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SOCIETY FOR NUTRITION, EDUCATION AND HEALTH ACTION

DISTRIBUTION OF FRESH FRUITS AND VEGETABLES IN DHARAVI, INDIA

Lessons and learnings from the Covid–19 pandemic

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EXECUTIVE SUMMARY

This report documents the efforts to provide food relief to households in Dharavi during the nationwide lockdown which was implemented to prevent the spread of the Covid–19 pandemic between the months of May and June 2020. Covid–19 stands for the Coronavirus disease-2019, a viral respiratory pneumonia caused by the recently-discovered novel coronavirus, Severe Acute Respiratory Syndrome Coronavirus-2 (SARS-CoV-2). This virus emerged in an outbreak in Wuhan City, Hubei Province, China, at the end of 2019, and spread across the world in the span of three months. Covid–19 was declared a pandemic in March 2020 by the World Health Organization.

As of 29 July 2020, according to the Johns Hopkins University Coronavirus Resource Center, there have been 16.73 million confirmed cases of Covid–19 and 660,383 deaths globally. In India, there have been 1.53 million confirmed cases and 34,193 deaths. With the exception of a few nations, every country in the world initiated nation-wide quarantines and lockdowns to prevent the spread of the virus. In India, which witnessed one of the harshest such lockdowns in the world, spanning over two months, millions of families struggled to make ends meet as their access to food and resources were severely constrained. One such area was Dharavi, one the largest slums in India and Asia.

The Society for Nutrition, Education and Health Action (SNEHA) is a secular non-governmental organization (NGO) that works towards improving the health and wellbeing of women and children in Mumbai's urban informal settlements since 1999. SNEHA programmes work in domains of maternal and child health, nutrition, adolescent health and sexuality, prevention of violence against women and children, and palliative care. At present, SNEHA programmes work with communities as well as health systems, and are operational across 20 communities in the Mumbai Metropolitan Region (MMR).

The ATE Chandra Foundation (ATECF) is a Mumbai-based organization that anchors the philanthropic giving of the Chandra Family. The Foundation is involved in various sectors, like agriculture, arts and culture, education, gender, governance, health, livelihood and poverty alleviation, nutrition, water and sanitation and hygiene. The Foundation's primary beneficiaries include children and youth, people in poverty, persons with disabilities and medical needs, the unemployed, and women and girls.

Between April and June 2020, with initial funding from ATECF, SNEHA distributed 30,000 boxes of fresh fruits and vegetables (FFVG) to vulnerable inhabitants in Dharavi across two phases. As the lockdown had severely restricted the supply of fresh produce across the city and the Covid–19 containment zones, SNEHA and ATE Chandra Foundation partnered to initiate food relief efforts to ensure that vulnerable inhabitants received food items rich in nutrients like Vitamin C, which could also help boost their immunity in times of the global pandemic.

Drawing on telephonic interviews with key stakeholders involved in planning, coordinating and implementing distribution efforts—both, from SNEHA programme

teams as well as independent volunteers—this document provides an overview of the process, as well as emergent thematic learnings on engaging in food relief efforts in urban informal settlements. While not a comprehensive process evaluation of the programme, this document identifies key themes that emerged during this process—itself a new and daunting new task for SNEHA, as well as other stakeholders, like the MCGM and local communities.

This study found that despite severe challenges and constraints imposed by a global pandemic and state responses, SNEHA and ATECF were able to devise strategies to navigate this crisis situation. In particular, it presents some preliminary but promising evidence on how programmes can achieve convergence, not only in response to such situations, but by devising common strategies that involve staff from across different verticals. These findings should be of interest to researchers and administrators working toward achieving convergence.

Finally, this report also provides a few brief directions for pursuing advocacy with regard to coordinating relief efforts alongside state and municipal agencies. First, there is a need to strengthen inter-sectoral collaboration between civil society organizations, as well as between civil society and the state; second, coordinated responses toward relief efforts should function at appropriate levels of centralization and decentralization; and finally, relief efforts require their own independent infrastructure, like dedicated control rooms.

