistant Medical Officer. Every health post caters to a predetermined neighbourhood, based on the population size. The Malwani health post, in P/North, caters to a population of 73,000 residing in slum areas.

The main role of the health post is to provide health services like vaccination, regular check-up, healthcare initiatives by state or centre. Every health post has a designated medical officer, nursing staff and CHV (community health volunteers). During COVID-19, they played a very important role in screening and testing in high-density areas. Apart from COVID-19, the CHVs tracked influenza-like illnesses, conducted regular scanning of the population and made people aware about new health initiatives of the government.

In this decentralised, yet highly-connected system, one thing that was highly appreciated was that the health department at MCGM directly received test reports from ICMR which was then sent to the respective ward. Following this, the war rooms along with medical officers at designated health posts would track down the infected household. The doctor would visit the patient and check for the symptoms and space availability for the isolation. Based on that information, the health post would take a call on further treatment of the patient and if they required closer monitoring and/or hospitalised treatment, to which centre they should be taken.

Relief provided by Non-government actors

Non-government organisations played a critical role in several humanitarian relief aspects, yet they were not far behind when it came to medical support. Certain NGOs who had previously focussed on medicine and nutrition were at the forefront of such work, particularly in lower-income neighbourhoods. In Malvani, for example, SNEHA had developed teams of CAGs who were community volunteers that served to link the community and public health services, while also encouraging community members to improve their health seeking behaviour. During COVID, these CAGs support the MCGM to identify COVID-19 patients employing their previously established networks in densely populated slums with migrating populations (Venkatachalam & Memon, 2020). The CAGs also assisted patients with information about self-isolation and by guiding them to the local health posts to receive treatment, while ensuring their confidentiality to prevent any social stigma.

With mental health being a core focus at SNEHA, the CAGs also took the additional measure of informing SNEHA's staff with regular updates on pregnant women who test positive for COVID-19, so SNEHA can counsel and support them. The organisation also understood that the non-medical effects of the lockdown had also caused several social stresses due to job losses, inadequate indoor-outdoor space, and ambiguity on future and access to resources and correct information. Hence, through their team of clinical psychologists and community based volunteers, SNEHA conducted emotional resilience sessions & counselling through online group calls. Along with this they also provided mental health counselling, anaemia follow-up and nutrition counselling to adolescents from *bastis* (Venkatachalam & Memon, 2020). Similarly, Cheshire Homes India organisation through their outreach centre in *bastis* of Malad provided therapy services to children with disabilities.

With the rise in severe cases during the second wave, most medical facilities were overwhelmed. With the government prescribing home isolation or treatment in many cases, people found their homes to be ill-equipped. Amidst the dire shortage of oxygen cylinders, conscious citizens stepped in along with local CBOs

to meet the needs. Unity & Dignity Foundation and individual volunteers like Rozy and Pascal Saldanha from Malvani bought oxygen cylinders for hospitals (Jain 2021), (Sud 2021).

Similarly, organisations, like HOPE Foundation, which had worked steadily on childhood nutrition providing relief to 950 children from Malvani (Bhattacharya 2021), also initiated several other healthcare interventions like supplying medicines, oxygen concentrators/ cylinders, masks, and sanitary pads for prison inmates etc.

Image 2.4: Health Awareness through posters and mics at public locations (Source: Maha PECOnet)

NGOs like YUVA and SNEHA, also ensured that information was not lacking among the communities. Hence, through their network of staff and volunteers they made announcements through mobile microphones about the prevention, symptoms and control of the virus. Similarly, they partnered with religious leaders, to make announcements over loudspeakers after prayer times, hence appealing to people of faith in a language and medium that they were familiar with (Venkatachalam & Memon, 2020).

1.4. Water, Sanitation and Hygiene (WASH)

Relief provided by the State mechanisms

The MCGM used widely social media i.e. Instagram & Twitter, to disseminate awareness on WASH, correct information on the virus, and number of patients, helpline numbers and resources. Another factor that enabled large-scale outreach to spread awareness on hygiene and sanitation was its partnerships and programs with funding organisations, private sector, NGOs, RWAs, etc (India Today 2020) (Singh 2020).

The MCGM had undertaken the Slum Sanitation Programme (SSP) from 1997 to 2005, which was re-introduced in May 2020 to facilitate WASH outreach in *bastis* (Khambete 2020). For this, the municipality partnered with CBOs for the maintenance of community toilet blocks constructed under the SSP. In fact,

several of the MCGM interventions in the area of water and sanitation, showed the tremendous potential for collaboration with non-government actors, elaborated further below.

Relief provided by Non-government actors

In order to tackle WASH, shelter and migration issues of urban poor communities at a municipality level, more than 50 organisations came together during the pandemic under the SSP. In order to plan and implement SOPs for operating community toilets, protocols for sanitising community toilets, relief distribution near CBO-run community toilets were developed. This was coupled with rapid grassroots surveys and awareness raising. Various organisations collaborated to design and implement simpler solutions to prevent the disease from spreading, for e.g. designs for zero-touch, foot operated hand washing stations and sanitiser dispensers (Rangan 2020). Many trusts and organisation's inter-partnerships enabled last mile connectivity of relief. For instance, the Siddiqui Education and Welfare Trust collaborated with Fire and Safety Association of India (FSAI), to prevent the spread of COVID 19, carried out sanitisation of *bastis* of Malwani and its neighbouring urban poor settlements Ambujwadi and Azmi Nagar.

Image 2.5: Awareness-building session organised in Ambujwadi, P/North (Source: YUVA)

Awareness is also effective in bringing about behavioural changes related to WASH, particularly in the context of the pandemic. For this, the MCGM collaborated with several non-government organisations through their previous work in different dimensions. With Citizens Association for Child Rights (CACR), UNICEF Maharashtra and Tata Trusts Mumbai, the MCGM used their previous work on strengthening of school management committees, mid-day meal program and developing a school health program, to ensure wash supply like pedal-operated taps in over 50 MCGM schools. At the same time this partnership aimed to engage CBOs and Community Toilet Operators to reach out to 150,000 people and 30,000 children in the community in order to sensitise them about the importance of Infection Protection and Control as well as Risk Communication and Community engagement (Khambete, 2020).

In addition, in partnership with Hindustan Unilever Limited (HUL) and HSBC, the MCGM established 7 Suvidha centres in Mumbai, one of which is in Malvani in P North ward. These Suvidha Centres include toilets, hand

wash stations, cloth washing machines, and drinking water stations etc., which are aimed at improving access to WASH for urban poor communities. Additionally, in order to ensure maintenance of these centres and other existing infrastructure on WASH, MCGM prepared a set of SOPs and also conducted training in *bastis*.

Solid waste management is also a key component of sanitation and hygiene. Especially during COVID times, with the generation of waste from medical facilities, from cooked food and ration packaging, etc., the need to focus on this aspect grew to be more critical. Moreover, with restrictions on mobility, several community members reported that government services like garbage collection were lacking or reduced in frequency. In this context, in Appa Pada and Ambedkar Nagar, along with YUVA staff from the area, communities directed their focus to influencing governments to provide access to clean water, sanitation, and waste disposal services by writing letters and tweets to local businesses and authorities. In what was a pleasant turn of events, the MCGM stepped up their services to collect and dispose of 10 tons of piled up waste on one day, followed by weekly cleaning and sanitization of common spaces and community toilets. Additionally, youth collectives such as Malvani Yuva Parishad proved effective in catering to unmet community needs, like manufacturing masks, operating community kitchens, providing psychological peer support (Venkatachalam & Memon, 2020).

2. Vaccination

Relief provided by the State mechanisms

2.1. Planning & Infrastructure

As part of the Maharashtra government's Covid-19 vaccination campaign called Mission Kavach Kundal, the MCGM directed ward officers to organise camps in slum areas and create awareness about vaccination against coronavirus. In order to do this the slum clusters in Mumbai were used as the areas of focus. The P-North Ward has 212 slum clusters and vaccination outreach took place keeping in mind the needs of these communities. Officials were given the target of vaccinating more than 10,000 people in each slum with the time and session of the vaccination drive decided at the ward level (Mishra, 2021).

The MCGM also used effective strategization to repurpose the five Jumbo COVID-19 Centres previously created to respond to the surge of patients during the first wave, to later utilise a part of the venue as vaccination centres (WHO, 2021). In order to operate a successful vaccination drive, the vaccination teams were trained by WHO officers, UNDP teams and MCGM medical officers.

2.2. Registration & Transportation

In order to reach the populations that were hesitant, or unable to travel to the vaccination booths, the MCGM employed multiple strategies. For bedridden citizens, the corporation requested family members to email their vaccination requests to covidvacc2bedridden@gmail.com. Additionally family members could call in and make such requests through COVID-war rooms, too. Based on which they planned the first phase of home vaccination for 4,466 registered people, along with Project Mumbai. (Trivedi, 2021). This model

later received appreciation from the Bombay High Court which prescribed it for other civic bodies in Maharashtra.

In another venture, the MCGM identified areas where the vaccination counts were extremely poor given the population numbers. Here, the municipal corporation pioneered their mobile vaccination centres, operating in private and BEST buses. In late 2021, this was the attempt of the MCGM to reach those populations that were unable to avail of vaccination due to various reasons that included technological impediments (ANI, 2021).

Realising that women were another population who were getting left out of the vaccination drives, on September 17, 2021, the MCGM announced an exclusive day of vaccination for women across all MCGM centres. To increase the access, and draw more women in, the corporation announced that no prior registration would be required for women on the day, and vaccination was on a walk-in basis (Sinha, 2021).

Relief provided by Non-government actors

2.2. Registration & Transportation

One of the earliest signs of partnership between the government and civil society for vaccination was seen when the MCGM reached out for support to the Bhartiya Jain Sanghatana. The organisation agreed to set up help desks in vaccination centres to address queries of people and coordinate between vaccination officials and recipients. Simultaneously they conducted awareness drives to draw in greater numbers, and also took on the responsibility to conduct follow-ups post-vaccination with recipients (Express News Service, 2021).

A joint venture between the MCGM and the American India foundation saw the launch of the "Vaccine-on-Wheels" drive. They were provided with laptops and WiFi connection to register beneficiaries on CoWIN. Since each mobile vaccination centre comprised a doctor, two nurses and medical assistants, along with an ambulance driver, the inoculation took place on the spot. The initiative focused on administering the Covid-19 vaccine to commercial sex workers, HIV-positive persons, migrant workers, labourers, street vendors and hawkers, and covered Malvani under the Bhandup-Malad outreach effort (Express News Service, 2021). The CAG network of SNEHA reported to have facilitated the vaccination process to vaccinate 27,255 people in Malwani, Dharavi and Mankhurd at common municipal centres (SNEHA 2022).

2.3. Awareness

Several reports have highlighted the rapport and presence of CBOs and CSOs among the urban poor. This proved to be fruitful in raising awareness about the vaccine and dispelling myths associated with it. Several organisations have engaged with communities, one such effort of YUVA and Jamaat-e-Islami Hind saw the coming together of two organisations with different visions to see that the vulnerable Muslim community in Malvani was drawn into the vaccination process. Circulating videos with endorsements by religious leaders, and setting up vaccination desks in the community with influential members of the community frequenting the desk allowed people to develop a trust and find guidance to ensure the completion of two doses.

Image 2.6: Awareness and Registration on COWIN at vaccination helpdesk in Ambujwadi (Source:YUVA)

A representative from the Samyak Prayas Foundation spoke of the vaccination drive which was aided by the NGO. It began with awareness about the vaccine, its need and possible side-effects, which was followed by registration of those who were willing. They also organised three vaccination camps in Ambujwadi, serving over 1500 residents, in association with ChildFund India and American India Foundation. In January 2022, they also addressed the vaccination of children between 15-18 years, which was complemented with a general health check-up.

II. Vasai Virar City Municipal Corporation (VVCMC)

The Vasai Virar City Municipal Corporation was established in 2009 and it was in 2014 that Palghar district came into existence, prior to which it was under the administration of Thane. Historically and even today, the Palghar district predominantly consists of tribal population in its 8 blocks/tehsil i.e. Wada, Mokada, Talasari, Jawhar, Vikramgad, Dahanu, Palghar and Vasai. The Vasai block is an exception as it has a high percentage of urban population, which is why most concentrated urban demography of Palghar district resides in Vasai Taluka. Before the VVCMC came into existence, the Vasai taluka had a rural administrative structure with the Collector as the highest authority and Gram Panchayats with Panchayat Samitis at the grassroots level. Thus, the District authority, i.e. Zilla Parishad (ZP) was responsible for education, healthcare and other essential services with the support of the state in terms of transport, water supply etc. When VVCMC was handed over to the administration, they only took over certain systems like water supply, city planning, solid waste management and electricity department amongst others and the healthcare and education is still managed by the ZP. Thus, we observe a dual governance system in the Vasai Virar region with ZP influencing largely the rural areas and the VVCMC in urban areas.

Initially, when VVCMC received orders from the state indicating that as per the Census 2011 Municipal Corporations having a population of more than 10 lakh will be considered as the independent administrative units for curbing the spread of COVID-19 it meant that the VVCMC was responsible for the entire disaster

management. This would include providing relief measures, crowd control, tracing listing, active surveillance, providing healthcare and vaccinations at a later stage. But due to the dual form of governance there were some overlaps and gaps in collaboration between VVCMC and ZP. Thus in terms of the COVID disaster management and relief, this section discusses measures taken by the Municipality and the Zilla Parishad in coordination with the state government for the urban poor communities.

1. Relief

1.1. Ration & Cooked meals

Relief provided by the State mechanisms

At the start of the pandemic, when the state announced a lockdown the fear of coronavirus exacerbated, especially within informal settlements, where myths and rumours spread overnight. To plan for the lockdown, the Taluka authorities i.e. the Tahsildar, Niwasi Naib Tahsildar and Prant Adhikari devised a system for food, transport and shelter relief. Initially the authorities identified 10-12 large hotels in the region and approached the management staff for food preparation. Along with this ration i.e. dal, rice, vegetables and daily essentials were borrowed from Karadi mills and shopkeepers on a credit system. For distribution, 10 tempos were bought and for outreach the ZP schools were tapped, since the schools were situated within the community. The food relief distribution was carried out from around 38 ZP schools, and one Talathi was appointed to look after one school. Then the VVCMC set up 45 community kitchens - 9 in ZP schools and 36 other locations which included private schools, community halls, temples & anganwadi but locals complained that these were to be shut due to overcrowding (Barnagarwala 2020). In the first lockdown the demands for food relief were received on personal phone calls and a helpline was set up at a very later stage.

