

# Improving Health, WASH and Risk Communication for COVID-19 response and control in urban slums

## Why COVID-19 prevention and control in informal settlements should be prioritized

Almost 30% of India's urban population live in slums. To date, a large proportion of India's COVID-19 cases are concentrated in urban sprawls: Mumbai, Thane, Delhi, Ahmedabad, Indore, Chennai, Pune, Jaipur, Kolkata, Surat, Hyderabad, Vadodara, Agra and Bhopal.

Working in urban slums is particularly challenging and requires strong leadership of the Municipal commissioners and ward officers empowered to coordinate the various sectors and stakeholders, including governmental departments and NGOs, MPs and MLAs, to mobilize human and financial resources and drive operations in a participatory manner with communities.



Informal settlements and slums are unplanned. Many are overcrowded, both at the neighborhood and house level, with very limited public space, and have limited or no access to basic services such as affordable water, sanitation and health facilities and other essential services. These slums are not isolated from the cities where they are located. Daily workers move from slums and may affect other neighborhoods. Many migrants also reside in slums.

### Major risk factors for people living in informal settlements

- **Higher transmissibility** (crowding, social mixing, large households living in small (1 room) houses, poor water services, communal toilets and water points, mass gatherings)
- **Higher prevalence of severe diseases** due to prevalent co-morbidities (e.g. under-nutrition; tuberculosis; hypertension) or risk factors (e.g. tobacco)
- **Higher concentration of marginalized, migrants and forcibly displaced populations** who engage in informal economy to survive, that are also culturally and socially diverse
- **Prevailing gender inequalities** coupled with measures to control the spread heightens safety and wellbeing risks for women and children
- **Higher case fatality** due to COVID-19 and to other ill health conditions, to inadequate access to care services
- **Low awareness on certain prevention behaviours where only a handful of the population** cited physical distancing and handwashing with soap and water when hands are dirty.

**Every slum is different** which **makes them complex**, in terms of the diversity of the roles and responsibilities of various local stakeholders, including government, non-government organizations, local social networks. Stigma and discrimination issues constitute an additional concern, since the where majority of the population fear how they will be treated at the isolation facilities, and health workers are perceived as the ones who spread the infection.

### Access to water, sanitation and hygiene in slums is problematic

- 60% of people served by piped water receive less than 3 hours a day<sup>1</sup>, and water storage capacity in slum areas is limited
- Only 57% of slum households access water within premises, compared to overall 71% of urban population<sup>2</sup>

<sup>1</sup> Source: State of Urban Water and Sanitation in India, TERI university, 2017

<sup>2</sup> Source: Census 2011

- Only 66% of slum households has access to latrine within premises, remaining use shared facilities or defecate in the open<sup>3</sup>. Operation and maintenance (including emptying of septic tanks) is critical for community toilets, and often neglected.
- Only 37% of slum households has their wastewater outlet connected to a closed drainage<sup>4</sup>

The recent guidelines issued on 16 May 2020 by MoHFW for preparedness and response to COVID-19 in urban settlements mostly consider health and risk communication measures, while further guidance on WASH measures for COVID-19 prevention and control should be implemented with strong leadership and coordination.

### What can be done?

- **Contextualize:** Not all slums are the same, heterogenous vs homogeneous population, languages, traditions and habits are different, and solutions and key messages need to be contextualized.
- **Leave no one behind:** Support should be extended to both notified and non-notified slums
- **Understand the needs:** mapping and rapid assessments involving ward officers and CSOs to understand critical WASH, Health and Risk Communication needs and opportunities for COVID-19 prevention and control
- **Develop and implement multisectoral micro plans** to improve COVID-19 prevention and control
- **Ensure flexible means to provide access** to those zones of the slums areas that are under perimeter control (containment zones)
- **Mobilize funds** from existing government flagship programmes: NHM, PMJAY, SBM-U, SMART CITIES, City Sanitation Plan, NULM and adopt a **blended approach of centralized and decentralized resource utilization** (sharing resources and responsibilities between Municipal Corporation and Ward Councilor)
- **Intersectoral /departmental linkages and coordination** – support linkages with other relevant departments, Ward Councilors, and Municipal Corporations
- **Engage communities:** work at the community level and with CBO and CSO partners