It is our hope that this document opens up the possibility of bringing relief work within the fold of intervention services, as well as engages in advocacy with local governance to ensure basic rights, such as the right to food security, and their linkages with organizational outcomes on health, nutrition and wellbeing.

CONTENTS

LIST OF ABBREVIATIONS

ASHA	Accredited Social Health Activist
ATECF	ATE Chandra Foundation
BMC	Brihanmumbai Municipal Corporation
BMGF	Bill and Melinda Gates Foundation
CEO	Chief Executive Officer
CHN	Child Health and Nutrition
CHV	Community Health Volunteer
Covid–19	Coronavirus Disease 2019
EHSAS	Empowerment, Health and Sexuality of Adolescents
FFVG	Fresh fruits and vegetables
FPO	Farmers Producer Organization
HCQ	Hydroxychloroquine
ICDS	Integrated Child Development Scheme
IEC	Information, Education and Communication
MCGM	Municipal Corporation of Greater Mumbai
MERS	Middle East Respiratory Syndrome
MMR	Mumbai Metropolitan Region
MNH	Maternal and Newborn Health
MOHFW	Ministry of Health and Family Welfare
MOU	Memorandum of Understanding
NGO	Non-Governmental Organization
PDS	Public Distribution System
PVWC	Prevention of Violence against Women and Children
RT-PCR	Reverse Transcription Polymerase Chain Reaction
SARS	Severe Acute Respiratory Syndrome
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus-2
SNEHA	Society for Nutrition, Education and Health Action
WHO	World Health Organization

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1. INTRODUCTION

This document arose out of internal conversations and discussions among SNEHA programme staff members regarding the need to document the organization's efforts to engage in food relief in Dharavi between April and June 2020, when the country was under a strict lockdown. In particular, these questions concerned the challenges of engaging in direct food relief—a task that had never been undertaken before—in relation to the community interventions that were already active but shifted to remote modes.

As an organization that primarily worked on issues of health and nutrition especially among vulnerable women and children in urban informal settlements, it was imperative to engage in, coordinate, and implement food relief efforts. Both, the pandemic and the strictly-imposed lockdown, created a crisis situation in densely packed urban informal communities. As a result, the immunity and wellbeing of the main beneficiaries of SNEHA programmes—women and children—had been compromised due to dense living conditions and hygiene and sanitation constraints. Furthermore, in informal settlements like Dharavi, public health officials faced other challenges like demarcating containment zones as part of the MCGM's overall crisis management strategy. In such a public health crisis, proper nutrition is even more vital. A well-balanced diet contributes to a healthier and stronger immune system, as well as lowers risk of contracting infectious diseases.

This motivated SNEHA and ATE Chandra Foundation to undertake the mammoth task of distributing fresh fruits and vegetables (FFVG) to Dharavi residents living in vulnerable containment clusters to provide them with nutritious food, boost their immunity, and reduce food insecurity during such a time of crisis.[1] Since much of this process was emergent, there was a need to understand the processes through which such efforts were initiated, implemented, and sustained.

Thus, by the end of May, the author of this report and the Research Director at SNEHA had a series of brief consultations on drawing up plans for a documentation project. We started with an initial list of questions which covered the logistical issues in food relief—like procurement and distribution—as well as other issues, such as coordinating with MCGM officials, local communities and volunteers. However, considering that other programmes and research teams at SNEHA were already engaged in researching healthcare responses to Covid–19, this particular project's aims were limited to food relief efforts.

We decided to conduct telephonic interviews with 6–8 key stakeholders engaged in food relief efforts in Dharavi. At the beginning of this project, the author had an in-depth interview with a Programme Director and an Associate Programme Director, who were coordinating relief efforts in Dharavi, to get a picture of the situation. At this point, our

[1] Adapted from: SNEHA. 2020. Report of fresh fruits and vegetables distribution in containment areas of Dharavi: First round – 21st April to 15th May 2020. Unpublished report. SNEHA: Mumbai.

efforts were at establishing a timeline of food relief efforts and outlining the roles and responsibilities of SNEHA programme teams and ATECF representatives.