Relief provided by Non-government actors

During the first lockdown, the system for transportation, healthcare, and ration broke down in urban poor *bastis* and the local groups and organisations came together to provide relief. NGOs like YUVA, Kilbil, Paryavaran Sauvardhan Samiti amongst others worked in Nalasopara East *bastis* namely, Bhim nagar, Valaipada, Rathodi, Dhaniv Baug, Dhaniv Talao, Jadhavpada, Gangripada, Ganesh Nagar, Dhaniv Naka, Vanotha 1, Vanotha 2, Classic, Vakanpada etc. The food relief was required in 3 sectors- first being the vulnerable families in the *basti*, second being migrant labourers travelling on foot to their home states, third being migrants waiting at the Sun City ground for trains.

The NGOs YUVA and Kilbil realised that naka distribution system[5] does not work in such a crisis. Thus they developed their own methodology for relief distribution. The relief system included a team for listing, another team was assigned for packing and lastly a team for transport & distribution. The listing team went door to door and conducted surveying and listing of the most vulnerable family/person. The listing criteria

[5] Naka distribution- Many relief volunteers & organisations opted the method of naka distribution-where the food van is parked at a road juncture in the *basti*. This leads to overcrowding and people tend to hoard ration/relief kits.

included - are they handicapped, does the family have a ration card, do they have savings or any other form of help, are they homeless/beggars etc. After listing on day one, the distribution of ration started which included daily essentials, pulses & condiments. Joel Dabre from Kilbil Samajik Sanstha states that, “Per day around 300-350 kits were distributed and in this area we have helped more than 10,300 families.” Initially when people were scared due to circulating myths and rumours, grassroots karyakartas from YUVA NGO tried to initiate relief efforts by identifying local leadership and building a team of volunteers from the community youth groups. This helped to establish trust and also assist in generating awareness on COVID-19 in the community. Second type of ration distribution took place along the NH8 highway where ration kits were distributed to the travelling migrant families. “There were 70 people packed in one tempo with pregnant women and children, and people crowded the highway at 3 am in the morning. We sought to distribute water bottles, snacks and electral powder to them.” said Sameer Vartak from Paryavaran Sauvardhan Samiti. Lastly, since the announcement of railway reopening, the outer state migrants flooded the Sun City Ground where there were no provisions of shelter, food or water, thus Kilbil volunteers also distributed food relief here. Around 25-30 religious trusts from Vasai which include Churches from Vasai West, Madrasas & Temples started distributing Khichdi. Besides, Gurudwaras held langar twice a day for underprivileged groups.

Image 2.7: Distribution of Ration Kits to women in informal settlements. (Source: YUVA)

The west zone is a fairly low density settlement with farmlands and around 10% of its population includes tribal households, who live in Bhongas[6]. Jivandan Foundation & Jehona Nazareth from Vasai West undertook food relief for them along with local residents during the lockdown. The relief was carried out in Uttar Vasai

[6] Bhongas are temporary houses built using large palm leaves.

i.e. the coastal belt from Bhuigaon to Arnala which includes - Agashi, Nirmal, Nandakhed, Gas and Rajodi. Their relief team included - packaging, delivery, distribution and fund collecting teams. Through these and along with help from local police inspectors they were able to reach around 10,000 people. Besides, the CPI (M) volunteers also distributed ration kits to 500 urban poor families living in Nalasopara, Vasai and Virar (Rege and Hatiwlekar 2020).

1.2. Transport & Shelter

Relief provided by the State mechanisms

Nalasopara East is inhabited by large numbers of construction, industrial, daily wage, domestic and informal workers from other states like Bihar, Madhya Pradesh, Uttar Pradesh, Rajasthan etc. With the lockdown announcement the migrant population from Nalasopara East started travelling to their home states on foot. But, by the end of March 2020, the state government closed state borders, and the travelling migrants were left stranded on highways. Thus, relief camps were set up by approaching resorts along the NH8 highway, for e.g., the Nandanvan Resort where 40 migrant families were given food and accommodation for a limited period. Also to resolve the issue of transportation, around May 2020, the district level authority i.e. the Zilla Adhikari along with Vasai Taluka authorities approached the Railway Department to start inter-state rail transport during lockdown.

Image 2.8: People waiting at Sun City ground for out-bound trains. (Source: Maha PECOnet)

Around 65 trains were operated wherein, around 25,000 to 30,000 passengers were gathered at the Sun City ground in Vasai, and the entire system of ticketing, crowd management, and distribution of tickets was managed by the Tehsil authorities. Complaints of breaking social distancing norms, along with black market ticketing and unbearable heat were received during this period.

Relief provided by Non-government actors

Throughout the lockdown all state managed transport services were shut for the public, particularly the local train and bus services. Around 2014 all the State transport bus services in the region were discontinued after

which the VVCMC only started operating the services on contractual basis on routes that were profitable. Thus, most urban poor populations were deprived of reliable transportation services, thus depended on auto rickshaws for local transportation. But since lockdown restricted movement of people, auto rickshaw services also stopped. The patients suffering from severe health conditions were unable to access hospitals and there were no options to travel. Thus some organisations and individuals sought to provide for transportations costs of such patients. Volunteers from Kilbil also organised to and fro van service for patients in dire need. Lixson Almeida from YUVA recalls an incident where he mentions, "There were three cancer affected patients from *basti* who were rushed to Tata Hospital in Mumbai, 2 hours away from Nalasopara and could not be saved." But these requests for relief came when the organisation distributed rations in the urban poor localities, it was observed that initially no specific healthcare relief or mechanisms were active.

1.3. Healthcare

Relief provided by the State mechanisms

The Corona Virus Control Unit of VVCMC was formulated which looked after sanitisation, hospitalisation, quarantine etc. For this, the VVCMC set up COVID Care Centers (CCC) in cooperation with industrial sheds in the region, for e.g. the Varun Industries complex, was converted into a 1,200-bed CCC. The VVCMC like other municipalities reached out to private hospitals where they took over a few beds, for e.g. the Riddhivinayak Hospital where they took over 50 beds at this hospital for COVID-19 patients. In such cases, the staff, services and expenses were borne by the corporation. The civic authority also set up a 100 bed Dedicated COVID Care Hospital Centre (DCCHC) along with a testing laboratory at Chandansar in Virar (East) (Nair, 2020). Likewise, 12 other DCCHCs were set up in VVCMC, by taking over a certain percentage of beds & facilities from private hospitals.

The VVCMC also set up a Corona Control Room supporting relief work with Helpline services around second lockdown, previously the requests were coming in through offline or through phone calls in the VVCMC office. Also, tracing patients, listing hospitals, emergency contacts and other important information needed to be disseminated. Thus VVCMC developed a COVID Health Portal linked to its official VVCMC webpage where important lists along with phone numbers such as Primary Health Centers, medical doctors, positive patients, containment zones etc. were updated. Similarly the Zilla Parishad also developed and linked a COVID-19 Information webpage to its official website, where notices, bed availability, location of centres etc. were updated.

Rural Hospital	Primary Health Centres	Sub-Centres	Urban Primary Health Centres	Primary Health Unit	ZP Dispensary
1	8	38	21	1	1

Table 2.2: Vasai Taluka level healthcare infrastructure by Zilla Parishad

While VVCMC predominantly focussed on urban areas, the healthcare relief for rural regions was carried out by the Tehsil authorities. The ZP has an existing network of healthcare infrastructure (see Table). Along with this they also have ASHA workers, Auxiliary Nurse Midwife (ANM) and Aanganwadi Workers (AWW) working in the region. Thus, with this robust system, the ZP started basic healthcare relief and referral services. Initially district level meetings were held with Medical officers and then health staff along with officers were trained. Post this ASHA workers started listing, tracing, monitoring and tracking COVID patients. In August 2020, the 'Mission Super 30' was launched by a political party to rapidly test people for the COVID 19 virus over the next 30 days. This mission was aimed at conducting rapid tests within which the people detecting COVID positive can be contained and quarantined. Along with this, they also planned to distribute safety gear (Parmar, 2020).

Relief provided by Non-government actors

Similar to food relief healthcare relief was active most due the first lockdown and later the non-government actors inclined towards vaccination. Apart from COVID patients in the *bastis* there were also patients suffering with other health issues. Since the municipal hospital was overcrowded, we helped pregnant women or people requiring urgent health check-ups by providing transportation." RTPCR tests or dialysis were also conducted through NGOs in *bastis* as there were no accessible municipal health centres or laboratories nearby. Similarly since people were short on savings medicines along with masks, sanitizers, gloves etc. were also distributed. Indian Cancer Society held 2 medical camps in *basti*, where free medical and cancer check-ups were organised for the *basti* community.

1.4. Water, Sanitation and Hygiene (WASH)

Relief provided by the State mechanisms

Under City Services the VVCMC's Public Health Department is responsible for Water, Sanitation and Hygiene (WASH). During the pandemic the department repaired community toilets that were in poor condition. This repair was carried out for around 5 community toilets near private hospitals in Nalasopara East, particularly at Gokhivare, Kaner, Bori colony and two toilets in Tulinj. Under the program '*मि माझा रक्षक*' ('*I am my own protector*'), through the scheme "कोव्हीड-१९ प्रतिबंधात्मक उपायोजना" (COVID-19 prevention scheme) the VVCMC installed multiple Hand Wash Stations. This scheme was implemented in Ward E, Ward F, Ward G, Ward C and Ward D. These stations were positioned only in the urban areas, especially at East and West entry/exits of railway stations and near public places. It was observed that post installation, the locals

complained of theft of the hand wash station's properties. During lockdown the municipality also assigned a special team for sanitisation of public spaces in urban areas.

Relief provided by Non-government actors

"There are very few organisations that work on Community Development of urban poor in the Vasai Virar region. There were a few organisations that supported ration relief but because of lack of exposure critical requirements of water, sanitation and hygiene are not prioritised here" said Mecanzy Dabre, an activist from Vasai. Many organisations here largely focussed on ration or healthcare relief, thus a limited relief on WASH was observed in the region. The measures on WASH were only initiated when requests came in from the community or when the situation on WASH worsened. For this, the non-government actors became instrumental in helping demands from the community reach the concerned authorities. When the lockdown was announced during peak summer season, the prices of drinking and daily usage water hiked. For this YUVA and the community approached Nagarsevak and demanded re-opening of 3 existing borewells around *bastis*. This relieved some pressure of residents from some localities on daily expenditure on water. During monsoons, issues on pests/rodents and the related disease arised, for which the Health department at VVCMC was approached through NGOs for pest control in *bastis*. Besides, garbage collection and its disposal was another issue that led to several health related diseases especially amongst children. For which the VVCMC's Waste Management Department was approached for timely and daily collection of waste. Along with this, after constant demands the authorities installed a few garbage collection bins around a few *bastis*.

As a part of the Jeevan Rath Initiative, FICCI FLO Mumbai and ELSA Mumbai collaborated to distribute sanitary napkins in Mumbai and surrounding regions. A part of this relief was also done in Vasai where 4940 packs were distributed to migrant women in Vasai, mainly belonging to families that depended on daily wage services like rickshaw drivers, plumbers, daily labour jobs etc. (Maha PECOnet, 2020). This initiative was achieved through collaboration with Asmita, a Maharashtra State Rural Livelihood Mission initiative.

Image 2.9: Distribution of Sanitary pads by FICCI Flo and ELSA Mumbai (Source: Maha PECOnet)

2. Vaccination

Relief provided by the State mechanisms

2.1. Planning & Infrastructure

The Tehsil level health authorities conducted training sessions of its staff on vaccination posts in which an action plan was prepared and submitted to the District Authorities. Based on this demand and supply was decided and post that the vaccinations were conducted in schools and anganwadis. The drive, which was very well received, was robust due to the authorities' and staff's previous experience in Polio vaccination drive. A lot of former healthcare infrastructure undertaken by the ZP helped smoother functioning of vaccination. Although initially The VVCMC in coordination with the Tehsil & District authorities along with the state conducted vaccination drives.

2.2. Awareness

The VVCMC and ZP both conducted vaccination drives at different scales. For ZP the PHCs were largely responsible for vaccine awareness, whereas the District authorities' health department with its health staff, ASHA workers, ANMs and AWWs conducted vaccination drives. The PHCs conducted vaccination awareness through articles, pamphlet distribution and announcements in Church microphones.

2.3. Registration & Transportation

In June 2021, the VVCMC conducted Mobile Vaccination Drive primarily for elderly, differently abled persons and tribal communities (Midday India, 2021). The VVCMC also received requests from urban poor *bastis* for which they coordinated with grassroots karyakartas and conducted vaccination drives in *bastis*. For differently abled persons in *bastis*, they gave vaccinations at the resident's homes. Also, the Railway Ministry carried out the vaccination task at the suburban railway stations which included Vasai & Naigaon stations from VVCMC (Ahmed 2021).

Image 2.10: Vaccination of a Senior Citizen at a Municipal Vaccination Centres (Source: Maha PECOnet)

Relief provided by Non-government actors

2.1. Planning & Infrastructure

The Municipality along with the District authorities started vaccination drives but similar to relief their outreach towards urban poor settlements was low, thus non-government actors sought to extend vaccination support. "Initially when vaccination drives started nationally, many people were scared to take vaccines due to rumours of death. Thus, we organised with volunteers and faith based organisations from the *basti* and started spreading awareness on vaccination. We also approached VVCMC to open vaccination centres in *bastis*" said Namdeo Guldagad from YUVA. Later, the central government notified the vaccination certificate to be compulsory for travelling, after which the centres near *bastis* started overcrowding. Seeing this, Jagruk Nagrik Sanstha (JNS), Vasaicha Raja Ganeshotsav Mandal, New English School Vasai Alumni and Team Vasai contacted VVCMC chief medical officer Dr Surekha Walke to provide vaccination (Nair 2021).

2.2. Awareness

Ambawadi, a dense slum population in the jurisdiction of VVCMC, despite its location in the corporation limits, had no vaccination centre which was accessible by the residents. Through YUVA, communities approached local political leaders. When the vaccination centre was sanctioned in October 2021 near Ambawadi the local youth groups started bringing people to the centre voluntarily. Due to their constant meetings, YUVA received support from the municipal authorities who allowed the space outside the centre to be used for street plays and distribution of pamphlets, allowing the message to reach the people where it was most needed. More than 17,500 people have received a vaccination at this centre since (YUVA internal report). The volunteers in Bhim Nagar, Dhaniv Baug, Valaipada and several such locations started educating communities on vaccination.