### Specifically, in Health, WASH and Risk Communications & Community Engagement

1. **Special guidance/provisions/advisories** issued for families and communities in slums to adopt and maintain recommended practices. The adoption of **Physical distancing** is particularly relevant in common areas such as retail shops, community water points and community toilets, markets, transport facilities, where regular disinfection (and protective gear for service providers) is essential and feasible.
2. Work with the most trusted **influencers and faith leaders, social networks**. This is critical to ensure that urban social influencers, trusted urban community leaders, workers and volunteers play their role in supporting **preventive practices** and disseminating **practical and actionable information** on how people can protect themselves and others, stay healthy and reduce risks.
3. **Scale up** affordable provision of quality basic care (preventive/curative) for all medical conditions, particularly acute respiratory infections.
4. **Engage with private sectors** providers, to facilitate their contribution to a multisectoral support to slums
5. Facilitate **solutions** for integrated testing, contact tracing and isolation solutions
6. **Protect those most at risk**, such as elderly people, or people suffering of chronic disease or other medical conditions.
7. Address the **mental health and psychosocial needs** of children, their caregivers and families during this pandemic.
8. **Intensify capacity building** on RCCE, WASH, social services for frontline functionaries on prevention and control
9. **Plan for dual risk**, taking into account seasonal events that typically occur in urban settings and that require careful planning and response (e.g. dengue outbreaks; rains and flooding; heatwaves)

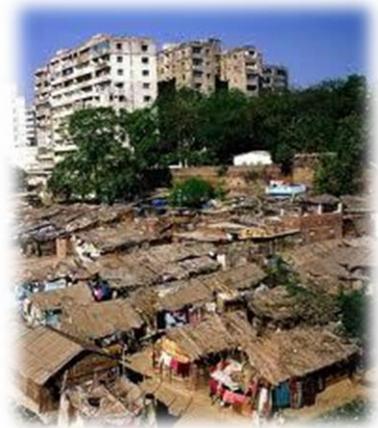
<sup>3</sup> Ibid.

<sup>4</sup> Ibid.

10. **Leverage appropriate platforms and partnerships** with government, CSOs, CBOs, FBOs to ensure appropriate communication mediums in slums are used to reach people and consider the most vulnerable
11. **Provision** of additional water points, community toilets and no touch handwashing stations to reduce crowding, including ad hoc structures in high risk high traffic locations such as marketplaces
12. Ensure **adequate access to WASH services** and facilities in schools, pre-schools and public facilities
13. Ensure **chlorination of drinking water supply** or promote household water treatment options

### How can UDD, PHD, MAD and MPCB support in preparedness and response to COVID-19 in slums?

1. Provide technical support on **surveillance strategy** and **roll out assessments** to understand Health, WASH and behavior change needs in slum hot spots.
2. Support multisectoral **community based micro planning – aligned to containment plans** – at Ward Level on IPC, WASH, Health and RCCE for COVID-19 response, and provide handholding support during implementation.
3. Develop and contextualize **training materials** for front line workers and service providers and facilitate trainings on Health, IPC/WASH and RCCE.
4. **Develop simple and practical SoP and checklists** available to Ward Councilors, CBOs and service providers such as toilet operators and waste collectors, and schools with quarantine centers, to maintain physical distancing, regular disinfection and IPC.
5. **Promote non touch paddle operated hand washing stations** (gender disaggregated) with soap, water and drainage facilities at community toilets and schools used as quarantine and isolation wards.
6. **Develop culturally appropriate RCCE materials** (audio, video, digital, online) and **implement RCCE campaigns** (including creative signages) focusing on hand washing, respiratory hygiene, safe disposal of waste, rumour monitoring and maintaining physical distancing at all common areas.
7. Engage **faith-based/community leaders, SHGs and influencers to facilitate local solutions** (using social marketing approach) so that control measures such as physical distancing, home care, self-isolation, masks or movement controls are contextually appropriate. This will include the **informal, unregulated and private providers** such as private pharmacists, local retailers, plumbers etc. for hygiene promotion and risk communication.
8. Provide technical support on establishing and implementing **Accountability and Feedback mechanisms** for the urban slum population



Slum in Gujarat