2.3. Registration & Transportation

Then local organisations helped vulnerable communities without access to mobile/internet get registered on the Cowin and Aarogya Setu application. Afterwards when people were struggling to book a slot through the COWIN App at private hospitals, people started travelling to Mumbai Navi Mumbai for vaccination. Since most vaccination centres in the East were crowded, NGO volunteers arranged transportation to help people from the east to travel west to vaccine centres. “We have helped form Bachat Gat of women from the community and during lockdown we helped them get their ration cards along with the supporting documents. For vaccination we helped access vaccines by arranging to and fro transportation to vaccination centres.” said Geeta Dabre from YUVA.

III. Navi Mumbai Municipal Corporation

Similar to the above two municipal corporations, in the NMMC, too, the localisation of management at the ward-level was considered as the most effective means to tackle the growing needs during the pandemic and lockdown. In Navi Mumbai, the official line-of-command for all medical matters was through the health officers in the Municipal Corporation, while matters pertaining to other kinds of relief (food, sanitation, etc.) were directed through the ward officers.

Both the State and the Non-government Actors spoke of the collaboration between both entities as an integral aspect to effective and timely last-mile delivery. The non-governmental organisations emphasised that the permissions that they received, in the form of passes for their relief workers or letters granting them access to certain regions, made it possible for them to penetrate through the lockdown, and reach the most vulnerable groups. The state representatives commended the work on non-government actors, who they claimed had a pre-existing rapport in marginalised communities and in some cases had comprehensive lists of households-in-need. The Municipal Corporation and police often collaborated with non-government actors in the provision of relief to the most vulnerable communities.

1. Relief:

1.1. Ration & Cooked meals

Relief provided by the State mechanisms

Realising the plight of the urban poor, amplified by their loss of livelihood, the Navi Mumbai administration quickly organised the supply of food through ward-level channels. Helplines were set up where people could call in and express their need for food. Prakash Kamble, a social worker in the Department of Social Welfare, pointed out that these calls came in from individuals, community leaders, NGOs who had a good connection in a particular slum or even State-Bhavans who pointed to the location of stranded workers hailing from their state. This allowed for comprehensive listing, in the form of relief databases, which were soon submitted to the Ward Officer.

The Ward Officer was the nodal point for all relief measures not pertaining to health. They would then call for tenders to prepare cooked meals from private parties, including larger catering companies, women-led SHGs and restaurants, too. Once the food was prepared the municipal authorities organised the transportation of these cooked meals, usually comprising a khichadi and maybe some vegetable, to the locations elaborated during the listing procedure. Prakash recognised the strong organisational and physical support of the gurudwaras and NGOs in Navi Mumbai, which prepared large amounts of food and supplied it to the slums themselves. The residents of Tata Nagar, who were regular recipients of the food from the local gurudwara, complimented the quality and quantity of these food parcels, expressing that there was no curb on how much one received or ate. In fact, if one person missed the delivery time, they could walk across to the local gurudwara and partake of a meal there instead.

The Ward Officers were also in touch with the larger NGOs who were providing cooked food or dry ration kits in the *basti*, to ensure that there was minimal overlap and a sharing of lists so that every last household was covered. Additionally, the Navi Mumbai Police distributed Dry Ration to 21,781 needy citizens & stranded labourers. In addition, they distributed 3, 31,050 cooked food packets & 1, 04,780 water bottles to needy citizens & stranded labourers. Another small venture by the police included the delivery of nutritional meals to COVID recovered patients (Maharashtra Police, 2021).

However, most people in the slums reported that the support in the form of food supplies was most efficient in the first wave. From 2021 onwards, they were largely left to fend for themselves, or rely on support from non-government actors.

Relief provided by Non-government actors

With COVID-19 disrupting food systems across the nation, the most brutal effects were felt by informal workers who upon losing access to livelihood experienced diminishing food and nutritional security. The NMMC, divided into 8 zones, used these administrative borders as a means to organise during the pandemic with each Ward Officer put in charge of relief in this region. NGO staff estimated that initially the ward office in Belapur was only able to distribute 250-300 meals a day, which did not cover the breadth of the population in need. Hence, independent activists and other organisations stepped in to fill the gap.

The government social worker, Prakash, recognised the efforts of the Sikh gurudwaras and the Sri Krishna Mission, who worked tirelessly to create food packages which were served at their venues. Later, on learning that many people who required the food were being stopped at police checkpoints, often located right outside the slum settlements, he said that the faith-based organisations partnered with the government to transport the food directly to the location. Residents of Panchsheel Nagar and Tata Nagar, who were interviewed for this study, shared their gratitude for this service that operated through the first two waves of the pandemic, on a daily basis.

The community kitchen model soon caught on as many stranded migrant workers were walking from or through Navi Mumbai to make their way home. Three independent activists partnered with YUVA to host the *Together We Can* campaign through a community kitchen at the D.Y. Patil stadium, and food was served

at the location and to other shelters. On a daily basis, 12,000 cooked meals were prepared and distributed, and the service was later extended to migrant construction workers who lived on site, but without work (Negi, 2020).

Simultaneously, dry ration kits were being provided by several independent organisations. Jaising Randive, staff of Youth for Unity and Voluntary Action (YUVA), said that it had provided ration kits to last a household for the period of a month; these included food supplies like, rice, wheat, oil, pulses, peanuts, masala powders, salt, sugar, tea powder, in addition to other household necessities like soap, toothbrushes and paste, masks and sanitary napkins. When the ration drive began, the organisation began by distributing kits in the communities where they had previously worked, knowing that among daily-wage earners a loss of livelihood posed a serious threat. Raju Vanjare, project coordinator at YUVA, highlighted how in the initial phases they distributed food to homeless people who were living on the footpaths, too, as these populations were in dire need and most accessible. He went on to say that as the distribution progressed in the urban slums, they realised that the need was enormous and their means limited, so there was a need for organisation within the NGOs distribution channels. Hence, on visiting new slums, they mobilised community volunteers and developed a loose leadership, which would help in the later distribution efforts. He said with time, the volunteers, often youth, came up with innovative techniques to ensure that the most interior households were reached. They often made detailed lists, which they shared with the organisation staff to inform them about how many kits were needed. Then, prior to distribution the volunteers distributed tokens to the households on the list, and informed them of the location where ration was to be received at. At this venue they used powder or chalk to draw circles to ensure social distancing while people received their kits. In the case of elderly families, single women, or disabled persons, they often took the ration right to their doorstep.

Shanta Khot, a community worker from YUVA, reported that every household must have received the kit at least 4-5 times during the one-year period. Yet the organisation's work was not only restricted to these provisions, they extended the relief on a case-by-case basis. For example, in some special cases, like when the children were left at home alone as the parents were admitted to a COVID centre, the organisation supplied milk, vegetables and gas to the door itself. Raju, added that some of the communities that were extremely affected by the lockdown that the organisation reached out to include a transgender *basti* in Turbhe (100-150 people), sex workers in the red light area of Turbhe (250-300 households), residents of the Jumbo circus at Airoli (80-90 people), students residing in Nagaand and Mizoram Bhavan (upto 70 people), and several orphanages and old-age homes.

Residents of Panchsheel Nagar said that the kit was so substantial that often an individual family could extend its use for two-months, if required. On other occasions, people redistributed their supplies within the slum, if they felt like any family had been left out. They felt that this was only possible because the organisation staff were in constant contact with them, and after having received the ration kits on a number of occasions they were certain that by the time the supplies ran out, another round of distribution would begin.

Hiraman Pagar, a housing activist with the Ghar Haq Sangharsh Samiti, noted that the approach of civil society organisations was likely to have better outreach, for unlike the government system that relied heavily on documentation, these organisations functioned on meeting the needs of the people. Moreover, their rights-based work in the city for many decades ensured that they were in the know and well-connected to the most marginalised sections, who were often left out of government food distribution systems.

In addition to NGOs, several youth groups and women-led SHGs also swung into action. A member, from the Sangharsh Mahila Bachat Gat, an SHG of women employed in informal jobs like domestic work and street vending, shared how they too were able to gather and distribute ration. She said that members from the bachat gat who were still in contact with their employers and customers living in the neighbouring buildings shared the stories of hunger in their *bastis* with their 'madams'. Soon enough, the women from the high-rise apartments mobilised funds and transferred it to the *bachat gat*, which was then enabled them to purchase ration and distribute it to the most needy households in the area.

At the same time, feelings of solidarity and charity persisted in the communities, and several cases were shared by women who participated in the focus group discussion. One domestic worker reported that she saw on several occasions the youth from her settlement proactively spending their own money to buy vegetables and dry ration for the elderly. Another woman street vendor shared that when people approached her for basic vegetables at the end of the day, she didn't have the heart to turn them away. After all, she was one of the rare persons who still had a source of income through the lockdown, and so she offered them the "basic vegetables, like onions, tomatoes, chillies, for free so that they could prepare a meal for their families." Yet another woman reported how she couldn't see women of 50-60 years go hungry or beg for food, so through her church group, she gathered money to provide food to the doorstep of the elderly.

Residents of Tata Nagar also reported that there were some independent activists who brought supplies with the money that they could garner, and then delivered smaller kits, often comprising 2 kg. Rice and 1 kg dal to families that didn't have ration cards.

However, as was in the other districts, too, the impact was disproportionately experienced by people hailing from socio-economically backward communities. With low social capital, and without any flow of income, these communities were often worse off. One example is of the Nathpanthi Dawari Gosavi Samaj, a nomadic tribe hailing from Maharashtra, who were pushed to the brink of starvation during the pandemic. The human rights group, Citizens for Justice and Peace (CJP), spent two whole days trying to reach the far-flung, remote settlements in Diva, Thane, and Kharghar, and provided them with approximately 100 ration kits (CJP team, 2020). YUVA, too, reached out to adivasi padas like Tembhurde, Talavli, Khuduk Pada, Phanaswadi, Pandav Kada and Vijau Hill, where people had been living for several days without any food supply and relief had not reached. Here, the organisation also stepped in by following up with the collector's office or police personnel

to check why ration entitlements had not arrived, and this proved fruitful as it put the padas on the government's radar, who then began to ensure that food supplies reached on time.

The urgency of requirements saw the birth of several partnerships between private companies and civil society organisations. Goonj, with support from Hikal Limited, provided 'Rahat Kits' to 250 daily wage workers, which covered their immediate material needs. Additionally, over 450 families in the slum areas of CBD Belapur, Navi Mumbai were supplied with groceries to last them for a period of 10 days (CII, n.d.).

1.2 Transport & Shelter

Relief provided by the State mechanisms

With the lockdown being extended repeatedly, many migrant workers had exhausted their savings and were finding it difficult to make ends meet. With no signs of their work resuming, several workers began making their journeys back home, on foot, cycle, motorised vehicle or by booking a space in private trucks and tempos that were transporting people across borders. The NMMC, too, organised buses for the workers (Srivastava, 2020). Prakash, a social worker from the Social Welfare Department, explained how this coordination was done through the Collector's Office. However, he pointed out that only those who made a call to the call centre, or their State Bhavans, expressing the need for immediate transportation were included in the lists. These lists were collated by the Social Welfare Department and submitted to the Collector's Office, where the staff would ensure that these persons were allotted seats on long-distance trains or ST buses which transported them to their villages.

Yet sometimes these vehicles made it to the state borders, and were denied entry into the next state. One ST-bus was carrying workers from Anand Nagar in Belapur, who hailed from Andhra Pradesh and Karnataka. As the residents later narrated to Shanta, when their bus reached the Karnataka border, the state police on the other side said that no permission had been sought and so the workers were all sent back. In the light of the inability for even the Municipal Corporation vehicles to make it across the border, the commissioner sought to open up shelters for the migrant workers when they returned. The first shelter was housed in the CIDCO Exhibition Centre in Vashi, and plans were made to open up 14 other shelters between Belapur and Dighar (Assainar, 2020). In the following months, schools, government buildings and previously established night centres homed several migrant workers, while local NGOs were roped in to provide food at the site (Gaikwad, 2020).

Relief provided by Non-government actors

While transportation of migrant workers back to their native villages or hometowns was largely carried out by the government, through special trains or buses, NGOs found it necessary to find authentic information about where to buy the tickets and which dates the trains were actually departing. In addition, organisations like YUVA, chartered buses from prominent locations like Panvel, Bandra, Vasai and Virar, from where they would provide migrants seats to make their journey. Shanta reported that in addition to a means of transportation, YUVA gave them food and some money in hand for the journey.

Image 2.11: NGO staff distributes water and dry snacks to migrant workers on the Panvel highway (Source: YUVA)

Additionally, several organisations stationed themselves along the highways leading out of the city to provide the migrants walking home some dry snacks or refreshments, energising them for the long-walk, or truck/bus journey ahead.

1.3. Healthcare

Relief provided by the State mechanisms

With the janta curfew announced on March 23rd 2020, the cases were still low in Navi Mumbai. Yet, considering that the first positive case in Navi Mumbai had been detected as early as 14th March 2020, and given that the government had invoked the Epidemic Act following which it gave Municipal Commissioners the authority to introduce measures to contain the spread of COVID-19, the ULB soon released a detailed health-plan. On 9th April 2020, a notification was released which stated that in the interest of efficient tracking and surveillance protocol while ensuring the speedy treatment of patients, certain medical facilities were declared as flu clinics, COVID Care Centres (CCCs), Dedicated COVID Health Centres (DCHCs), and a COVID hospital, as was indicated in the table at the beginning of the chapter.

Social workers from Navi Mumbai, as also community residents, recognised the efficiency of health-management if a person tested positive for COVID. Shanta relays how in every place that a patient was detected, be it a slum settlement or a high-rise building, the Municipal Corporation was quick to send an ambulance to take the patient to a COVID centre where they received good accommodation and food facilities during their treatment. At the centres almost all the patients reported to be treated well, kept segregated and fed a wholesome meal (three times a day, including egg and chicken for protein if the patient was non-vegetarian). Meanwhile, in the area surrounding the patient's home, the sanitation workers made

sure that the area was sanitised and sealed until all the people who came into contact with the patient tested negative.

Simultaneously, the NMMC also constituted a cell for telemedicine and tele psychiatry, where doctors (of physical and mental health) were appointed to give medical advice, on-call, to the patients who called in. A dedicated number for counsellors was also provided to the general public which was running from April 6, 2020 (Barnagarwala, 2020). The psychologist spoke to the patients in quarantine, those who had recovered as also their family members to help them deal with social, emotional and mental issues that they were facing at the time.

In the spirit of monitoring, Rapid Response Teams (RRTs) were constituted whose primary role was to conduct door-to-door surveys where they would assess the symptoms of the residents, and request further testing or contact tracing as the case may demand. In NMMC, ASHA Workers/Anganwadi Workers/ANMs constituted the teams that visited and monitored the residential areas. Pravatibai Hingole, an ASHA Worker from Nerul, shared that her days on the field began at 9 am and continued past sunset; all the ASHA workers would gather at a central point to learn of their allotment for the day. Soon after, they would put on the PPE kits given to them, and begin their rounds which included knocking on every door with the aim of checking on the household while also keeping a close-watch for persons who had recently travelled and those who displayed any relevant symptom (cold, cough, mild fever or body pain). They were allowed to advise the households about basic COVID protocol, acting as agents of information and also providing protocol-reminders. Pravatibai shared that often they would give the household members their telephone numbers as it reassured them to have someone to contact should the need arise, hence also becoming the first point of contact for communities. The reporting protocol required them to submit a numerical report of the number of houses visited, and number of symptomatic/suspected cases at 3 pm every day, via WhatsApp. If they did, however, come across a severe case during their survey, they would inform the Medical Officer at their centre, who would take the next action necessary.

Testing was another means to monitor the spread of the virus. Officials said the rapid antigen tests were used for larger surveys in specific locations, including containment zones, to plan further strategy. Another strategy employed was regular testing of groups who were performing essential services which forced them to interact with other people – Navi Mumbai Police officers and those who regularly go to the local APMC market in Vashi, including traders and loaders. Between July and August 2020 the Navi Mumbai Municipal Corporation (NMMC) conducted 33,453 rapid antigen tests, with over 3,000 people testing positive. (Modak, 2020)

As the cases escalated and beds were in limited numbers, people began visiting private hospitals for COVID and regular treatment. However, with minimal price regulation the Municipal Commissioner soon began getting complaints about overcharging. Taking the matter on immediately, the NMMC set up a committee to look into the specific cases in the first week of July 2020. The four-member committee reviewed the bills of COVID-19 patients and non-COVID patients complaining of exorbitant medical bills and by August 12,

2020, the commissioner had issued show-cause notices to ten private hospitals demanding an explanation for the discrepancies in the bills (Dhupkar, 2020).

In the second wave, as the virus spread, and the number of positive cases within the municipal boundaries increased, the NMMC began planning ahead. As the healthcare infrastructure was heavily burdened, the medical officers tried to ensure that most of the patients were treated at home. Here again, the network of ASHA workers and anganwadi workers was operationalised. Pravatibai, an ASHA worker, shared that they were often told which households had a positive case, and were handed the medicines to deliver to the homes directly. There was a protocol of leaving the medicines at the doorstep, and then calling the patient to inform them of the delivery while also checking in on their health via call, so as to minimise contact and interaction. The ASHA worker would then be responsible to check in with the patient regularly to check that the recovery was in order; if there was an escalation of manifest symptoms then they would inform the medical officer, who would try and find a bed at a local hospital.

Yet shortage of beds remained an issue. One key intervention to address this situation was the construction or refitting of infrastructure to meet the medical requirement. In April 2021, when the load on the healthcare system was reaching breaking point, the Municipal Commissioner announced that the NMMC would be regulating 80% of admissions at all private hospitals and treatment of COVID-19 patients would be done by its nodal officers (Assainar, 2021).

Yet as the second wave was proving to be the most threatening to individual health, and most burdensome on the health infrastructure, the NMMC started a helpline number — 02227567460 — for those seeking beds and ambulances. (Assainar, 2021). It also took on the responsibility of setting up more speciality hospitals with large capacities, to deal with the influx of the patients in the second wave, as also in anticipation of future waves. The NMMC began adding more infrastructure into pre-existing CCCs, as well as developing news centres in every ward (Srivastava, 2021). Finally, demonstrating interdepartmental linkages in NMMC a total of 25 corporation-owned buses were converted into ambulances for hospital services (Srivastava, 2020).

Relief provided by Non-government actors

Non-government actors often play a key role in promoting and advocating for healthy practices and lifestyles. During the pandemic, they often educated people about the latest information about the virus and the ways in which it spread. Jaising, a community worker from YUVA, shared how they would organise sessions along with a local doctor, often from the health post nearest to the settlement, where they would educate people about the new protocol, practices like wearing a mask, using sanitiser, keeping social distance, while ensuring that these was maintained during the training to put it into practice;. In addition, the doctor would address questions from community members about safe practices during the time, while dispelling any myths or misconceptions. In Navi Mumbai, they frequently visited Tata Nagar, Ganesh Nagar and Turbhe quarry,

where people were familiar with the organisation and also unreached by many other government and non-government efforts.

At the same time, he shared how they would organise health camps for people, for regular check-ups. A resident of Tata Nagar, corroborated this when he mentioned that between the waves, health camps were organised at the YUVA Centre, so as a community leader he and his team would mobilise people to travel by the bus sent by the organisation. Once, at the venue they would meet with doctors who checked all the children, elderly, women and men, diagnosing and advising as was necessary. This, for him, was a very essential service, as the doors to the hospitals were largely closed to non-COVID patients; therefore these health camps filled that void.

Image 2.12: Eye check-up during Health Camp organised by NGO. (Source: YUVA)

Transportation of COVID patients to hospitals in their vicinity proved to be another neglected area. With the cases climbing, the public and private ambulances were inadequate to meet the needs of the people. Some organisations donated ambulances to the hospitals, while in other cases, citizens reached out to provide their own vehicles as transportation services. One such person was Ayaz Faquih, hailing from Uran, who was moved whenever he saw COVID patients struggling to make it to hospitals. He sought permission from the police to give free rides to the sick and their families, after which he named his auto 'Khidmat' which means selfless service of others, which ran across NMMC and PMC through the lockdown (Karelia, 2020).

1.4. Water, Sanitation and Hygiene (WASH)

Relief provided by State mechanisms

Considering the communicability of COVID-19, regular hand-washing and maintenance of sanitary conditions was part of the mandate. The NMMC prioritised these activities and was later recognised for having

“disinfected and sanitised 100% of the public places within its area, employing 23 vehicles and 100 spray pumps have been specially procured to sanitise the slums and the hard to reach narrow streets and by-lanes” (MoHUA, n.d.).

Solid waste management is also an essential aspect of ensuring sanitation and hygiene. Garbage collection, though, was limited to more organised Sectors, such as 15 and 18. Residents from these areas reported that even during the lockdown, their waste was collected once in the morning and once in the evening. This, however, did not match the experience of the people living in slums, as has been elaborated in the gaps and barriers section.

Another strategy to deter people from littering and to reinforce COVID-Appropriate behaviour came under the Mission Begin Again, where the NMMC used fines for people not complying with safety rules like wearing masks in public places, maintaining social distancing, and spitting in public places. Reports revealed that since this policy was put into action, NMMC fined 23,188 people for not following the COVID-19 norms collecting a total of Rs 1,01,75,200 upto August of 2021 (Srivastava, 2021). While this programme used discipline and/or fear to ensure COVID-protocol, many from the poorer sections complained that at a time where their livelihood had barely resumed such fines served as yet another lash to an already struggling community.

Relief provided by Non-government actors

Several organisations in Navi Mumbai realised that people did not have access to clean water and other sanitation supplies, necessary in maintaining COVID-protocol. So organisations assembled hygiene kits, which included soap, masks and sanitisers, which were distributed in the slums after awareness programmes. In addition, one of the supplies provided by several NGOs was sanitary pads for women. Several women from Panchsheel Nagar were extremely grateful to YUVA, who had included it in the essentials and dry ration kit, to have thought about a basic need of theirs that they too often invisibilized.

Image 2.13: Distribution of hygiene kits in informal settlements (Source: YUVA)

In a demonstration of public-private partnerships, IKEA India partnered with several NGOs to provide WASH facilities to vulnerable people having lost their livelihoods and homes during the pandemic. With Shelter Associates and Collective Good Foundation, it focuses on sanitation in Turbhe slums (Indiranagar, Ganpati pada I and II and Hanuman Nagar), aiming to renovate 9 community toilets, facilitate 150 household toilets, and educate children on appropriate hygiene behaviour (IKEA, n.d.).

Similarly, management of solid and biomedical waste is also key to ensuring infection prevention and control. One organisation engaged in this practice was United Way, Mumbai, which obtained support from UNICEF to establish and strengthen the SOPs for IPC, Water, Sanitation and Hygiene (WASH) and Biomedical Waste Management (BMWM). The team also developed Information, Education and Communication materials, and organised regular training of doctors, nurses, and other ancillary staff.

2. Vaccination

Relief provided by the State mechanisms

2.1. Planning & Infrastructure

With vaccination proving to be effective in curbing the spread of the coronavirus, the central, state and local governments pushed for its speedy and inclusive uptake. In the entire MMR region, Navi Mumbai was the first corporation in the state to declare that the entire population above 18 years, had taken the first dose by October 2021 (Jeddy, 2021). This was made possible by setting up 111 vaccination centres (LiveMint, 2022) and strategic last-mile delivery to populations that were prone to being left out, through special camps for sex workers, elderly and sick. The NMMC also reached out to NGOs who have a good network and connect with vulnerable groups who might not have the necessary documentation to register, like homeless and transgender people, in order to ensure that every last person was vaccinated (PTI, 2021). Residents of Tata Nagar recognised these efforts. They said that albeit slightly delayed, the government did approach them making vaccine slots available to them even in the absence of documentation.

For the ASHA workers, the vaccination drive saw their deployment at municipal centres to aid in crowd management and monitoring of patients. Pravatibai, an ASHA worker from Nerul, shared how the latter consumed most of their time; with 300-400 people getting vaccinated each day, she said that most of her time went in monitoring their symptoms for half-an-hour following their jab.

2.2. Awareness

A community leader from Tata Nagar, shared that “first government social workers from the NMMC visited the basti to tell us about the vaccine; when they were leaving they told everyone that they had informed the staff in the Sector 2 centre that 20 people would come at a time from Tata Nagar for vaccination, and they should be helped with the process. This reaffirmed our faith, yet few people actually made the trip. Some months later, doctors from the Municipal Vaccination centres came directly to the *basti* for vaccination. Then many people got their shot; most have had their first dose and a few have finished both doses.” She went

on to speak of the vaccination of the youth; school students, like her niece who was in class 10, had both doses at school, as it was a condition to sit for the board exams.

As many people continued to have fears and misconceptions about the vaccination, ASHA workers reassured them about the efficacy and need of the vaccine to make sure that the nation was COVID-free.

2.3. Registration & Transportation

The NMMC later introduced a website - https://nmmcCOVIDcare.com/ - at the time where people could track the available vaccination slots in their area. Participants in the study pointed towards various additional efforts to ease the registration process for people with social and technological disadvantages. With help desks being set up at popular locations like railway stations and outside populated *bastis*, and ASHA workers taking groups of people to the municipal vaccination centres, the corporation approached universal vaccination.

Relief provided by Non-government actors

2.1. Planning & Infrastructure

Several organisations commented on the rapport built between the CSOs and the medical officers at the health post. During the vaccination drive, in particular, the medical officers would reach out to the organisations appealing to them to bring in persons from extremely vulnerable backgrounds, who might not approach the health system by themselves due to previous uncomfortable experiences, groups like sex-workers, transgender, people with disability, etc.

Some organisations also partnered with private companies to arrange for slots for marginalised communities. As mentioned earlier, the NGOs were also recognised by the Municipal Commissioner as valued partners who helped them take vaccinations people without documents, like WISE foundation who brought transgender persons to the NMMC vaccination booth in Vashi (Panicker, 2021).

2.2. Awareness

While on the one hand, the government was promoting vaccination as its strongest card to tackle the pandemic, there were several reasons for hesitation among the common public which affected the initial uptake of the vaccine. At this point several non-government actors played a key role in creating 'information-based' awareness about the need for a vaccine. YUVA realised that awareness at the *basti*-level was essential, so it created a detailed SOP to train its staff on setting up Vaccination help-desks, which would be one-stop venues for people from the community to not only learn about the need for vaccination, but also to register themselves on the COWIN-App and book a slot. As the desks spread across MMR, the teams realised other corollary functions too, for example, they made the help-desk mobile using mike facilities for general awareness, and door-to-door approach to register people on the COWIN app. They also connected to the municipal vaccination centres, to ensure that the people received the right information and were well-received when they approached the centre.

2.3. Registration & Transportation

When people found it difficult to reach the MVCs, organisations, like Shelter Associates, took the vaccination camps to the slum itself. They created a detailed approach, beginning with surveys to determine the number of people in the settlement awaiting vaccination, following which the partnered with ULBs and local MVCs, distributing tokens on the day of the camp, creating comfortable arrangements for the recipient of the vaccine to rest while their health-stats were monitored (Shelter Associates, n.d.).

Chapter III

Exploring Gaps and Barriers of Disaster Management during the Pandemic

I. Municipal Corporation of Greater Mumbai (MCGM)

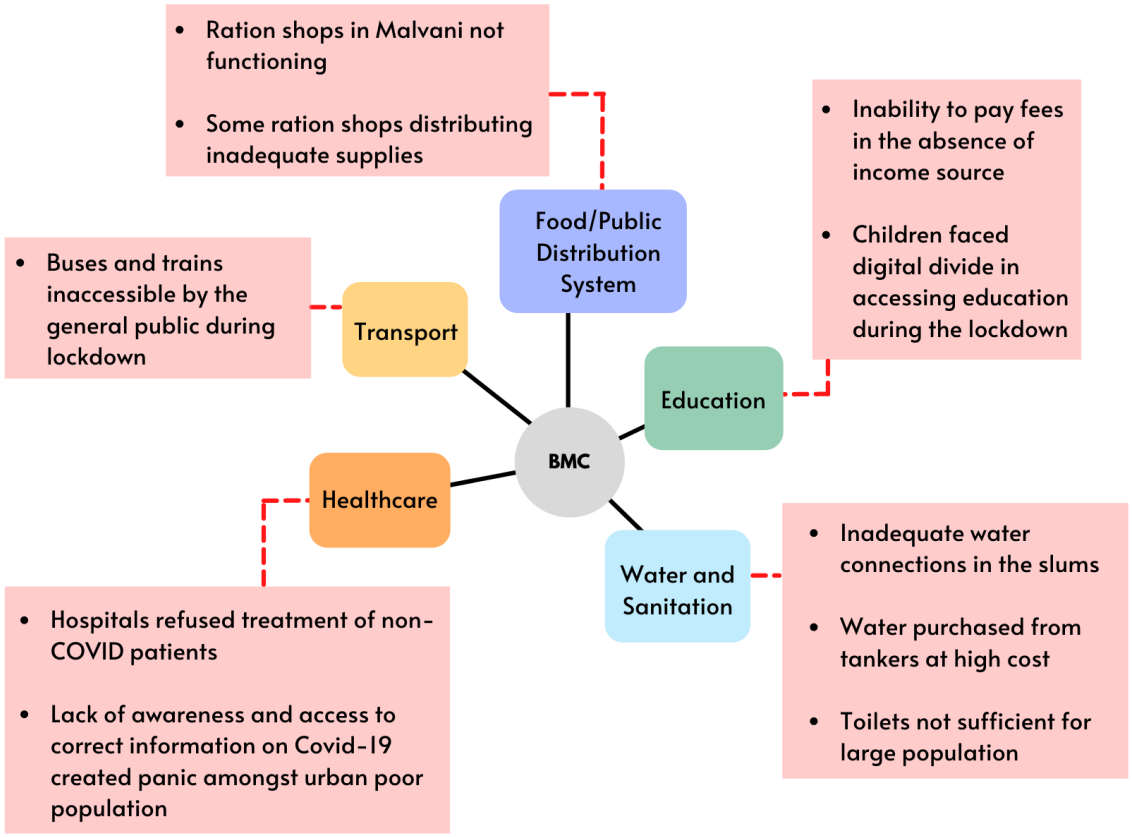

Fig 3.1. Diagram highlighting gaps for MCGM in Transport, Food/Public Distribution System, Education, Water-Sanitation and Healthcare. Source: Author

1. Poor last mile delivery

a. Absence of communication channels with vulnerable populations

Although MCGM drew up a decentralised system with clearly designed action plans and nodes of responsibility, there still remained certain loopholes which were highlighted by the NGOs and SHGs working on ground with vulnerable communities of Ambujwadi region in Malvani of P/N ward.

Civil society organisations, working through the pandemic, began their work with collection of data which consumed a lot of time to reach the vulnerable groups. Since SHGs, like Panchasheel katta in Ambujwadi,

began their food relief efforts by forming groups within their own neighbourhoods they were able to reach out to only few within their area limit. They reported that communities staying in the inner lanes and beyond the accessibility did not receive benefits. Thus, a loose network of community-based outreach needed to be scaffolded within a stronger, more far-reaching effort to assist vulnerable communities. The overall management and coordination should be the responsibility of the local body, which has access to maps, demographic data and a larger budget.

2. Gaps in Disaster Planning – Design, Delivery & Monitoring

a. Inability to deal effectively with a multi-disaster situation

In general the targeted approach of the MCGM was lauded by civil servants in the nation, and it also received international appreciation. In fact the model was used to tackle the virus in other high-density, income-divergent cities. Yet the one period where the planning slacked off was in the fact of multiple, simultaneous disasters. With the focus on COVID, the disaster response to Cyclone Tauktae was dispersed. While the government did issue warnings, human resources were already stretched so thin that they were unable to evacuate people from high-risk areas. The impact was felt in P/North. In Malvani, several fishermen who were out at sea were caught in the storm and while some escaped death a few went missing (IANS, 2021).

3. Existing governance challenges exacerbated

a. WASH - a loose chain in urban management

The pandemic brought with it several new challenges, yet as is the case with most disasters it served to accentuate pre-existing vulnerabilities often threatening socially and climatically vulnerable groups. Such effects were felt particularly in the WASH areas. Despite a High Court order claiming that every resident of the city should receive water supply irrespective of the type or location of their household, many residents of Ambujwadi continue to face water woes. During the COVID crisis particularly, when water for handwashing is a necessary protocol, residents reported to face trouble in getting a water connection (Ganpatye, 2020). Moreover, if they are to receive a connection and access to a shared tap, it requires carefully manoeuvring the MCGM offices with a file, first, followed by navigation through a channel of private contractors who often charge exorbitant fees. In the absence of a water connection, the families often pay anywhere between INR 10 and INR 40 for a litre of water brought to the slum via tankers (“Indian Cities: In-Adequacy of housing in times of COVID-19”, 2020).

A correlated need that has not been met in the settlement despite its establishment for decades, is that of adequate toilets. After the launch of the SBM, there were some make-shift structures erected, yet these community toilets rarely function properly and are inadequate to meet the needs of such a large population (“Indian Cities: In-Adequacy of housing in times of COVID-19”, 2020).

b. Non-approachability of elected representatives

Local collectives expressed difficulties while trying to receive help from the government officials. When asked why they didn't seek help from the officials, the answer received was that the nagar sevaks helped communities associated with their parties. This was echoed by community members, too, who claimed that food distribution was largely carried out in the regions from which votes have previously been cast in the favour of the elected representative, or votes are sought. Considering the elected persons are responsible to all those in their constituency, irrespective of any contingencies, if their responses are without bias then the data collection and relief distribution might have had a better outcome, particularly among marginalised communities.

4. Consequences of the pandemic on everyday life

a. Inadequate food supply via the PDS

Hunger was one of the most pressing issues among residents of urban slums. Despite government schemes to offer increased ration supplies at a subsidised rate, many families in P/North pointed to implementation issues. In Ambujwadi, four ration shops, denied ration to residents despite their possession of a ration card. Moreover, because of a delay in supplies, some others were only distributing rice. Local youth collectives claimed that the ration kits provided by CSOs would not cover the entire *basti*, and so it was necessary to ensure the smooth and appropriate functioning of government systems (YUVA, 2020 b).

b. Loss of livelihood opportunities

One of the impacts of the lockdown was felt by residents living on rent in the city. With income generation seizing, many reported to find great difficulties to cover their basic expenses for food and water. Paying for shelter, often accounting for a majority of the monthly expenses, was also hampered during this time. Several individuals reported to receive constant threats from their landlords, forcing them to take high-interest loans, or vacate their tenements for cheaper accommodation. They expressed that a government regulation recognising this difficulty in such unprecedented times was necessary.

c. Medical system inaccessible to non-COVID patients

Several persons reported to find that the medical system had been curtailed to dealing with COVID; in the bargain other health issues receded to the background. A woman residing in Ambujwadi shared that her daughter had a mild accident during the lockdown, but after being turned away from hospital after hospital she returned home helpless. She claimed to have performed whatever care she could at home, yet is still unconvinced of her daughter's recovery. In this case, and others, there was a need to have planned for medical facilities for treatments not-including COVID.

d. Gendered impact of disasters

The gendered impact of COVID, is often overlooked amidst the mass upheaval. Yet, poor women and transgender persons often faced the brutal lashes of the pandemic, in silence. Amongst them the loss of livelihood was found to be disproportionately higher, and this was coupled by increased social and domestic violence due to the restrictions on mobility. These effects increased their impoverishment and

disempowerment. Moreover, despite government schemes to offer financial support, a study by YUVA revealed that only 24.09 % of the urban poor households surveyed in MMR had bank accounts in the name of female family members and not all were Jan Dhan accounts. Hence, financial access stood in the way of them receiving benefits (Jaikishen & Dubey, 2020).

II. Vasai Virar City Municipal Corporation

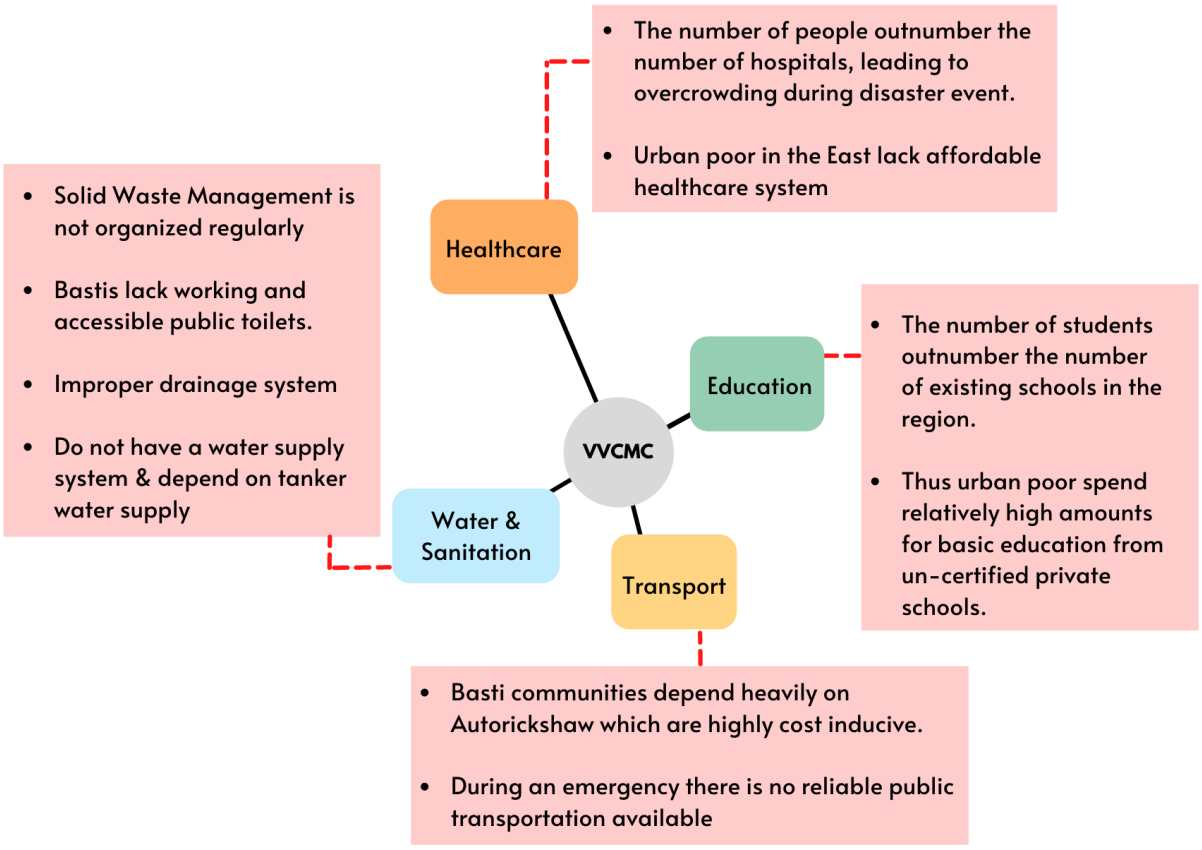

Fig 3.2. Diagram highlighting gaps for VVCMC in Healthcare, Education, Water-Sanitation and Transport. Source: Author

1. Poor last mile delivery

a. Unequal prioritisation in relief efforts

The governance system in the Vasai Virar region has several layers that need to be dissected historically in order to understand the disaster management gaps and barriers. For this research, only the four critical aspects that are interlinked with COVID disaster management are analysed. As discussed in the earlier section, the education and healthcare is managed by the Zilla Parishad, and transport along with water and sanitation is managed by the municipal corporation. Zilla Parishad is influential in rural areas, yet despite a robust system they lack capacity and resources.

Due to the dual systems of the VVCMC and the Zilla Parishad there are limitations in outreach to urban areas and rural areas respectively. Here, the urban area does not include the informal settlements and industrial units in the East due to the nature and form of their urbanism which is fairly temporal in nature. As discussed in previous sections, the VVCMC took over only limited management systems during the COVID-19 disaster management. Through this significant gap in the governance system, there emerged the issue of last mile connectivity of relief and management.

Food ration distribution was sought by the ZP and the locations for distributions were the Zilla Parishad schools. It is worth recalling that the Zilla Parishad has a large percentage of schools along the western rural belt. Thus, this choice of location for ration relief distribution restrained urban poor's access to food relief. Besides, although VVCMC commenced around 45 community kitchens, with most of them located in *bastis*, there surfaced several issues on outreach. The *basti* population outnumbered the amount of food and number of kitchens established, leading to poor quality of food and exhausted resources. For this reason, people stopped consuming them and the community kitchens ceased to function after a while.

b. Inadequate information dissemination in informal settlements

Initially, at the start of the pandemic, there was chaos among people living in informal settlements in the region, due to the ambiguity on the disease and situation. Awareness campaigns were initiated at a very later stage and they were largely digital in nature focussing on user groups with internet and mobile phones. This prevented the urban poor communities from accessing correct information which spiked panic and without relief support people started travelling to their home states on foot. Thus, during the lockdown, it was observed that in these industrial areas the contact tracing was low and several people had been found violating quarantine norms leading to a spike in COVID positive numbers.

2. Gaps in Disaster Planning – Design, Delivery & Monitoring

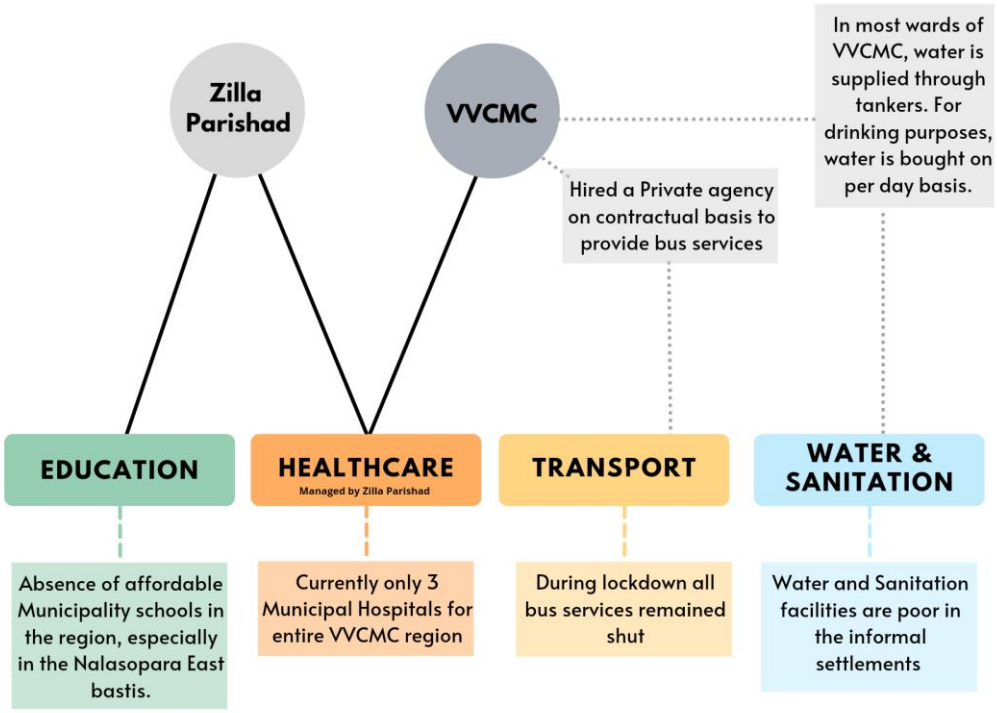

Fig 3.3. Diagram showing the dual form of governance system along with the issues that emerged during the COVID-19 pandemic in Vasai Virar Region. Source: Author

a. Inadequate healthcare infrastructure

Healthcare system collapse surfaced as a major alarming factor during COVID management. The dual governance also affected the healthcare system and its access for urban poor in the region. Pre COVID, the VVCMC had only one hospital for the entire region and rest healthcare is still regulated and managed by the ZP. “Before lockdown there was only one Municipal Hospital for the entire Vasai Virar Municipal Corporation, and it was after the surge of COVID that 3 more hospitals- 1 in Virar and 2 in Nalasopara have been set up in the region” states Mecanzy Dabre. This resulted in limited healthcare outreach of the authorities. Thus patients from *bastis* had to either travel to west Vasai and to Mumbai for hospitals or borrow money to be able to afford private hospitals in the vicinity. Likewise, since the vaccination drives were primarily initiated in hospitals by both authorities, similar to relief, they focussed broadly on rural & urban areas. Additionally, due to lack of correct source of information there was plenty of vaccine hesitancy within *basti* communities and many were against vaccination. The relief response by non-government actors was also insufficient due to limited resources and manpower. They lacked databases for outreach to the most vulnerable persons and large proportions of time and resources were invested in data collection.

During the FGDs at Dhaniv Baug and Gangripada the residents complained of the irresponsible attitude of authorities towards their needs. “If there is no system in the first place, how can we receive any form of healthcare relief? There's only one Mahanagar Palika PHC which gives calcium and iron tablets to pregnant women near (Dhaniv) talao, and non-certified private clinics in the *basti*. And there's only one government

hospital in Nagindas, which was overcrowded during vaccination and treatment" said Anju, a resident of Dhaniv baug. Due to several such issues in last mile connectivity during the second wave, the Vasai Virar region emerged as one of the worst-hit Municipal Corporations, of all the nine civic bodies, in the Mumbai Metropolitan Region (MMR). At the peak of the second wave, the positivity rate in the region exceeded 68% (Singh 2021). Patterns emerging from the high COVID hotspots showed that the Nalasopara region in the VVCMC was the worst-affected area. Specifically, the Nalasopara East's localities like Santosh Bhuwan, Bilalpada, Dhanivbaug, Shriram Nagar, which houses over five lakh people, mostly living in informal *bastis* were amongst most affected (Bose 2021).

The contractual nature of services also persists in the healthcare system, in June 2020, the contractual safai karmachari were laid off due to termination of their contract. In the next year, 450 doctors of VVCMC who had been hired on contractual basis since 2013, protested against the untimely termination of their contracts. In cases where the corporation took over a certain percentage of beds/facilities from the private hospitals large gaps of service provision which were similar to the case above were observed. Wherein, the safai karamcharis employed by the government in private facilities taken over, were unable to keep premises clean due to the contractual nature of their employment. These parallel issues in the system resulted in over burdening the healthcare staff & unhygienic Municipal hospitals & COVID Care Centre premises (Dhupkar 2020).

b. Challenges in access

During the second wave, the COVID Care Centres set up by the corporation during the first wave were unable to withhold the capacity of the second wave. Also, the treatment facilities were collapsing due to the high surge of patients and no new beds or oxygen plants were added in anticipation of the second wave. Specifically during this time, there was reported lack of resources at the private hospitals. Many also denied admission of patients due to shortage of beds, oxygen and manpower.

c. Cost fluctuations at a time of disaster

Although the VVCMC set-up large capacity COVID Care Centres in the region, there were complaints of untimely food supply to these centres (Parmar 2020). Moreover, once the patient and their family were admitted at the quarantine centre, the charges for food went up to Rs.250 leading to per day cost, per family up to Rs.1000. "With no jobs and salaries these days, the poor can't afford expenses and the hospitals should have tied up with NGOs for supply of the refreshments (food)." said the VVCMC Mayor Pravin Shetty during an interview with Mumbai Mirror (Tagore 2020). This also points out the communication gaps between the Commissioner, the Mayor and officials.

The analysis of this collapse requires a closer attention to the existing healthcare system's condition and their capacity. Post COVID there are only 3 municipal hospitals for the entire region which overcrowded during the pandemic. The response from FGDs states that the patients from *bastis* had to pay exhausting prices to get minor treatments. In the existing hospitals problems in healthcare exacerbated due to shortage of beds, low testing rate, shortage of ICU and ventilator beds and shortage of oxygen amongst others (Kotak 2021).

Also during the first lockdown, since shops and transportation services ceased, black markets surfaced within *bastis*. “To begin with nothing was available and whoever was selling was selling at double rates. Ration and transportation took up most of our savings, as everything was sold at double the rate”, said Gulshan from Gangripada. Ration shops where ration was to be given to ration card holders for free or low prices, sold goods at a high price illegally. Trends of price hikes also replicated in healthcare and transport and the municipality or government lacks control over these systems.

3. Existing governance challenges exacerbated

a. Gaps in planning, policy and implementation

The urban poor population in Vasai Virar region has triggered due to the planning methods in late 1990’s which sought to shift industries of Mumbai to the periphery. Vasai Virar due to the presence of industrial zones towards its west, has organically enabled informal forms of housing with industrial workers residing in temporary houses ever since. However, ever since its inception this region has been devoid of any basic services like water supply, sanitation, education, transport or even basic liveable housing. Over time several local groups and people within the community emerged to negotiate for these services. And till today the *basti* population exceeds the small number of services that have been negotiated with the city.

Moreover, since the past decade many locations in the Nalasopara area have become flood hotspots, and flood water levels in these regions go up to 2 to 3 ft. increasing every year. Even during disasters like floods or landslides, there are very few emergency response systems in support of *bastis*. “During the lockdown in 2020, we had water up to 2 ft. We picked up our belongings and put them over the cupboards. We had to wait until the next day to receive relief” said Alam Ansari, a resident and local activist from Gangripada. Due to lack of planning and ignorance from the VVCMC such issues have exacerbated.

Likewise, the temporary houses with tin roofs heat up during summer leading to unliveable indoor conditions. The municipality has also been ineffectual in developing proper road, drainage and sanitation networks. Along with this there is no planning on garbage disposal exposing the residents, specifically children to diseases. Besides, from the interviews of non-government actors in the region, it was evident that there were gaps in coordination between the state, VVCMC, Tehsil and Taluka authorities. This lack of coordination reflects on the condition of service provision to the urban poor in VVCMC.

The current planning regimes followed by the state and centre in collaboration with the ULB also seek to propose several infrastructure projects that cut across urban poor *bastis* rendering them extremely vulnerable especially during disaster events. Such planning decisions reduce the already low resilience capacities of the vulnerable group and tend to shift them further away to the peripheries.

4. Consequences of the pandemic on everyday life in the ULB:

a. Loss of livelihood opportunities

Nalasopara East inhibits large pools of industrial, construction workers, domestic workers and many of these fall in the ambit of 'temporary employment' category. Besides, there is also a large pool of informal sector and daily wage workers who depend on Mumbai for their livelihood. There are also people working in small scale industries for instance, most women from Nalasopara used to paste American diamond stones on imitation jewellery and assemble clips at home for mere Rs.60 per to stick 1000 odd imitation stones. During lockdown, when all services ceased, the urban poor population surviving on such subsistence or temporal work endured major brunt of the disaster. Many lost jobs during the pandemic, and small informal businesses from *bastis* suffered losses. Around February 2022, when the interviews were conducted most respondents brought up the issue of severe unemployment post pandemic. Owing to the majority migrant population, there are also a handful of beneficiaries of schemes launched at the state or national level. The National Urban Livelihoods Mission (NULM) under the Ministry of Housing and Urban Affairs or Deendayal Antyodaya Yojana-National Urban Livelihoods Mission have poor implementation in Nalasopara's informal settlements.

b. Challenges of limited mobility

The VVCMC retains resources and human spower yet their engagement in the sector of transport and WASH is limited due to the contractual nature of the system. Until 2014-17, for almost 6 to 9 years after VVCMC came into existence, the transport system for the entire VVCMC was managed by the ST Mahamandal. Later these services were discontinued citing revenue losses, after which the VVCMC started municipality inter-city bus service. However, the service provider was not the municipality, but a private party appointed on a contractual basis, which is why till today the services only ply on profit earning routes. During lockdown, since the local train services of Mumbai ceased, the entire vulnerable population relied on bus services, but since the buses were run by a private entity they did not play during lockdown and there was no accountability on the same. Thus to travel for treatment or vaccination urban poor had to pay double prices to private vehicles.

c. Gaps in education exacerbated due to disaster

Respondents also revealed gaps that widened due to pandemic in the education system. The VVCMC does not have a municipality school in Vasai Virar region or in Nalasopara East for a population of more than five lakhs. In such conditions the children from *bastis* are enrolled in private uncertified schools. Post lockdown when residents of *basti* tried to re-enrol their children in these schools, two year worth of fee was demanded by these institutions. Due to unaffordability there are several school dropouts from *bastis*.

III. Navi Mumbai Municipal Corporation

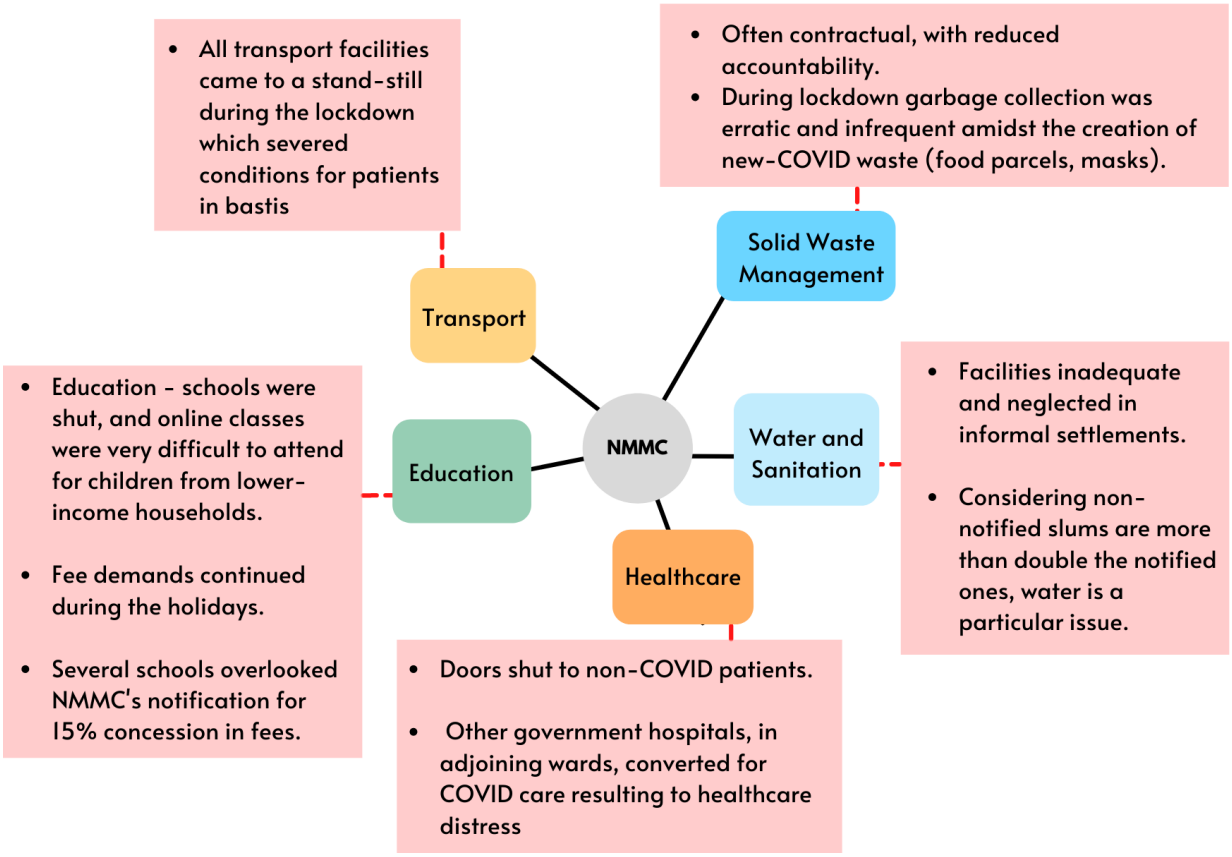

Fig 3.4. Diagram highlighting gaps for NMMC in Transport, Solid Waste Management, Water-Sanitation, Healthcare and Education. Source: Author

1. Poor last mile delivery

a. Absence of communication channels with vulnerable populations

The representatives of the NMMC recognised the lack of rapport between government authorities and residents of urban slum settlements and other vulnerable groups, as a drawback in relief work. The residents of a slum in Belapur highlighted the neglect on the part of the *nagar sevak* or elected representative, who they say didn't make a visit during the entire lockdown. Yet, a network of link workers who reached out to the people directly were the ASHA workers and anganwadi sevikas, who met them regularly and helped them when they needed.

In the absence of a network of workers who can act as intermediaries between the people and the government, the government was left to depend on an informal network of NGOs and faith-based groups, in an ad-hoc manner.

b. Non-utilisation of existing databases of vulnerable persons

The lack of a database of vulnerable groups was often voiced as the key difficulty of the government. In fact, from the Social Welfare Department, it was learned that the ward office only provided relief to those who reached out for aid, via the war rooms and help lines. Other lists of vulnerable groups, developed for schemes, were not used to identify people who did not contact the government directly.

c. Unequal prioritisation in relief efforts

A common sentiment among the residents of the informal settlements was that once the needs of the residents of towers and high rise buildings were met, then only did the authorities approach the slums. This was echoed among the residents of Tata Nagar who said that only 7-8 months after the vaccination drive was announced by the Prime Minister did the first health worker approach their community, to educate them about the process. Hence, they indicate that political interest and will are key determinants of last mile delivery.

Similarly, a discussion with members of a domestic workers union, revealed garbage collection from most slums of Belapur was decreasing in frequency as the lockdown progressed, sometimes being collected only thrice a month. This caused huge piles of waste gathering close to their residential quarters and proved extremely harmful. In June 2021 when heavy rains led to flood like situations, the water carried both garbage and sewage waste into people's houses in Panchsheel Nagar. Despite trying to reach out to the NMMC by phone, and also putting up images on their twitter account, residents say that no-one came to clean up.

d. Inadequate information dissemination in informal settlements

In addition to delivery of relief, general awareness among the vulnerable communities about what COVID-19 was, what were its symptoms, what individual and social practices were necessary to reduce contraction of the disease. While the government IEC material was not accessible by the residents of the urban slums, who said that they inhabited an information blackout at the time. Instead, fear reigned steadily in their minds which made them avoid many things without being sure of whether their actions were necessary. Jaising, a community worker for YUVA, highlighted that the government had done such effective campaigning to mitigate the stigma surrounding AIDS through the Balbir Pasha campaign. He suggested that similar information-based awareness programmes should have been spearheaded at this time too.

e. Excluded by the PDS

In many cases, as has been before, the lack of documentation proved to be one of the biggest obstacles in the path of receiving welfare benefits. In the case of the pandemic, this extended to relief, too. Take for example the case of hunger, which was the predominant concern among vulnerable groups through the lockdowns. People who did not possess a ration card were denied free or subsidised rations under PMGKY. In the urban slums, this was the case of numerous people who did not possess a ration card in the city due to the lack of a residential proof in that area. As was reported by a domestic worker from Belapur, “Most of

the people living in my building are living on rent. They have no proof and no ration card. I saw them sleeping through large portions of the day, during the lockdown, in order to handle their hunger."

2. Gaps in Disaster Planning – Design, Delivery & Monitoring

a. Governance challenges

HP, a social activist in Navi Mumbai, pointed out that during the pandemic, as well as other times, discord between the various layers of governance affected the delivery of services. He said, "When the central government and state government are in disagreement, or the state government and the municipal corporation are not on good terms, then the effect is felt by the poor delivery of services, and lack of implementation of schemes affecting the poor the most."

b. Lack of a disaster plan even during regular disasters

People from Tata Nagar, and Panchsheel Nagar reported that they understood that there was a lack of preparedness on the part of the government to disasters of the nature and scale of the COVID-19 pandemic, yet they had observed that general disaster planning was poor in NMMC. Residents of the settlements said that over the past few decades, the monsoons were becoming more erratic with fewer days of rain but more heavy showers. Yet during the pandemic, the floods inundated the *bastis* while the cyclonic winds which came later all but uprooted their homes. During these times too, no plan of evacuation was made and little relief was provided by the NMMC or Disaster Management Cell, instead they were left to escape and later rebuild by their own means, which were heavily diminished by the lockdown.

c. Inadequate healthcare infrastructure

Despite the first wave raising alarm about the lack of hospitals, staff and general infrastructure, the response of the municipal corporation to better prepare for the next waves was weak and delayed. Hence, when the second wave hit, with a stronger infection load and faster transmission, the already burdened healthcare infrastructure began crumbling. It was only in the later stages of the second wave, did new medical buildings get erected with greater scope of human resource and equipment.

d. Challenges in access

With most people finding the vaccination process quite simple, only one resident of Sanpada claimed that she had to visit the health post more than 3 times to get vaccinated. She was refused on the first three occasions as the health post officer only opened the vials when 10 people had assembled. Not wanting to eat into her working hours, she often approached the centre late in the day, and was asked to return the next day. Hence, it is important that such drives, and other benefits, be planned in such a way that the beneficiaries are given slots, and guaranteed access; this organisation would also allow the local government to ensure optimal coverage.

e. Cost fluctuations at a time of disaster

Given the free market economy, disaster situations often present a unique situation where the resources are limited but certain needs are significantly accentuated. Such was the case during the pandemic, too. Take for instance the case of travel costs an emergent need. In the lurch of the pandemic-induced lockdown, the migrant workers who make up a majority of Navi Mumbai's population were hardest hit as some queued up outside Panvel Station, while others paid as much as INR 3000 per person to journey back to their villages by bus or truck as the city offered no sense of a future of informal labour (Singh, 2020). Without any price regulation and control mechanisms the desperate poor are often forced to pay high costs for basic services, thus forcing them closer to poverty.

3. Existing governance challenges exacerbated

a. Gap between policy and implementation

A common challenge in governance is that at the time of policy formulation planners try to erect a robust policy, yet its implementation on-ground is often not sufficient. This is either because of lack of political will, or because in its composition the policy overlooked several structural barriers and obstacles. During the pandemic, this was observed in the case of previous policies, like the One Nation One Ration Card scheme which despite ratification in 2015 in Maharashtra was not being implemented at the fair price shops. Newer policy interventions, which were introduced to help people survive the pandemic, followed the same pattern. For example, domestic workers from the discussion pointed to two policies which they observed could have been very helpful yet in their non-implementation generated apathy in the common citizen. The first was the waiving of rents by the Municipal Corporation. A resident from Belapur shared, "we heard announcements being made from police vans in our areas saying "do not take rent from tenants." Yet in my building the tenants were often troubled by their landlords. If they did not pay, I saw instances where the landlords would empty the house of all its things and lock the tenant out." Another example came from a resident of Panchsheel Nagar, who said that despite the government announcing that school fees were to be reduced by 15%. Yet the school authorities demanded full payment. Considering her daughter was entering her tenth grade, she was forced to borrow money from her neighbours and relatives to ensure her child's education continuity and forfeit the concession which she believed to have been her right.

b. Priority imbalances

Urban planning and development is a core responsibility of the ULB. Yet as many respondents noted, certain aspects of planning receive more importance than others, as do certain regions in the larger constituency. The work of the NMMC on roads, street lighting and maintenance of public spaces was largely appreciated. Yet the participants who largely lived in notified slums pointed out that these were guaranteed in areas adjacent to large apartment complexes. In the slums, not only did they receive less attention, but other core issues like universal access to water, sanitation and waste collection were not guaranteed.

c. Non-approachability of elected representatives

There was a general sentiment among the public that their elected representatives, including nagar sevaks, MLAs and MPs, visit most at the time of elections. At other times, they make brief appearances to launch a new programme or scheme. Yet, given that the COVID-19 protocol called for minimal interactions forcing policies to reduce mobility, the residents of several slum areas felt that their local authorities were even more absent. This contradicted their expectations, as they felt that at times of crisis the responsibility of the elected representatives to the people should instead increase.

4. Consequences of the pandemic on everyday life

a. Loss of livelihood opportunities

Much like other urban areas across the world, in Navi Mumbai, too, informal workers who live hand-to-mouth saw that the economic clamping down in the form of a lockdown had multiple adverse effects on their quality of life. The most prominent concern was for health, as highlighted earlier. Yet, the lack of any source of livelihood also forced many to eat into their life-long savings and/or sell their assets to merely keep afloat. This increased their vulnerability and pushed many into the category of the 'new poor'. A female domestic worker who was asked by her employers not to return shared her woes of having to return to the very slum that she had escaped a few years ago, as a mark of her income and social mobility. Yet the pandemic forced her to first sell all her jewellery, and later give up a life that she and her husband had made in a smaller apartment complex, to take their children to live in a slum, a day that they had thought they would never see again.

b. Medical system inaccessible to non-COVID patients

The pandemic was categorised by the WHO as a healthcare emergency, yet across the world the glaring nature of the crisis signified that other healthcare issues took second seat. In fact, so overburdened were the hospitals that they often refused patients with any ailments. The young women from Belapur said that after repeatedly trying to reach doctors for regular illnesses, they chose to revisit traditional medicinal practitioners for herbal medicines, as even though it was a practice they had given up on, it was the only accessible solution.

c. Challenges of limited mobility

The lockdown introduced significant curbs on any kind of mobility, even those of an essential nature. Residents of Tata Nagar shared how police were stationed outside their settlement, on both sides, with lathis in hand who questioned the people about where they were going. Often, even if they reported needing vegetables, and basic food supplies, they were turned away aggressively and forced back. With time, barricades were erected on both sides of the settlement. At times like this, little went in or out and people were forced to subsist on what they had and what was allowed to enter.

d. Poor sanitation and hygiene compromised the health of citizens

In and around many slums, residents reported that collection of garbage and cleaning of sewage lines had an impact on their health. As mentioned above, garbage collection was extremely rare, and further delayed in the times of the pandemic. Also, with the arrival of food parcels, to feed the residents, the piles gathered at a faster pace than before.

In another caution of sanitation and health, even after 35 cases of COVID were reported from Tata Nagar, the municipal authorities did not come to sanitise the area. Instead young boys who were employed on a contractual basis with the municipality in the sanitation department brought across a sanitisation van and sprayed the area. Another issue, for the people of the settlement, arose as they used a community toilet. Given the uncertainty about how COVID was transmitted, several people, women in particular, stopped using the toilets and resorted to open defecation practices.

Water lines to the non-notified slum have been an issue from the community residents before COVID, and this continued well into the lockdown. People from the *basti* lamented asking how they were to wash their hands as frequently as was advised if they didn't have access to proper water supply.

Chapter IV

Recommendations

1. Towards developing last mile connectivity with people via institutions

1.1 Developing and nurturing grassroots connect - implementation of Area Sabahs and Ward Sabahs as crucial to the process

It is evident that several issues in terms of outreach and connectivity emerged due to lack of connection between governing authorities and vulnerable communities. The gap also persists due to the inaccessible government agencies during a disaster event. Among the government intermediaries, anganwadi workers, CHVs, ASHA workers and ANMs were the ones who had networks which were established on years of trust. Within communities there exist local organisations - Self Help Groups, Mahila Mandals, Youth Mandals, workers unions etc. Several grassroots workers and volunteers from these local organisations were involved in COVID-19 relief. This loosely-bound network could serve to be a strong community-based task force in the times of later disasters. It would be useful for ULBs to compile a registry of such collectives and volunteers and organise timely capacity building sessions to ensure that a citizen task-force for relief and response is formed. These groups should more specifically be tapped during a disaster event so that relief is received by the affected people at the earliest.

This can be formalised through encouraging and enabling formation of area sabahs and representation of these members in ward sabhas who can represent community concerns and put the community first during disasters.

1.2. Collaboration with non-government actors - ensuring people's participation in governance

NGOs and CBOs proved to have strong networks among vulnerable groups and within informal settlements. All these agencies employed door-to-door campaigning to reach the last house and the most vulnerable - these are methods that ULBs can learn from and implement in the future. Moreover, during the pandemic these networks were utilised in ad-hoc initiatives, it is necessary to recognise these workers and include them in planning and implementation of any ground-work, particularly at times of emergency where rapid action plans are necessary. These non-government actors also retain knowledge about the community which can be helpful not only during disasters but also uplift the community. Specifically, there are organisations in each ULB that are inclined towards social upliftment who can support the municipality to resolve the existing state of affairs of the community, while also providing support for outreach.

2. Towards Improving Disaster Planning and Management

2.1 Designing a disaster management model using existing databases to ensure last mile connectivity

When planning a disaster management model, participation from vulnerable groups should be prioritised. Gaps in terms of databases on the vulnerable groups also limit outreach for both state and non-government actors. Thus, a comprehensive enumeration of the urban poor population along with categorising most vulnerable within them.

Moreover, several comprehensive databases exist which need to be made accessible to the ULB (for example - voters' lists, PDS database, etc.). The government already has several detailed databases specific to the vulnerability of the population based on their application for various schemes because of their social vulnerability (disabled, widows, elderly who are recipients of pension, for example), economic vulnerability (domestic workers or construction workers who are registered with their respective boards), among others. These lists can be used to contact those persons who might be pushed into more vulnerable situations due to a disaster. Additionally, there is the need to consolidate and regularly update these lists so that at a time when delivery of goods and services requires to be comprehensive, all-inclusive and timely, these lists can be put to use.

However, this will not attend to one issue. Since most residents in *bastis* are migrants from different states, they lack documents that are linked to their current locations. And during the pandemic due to this gap they were unable to access government reliefs or services as most of them require basic documents like ration card or Aadhar card. Thus, during a disaster event necessary provisioning should be made considering people that lack documentation.

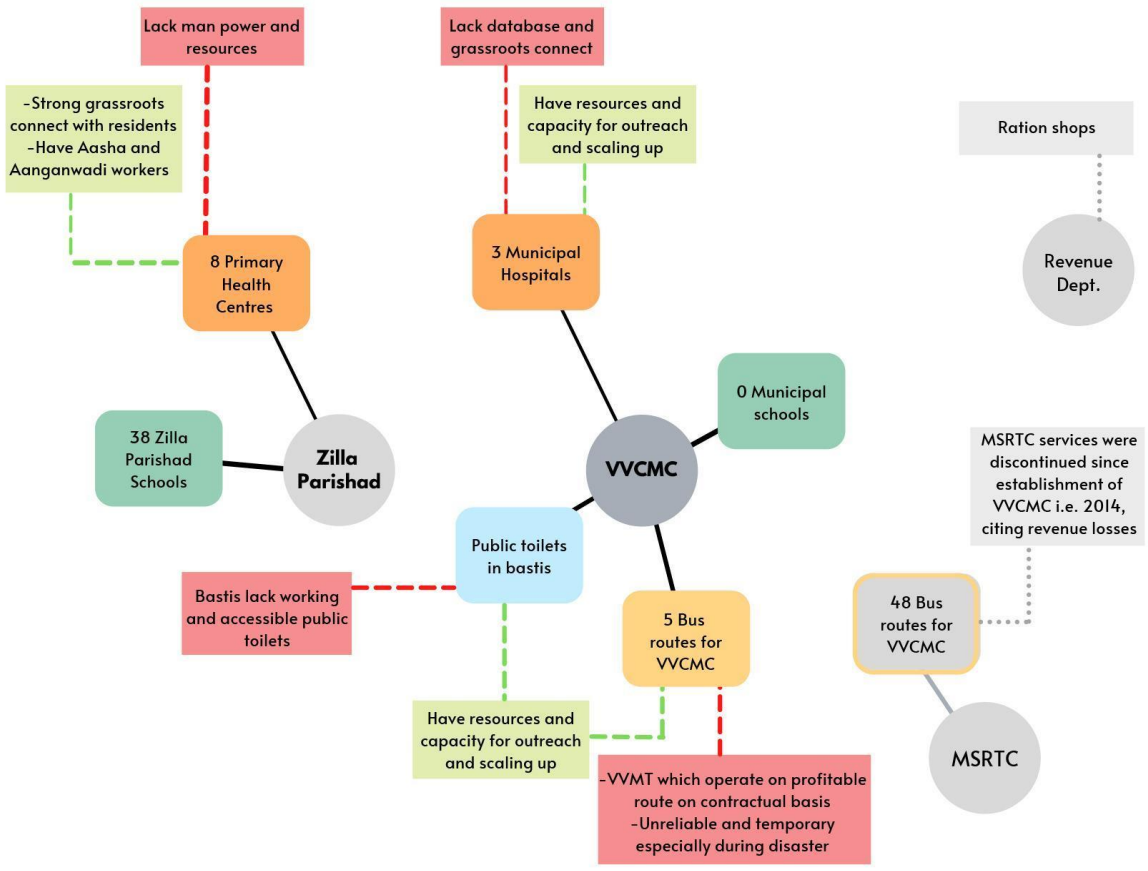

Fig.4.1. Diagram highlighting possibilities (green) for addressing gaps (red) in VVCMC. Source: Author

2.2. Transparency and clarity on disaster management planning among various departments (local, state and central)

Under the Disaster Management Plans there should be a clear delineation of roles during a disaster which are in keeping with the functioning, budgetary allocations and geographical relevance of the body. For different scenarios, SOPs with a clear chain of command should also be formulated as this will make planning and implementation smooth, and reduce the chances of overlaps or chances for power dynamics that diffuse the relief work when several systems of governance are working parallel. Most importantly, ULBs must be capacitated and encouraged to take on disaster management roles with a full devolution of power. Specific departments should also be accessible to the vulnerable groups so as to enable communication and resolution of issues at the local level.

2.3 Enforcing disaster related government orders and spreading awareness at the local level

For many schemes, including ration and vaccination, there were several GRs and circulars that were issued by the government, yet the information rarely reached the people who needed these services most. ULBs

could constitute several means of information dissemination through social and institutional networks, as also by employing social media effectively. (ULB's twitter handle/Mumbai Police Twitter). Which should also be made available in multiple languages and through oral media, to reach a larger audience or migrant workers.

Price fluctuation in the free market (food commodities, travel fares, educational fees, etc.) is another common consequence at times of emergency. The government, at every tier, should introduce notifications restricting these practices and means to monitor the implementation of these measures in order to protect the urban poor. Implementation of ONORC to ensure that migrant workers can access basic food supplies at affordable prices wherever they reside can be enforced by the ULB.

3. Towards. Improving Services Provided by the ULB

Acknowledging that municipal boundaries particularly in MMR are permeable, all municipal amenities and facilities should ensure that they are able to cater to the residential population (permanent and floating), so as to reduce cases of people crossing municipal borders to avail of certain services as was observed during the pandemic (particularly for healthcare and vaccination). This will cater to the needs of the citizens at a convenient location, and eliminate the possibility of undue burden on the neighbouring municipalities.

3.1 Investment in public institutions and scheme implementation

The case of VVCMC brought to light that the public health institutions were inadequate. There needs to be greater investment on these public institutions so that they are well-equipped and accessible by all during peacetimes. This habit of utilisation and trust that is established will pay off in circumstances of disaster, as people will rely on the public institutions based on their past experience. The same holds true for public toilets in dense informal settlements.

Many of the health and sanitation requirements during the COVID-19 pandemic, were requirements of previous schemes (for example the SBM includes the facilities for community toilets, hand-washing). A stringent enforcement that these schemes are implemented at peacetime, will ensure that they do not manifest as triggers of heightened vulnerability during disasters.

3.2 Continuation of pandemic initiatives owing to the peace-time needs

Homeless shelters and Migrant Worker Helplines set up at the time of the pandemic crisis should be sustained (financially and man-power). The crises faced by these populations are multi-fold and these centres/institutions can be used as an effective medium to help alleviate multiple plights of these groups. These helplines should work in association with the relevant government departments at peacetimes too; this will ensure that people develop are aware of their existence and trust that they will receive help via these entities.

3. 3 Creation of sub-offices of workers' welfare boards at the ULB level

Welfare boards for Informal Workers employed in all sub-sectors should be created, along the lines of the BOCWB or MDWWB, so that at times of emergency the governance institutions have ready channels to distribute relief, in cash and kind. This could be also linked with the e-Shram portal database of informal workers.

3.4 Participation of people in urban planning as key to the process

While ULBs are in the process of creating Development Plans, these should include the voices of socially vulnerable sections by representing their specific needs. This is necessary, as it will help uproot social inequality by ensuring that basic services require that the excluded groups are addressed at the stage of planning. In order to ensure smooth implementation, citizen-led monitoring groups should also be instituted.

Gender sensitive urban planning which takes into patterns of harassment faced by women and transgender persons in accessing water and using public toilets. If this is addressed at the stage of planning, by involving women from the community at the stage of policy/plan design, it will ensure that certain threats are eliminated

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Annexures

A. Questionnaire

A.1. State Actors - ULBs/Authorities

I. Overall Situation

1. How did you organise yourself/ your department/s at the onset of the 1st wave?
2. What challenges did you face in the early weeks?
3. Can you highlight some unique management lockdown measures that were taken up by your Municipal Corporation in all waves of the pandemic?
4. Did you highlight any specific zone, what were those zones?
5. How were you able to overcome these challenges?
6. What were the major challenges faced in terms of

a. Design

b. Delivery

c. Monitoring

7. Ask same questions about second wave
8. Ask same questions about third wave

II. Relief (Part 1)

1. Did the MC receive relief requests? If so, which departments, how were these requests coming in? What were the kinds of relief people were asking for? How did you respond initially?
2. Who were the main relief providers
3. Did you have data on vulnerable communities? If Yes, How was the data used for management of the relief needs in the 1st wave?

III. Relief (Part 2)

III. A. Food relief: Cooked meals

1. How were the requests coming in? Did you have any data on vulnerable communities in need of food?
2. How did you respond to the demand? Were there any specific zones highlighted to provide food?
3. Was cooked food distributed by the MC? If Yes, What was the process of the food distribution?
4. What partnerships were forged wrt to ensure delivery of cooked food?
5. Was there any specific process followed to achieve well distribution of food relief?
6. What were the gaps and the good practices?

III. B. Food relief: Ration

1. Were ration kits distributed by the MC? How were the requests coming in?
2. If yes, what was the process of distributing ration?
3. What partnerships were formed for ration distribution?
4. Which were the different authorities involved? (Link: Ration Controller, Ration shops linkages if any)
5. What documentation was mandatory? Was it mandatory to have ration cards?
6. What could have been better and what were the good practices?

III. C. Shelter

1. How did you identify vulnerable communities in need of shelter?
2. How were the requests coming in? What strategies were taken up to manage dense slum areas? If No, How did you manage to identify such groups?
3. How did you respond to the demand? How many camps and what kinds of camps (temporary, makeshift) were set up?
4. How many people were accommodated /received shelter relief and what was the duration of the shelter?
5. Partnerships initiated
6. Any aspect that could have been better? What were the aspects that helped?

III. D. Healthcare

1. How were the requests coming in for healthcare? Were there any helplines offered? Were there any Check-up camps set up? How many? What types?
2. How did you manage the huge demand specifically in the 2nd wave? Any model for healthcare that was followed (MCGM Model of DCHC, CCC)? How were the CCC in makeshift infrastructure identified?
3. Different authorities that were involved in planning?
4. What were the partnerships formed?
5. What were barriers & good practices?
6. Sanitation/WASH- Did you give any provisions for water/hygiene/sanitation for vulnerable communities?

IV. Vaccination Drive

1. How were the requests coming in? What was the alternative for online? How did the state allocate vaccine doses?
2. Were any special drives conducted for vulnerable groups? What were the vulnerable groups?
3. How did the MC deal with vaccine hesitancy and what initiatives were taken to improve awareness?
4. What was the Makeshift infrastructure set up to fasten the drive?

5. How were free Vaccination drives handled?
6. What efforts are taken for children vaccination and booster dose?

V. State Disaster Management Authority

1. What was the DM and its machinery? What were the gaps? How and who helped in overcoming these?
2. What support did the SDMA extend to MCs?
3. Was the disaster management plan helpful if not how it can be made helpful or if yes how and what kind of help was received?
4. What do you see the role of MCs in a disaster situation

VI. Recommendations

1. What more could the state have done in terms of support/management?
2. What do you think are aspects that require most improvement?
3. What aspects do you think should be focussed on?
4. What agencies/organisations should be tapped for support?
5. What are the major resources lacking - Human resources, finance/funding, system issues? How should this problem be dealt with?

A.2. Non- State Actors - NGOs/ Unions/ Mandals/ Volunteers etc.

I. Relief: Food, Ration, Shelter, Healthcare

Note - Ask the interviewee to specify which lockdown period / month & year

1. Your areas of work- exact location in the mc
2. Your outreach in terms of relief - in numbers- no of people, families, relief distribution numbers etc
3. How many and what organisations were working in the same localities/*bastis* as you? What was their role
4. What were the kind of services you provided?
5. How did you organise yourself at the onset of the 1st wave?
6. What challenges did you face in the early weeks?
7. How were you able to overcome these challenges?
8. Did ULB's approach you? If yes, what specific requests were coming in from the Municipal Corporation? Did you receive any Data on where and how much relief was required? Was there any overlap on ULB's service provision and yours?
9. Did you form any partnerships with other organisations?
10. How are slum leaders positioned to address the health and livelihood threats of the pandemic within their neighbourhoods?
11. Please explain the planning and process involved in you relief work
12. What were the major challenges faced in terms of

a. Design
b. Delivery
c. Monitoring

13. What aspects required maximum funding? What were the major gaps assessed in funding?
14. What were the barriers and good practices?

II. Vaccination drive

1. How were the requests coming in? How did you help communities overcome the digital divide?
2. How did you make communities aware about vaccination?
3. What did you do to respond? Did you have any database or records?
4. Did you form any partnerships? Did the Municipal Corporation approach you or organisations similar to you?
5. What was the process and planning involved?

III. Management recommendations for future

1. What could the Municipal corporations have done better? What aspect should they focus on?
2. Which other non-government actors who are currently not involved should participate in management/relief?
3. Do you suggest any policy recommendations?
4. What do you think are aspects that require most improvement?
5. What aspects do you think should be focussed on?
6. What agencies/organisations should be tapped for support?
7. What are the major resources lacking - Human resources, finance/funding, system issues? How should this problem be dealt with?

A.3. Vulnerable communities - Focus Group Discussion

I. Situation

1. Did you receive any help for relief - food, ration, shelter, healthcare/medicines? If yes, what support, who helped and how? Did you incur any relief expenses? If yes what % was it from you earning?
2. What has been the impact on earnings and incomes during lockdown? What was the aspect which incurred maximum expenditure?
3. Have unemployment and earnings worsened over the course of the lockdown?
4. What did you do when you received no relief support?
5. What did you do to maintain social distancing and what were the barriers in achieving the same?
6. How are slum leaders positioned to address the health and livelihood threats of the pandemic within their neighbourhoods?

7. What problem-solving activities, if any, have they performed for residents during the pandemic? What factors shape success in those efforts?
8. Did you face any problems due to sanitation service quality, and waste disposal management? Was there any support provided?

II. Barriers

1. Did you face any difficulties due to lack of documents?
2. What was the condition of public infrastructure in your locality?
3. What did you do during an emergency?

III. Accessibility

1. Did you/your family get vaccinated or any COVID health treatment? If yes, did any state/non-government agency support you for its accessibility/funding?
2. Has outreach of public support improved?
3. How and what other assistance did the government provide?

IV. Awareness

1. Were you aware of all the government relief/ resources available? If yes, from where did you get the information? If not, what were the barriers?
2. Are you aware of the 'one nation, one ration' scheme?
3. Were any awareness programs on vaccination conducted in your locality?

V. Recommendations

1. What could the Municipal corporations have done better? What aspect should they focus on?
2. What aspects should have been prioritised?

B. List of Interviewees

I. MCGM - P North Ward	
1.	Kamlesh - Assistant Medical officer at Malwani health post
2.	Prashant Jadhav - Ward level, Public Health Department
3.	Assistant of Community Development Officer
4.	Mukesh - Member of Panchsheel katta, Ambujwadi
5.	FGD- Women residents at Ambujwadi
II. VVCMC	
1.	Niwasi Naib Tahsildar (Deputy Tahsildar), Vasai Virar Sub Region
2.	Medical Officer at Nirmal Public Health Centre (PHC)
3.	FGD- Dhaniv Baug, Nalasopara East- Mahila Bachat Gat
4.	FGD- Gangripada, Nalasopara East - Workers Union
5.	Youth for Unity and Voluntary Action - 3 Volunteers
6.	Kilbil Samajik Santha, Head and Volunteers
7.	Jivandaan Foundation- Jehona Nazareth, Head
8.	Paryavaran Sauvardhan Samiti Vasai-Virar, Volunteer
9.	1 Activist from Vasai Virar
10.	Community leader - Gangripada, Nalasopara East
III. NMMC - Belapur Ward	
1.	Social Worker from Social Welfare Department, NMMC
2.	ASHA Worker, Nerul Block
3.	Youth for Voluntary Action - 3 Staff Members

4.	Activist from Ghar Haq Sangharsh Samiti
5.	FGD with Domestic Workers, Belapur
6.	Discussion with Two Community Leaders from Tata Nagar

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