The author then undertook telephonic interviews with a SNEHA Fundraising Coordinator, and two Programme Coordinators, a Programme Officer and a Community Volunteer, who were all involved in distributing boxes of fresh fruits and vegetables (FFVG) in Dharavi. In addition to this, the author also interviewed an independent volunteer who had coordinated the logistics of procurement and distribution of FFVG as an intermediary between SNEHA and ATECF.

The rest of this report is structured as follows. The following section provides an overarching background of the Covid–19 pandemic, its origins, its global spread and how it spread in India and Dharavi. This section also briefly presents the efforts of the national, state and municipal government in preventing the spread of the pandemic—that is, the implementation and enforcement of lockdowns and quarantines. However, this section does not deal with the testing, tracing and treatment of Covid–19 as these concerns lie outside the objectives of this report.

The third section provides an in-depth account of planning, coordinating and implementing food relief efforts in Dharavi, drawing on the interviews with programme staff members and other key stakeholders. The fourth section discusses some of the key themes which emerged from staff narratives. These refer to the larger conditions of the pandemic itself, and how local communities negotiated these conditions, as well as illuminate on the possibilities of working in vulnerable communities in such unprecedented times. Finally, the fifth section presents certain recommendations for advocacy that can guide further discussions and policy formulation for NGOs and civic agencies to plan for such contingencies.

2. COVID–19 FROM THE GLOBAL TO THE LOCAL

2.1. From a virus of unknown origin to a global pandemic

In late-December 2019, news agencies reported the outbreak of viral pneumonia caused by an unknown pathogen in several clusters in Wuhan City, Hubei Province, China. Researchers identified the virus as a novel coronavirus—a family of viruses which include pathogens like H1N1 (swine flu), SARS (Severe Acute Respiratory Syndrome), MERS (Middle-East Respiratory Syndrome), and even the common cold virus.[2] Scientists named this novel coronavirus as SARS-CoV-2, and the disease it caused as the Coronavirus Disease-2019, or Covid–19.[3]

Like some other coronaviruses, the SARS-CoV-2 has a zoonotic origin, that is, the virus originally infected mammalian species like bats or pangolins, but then mutated and crossed the species barrier to infect human beings.[4] In Wuhan City, the first cases of the infection were traced back to a wet market—a market selling fresh vegetables, fruits, and meats. However, researchers later suggested that the virus may not have originated at the wet market.[5]

As the virus is completely foreign to human biology, human beings have no immunity to it and contract the disease when infected. SARS-CoV-2 is transmitted via respiratory droplets from coughs or sneezes of an infected person. Transmission may also occur via surfaces contaminated by the virus, such as door handles, windows, or railings.[6] The symptoms of Covid–19 include fever, cough, fatigue, shortness of breath, and the loss of smell and taste.[7] The onset of the disease happens at 2–14 days from exposure. Diagnosis of Covid–19 is done via real-time reverse transcription polymerase chain reaction (RT-PCR) from nasal swabs.[8] As per WHO guidelines, infected patients are required to quarantine themselves for 14 days until they are tested negative. However, many infected persons have been known to be asymptomatic and have spread the disease. Thus, the

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[2] World Health Organization. 2020. Novel Coronavirus (2019-nCoV): situation report, 22. World Health Organization. https://apps.who.int/iris/handle/10665/330991

[3] BBC News. 2020. Coronavirus disease named Covid–19 (11 February). https://www.bbc.com/news/world-asia-china-51466362

[4] Shield, C. 2020. Coronavirus: From bats to pangolins, how do viruses reach us? *Deutsche Welle*. (26 March). https://www.dw.com/en/coronavirus-from-bats-to-pangolins-how-do-viruses-reach-us/a-52291570

[5] Cohen, J. 2020. Wuhan seafood market may not be source of novel virus spreading globally. *Science Magazine* (26 January). https://www.sciencemag.org/news/2020/01/wuhan-seafood-market-may-not-be-source-novel-virus-spreading-globally

[6] Centers for Disease Control and Prevention. 2020. How Covid–19 spreads. https://www.cdc.gov/coronavirus/2019-ncov/about/transmission.html

[7] Centers for Disease Control and Prevention. 2020. Symptoms of Coronavirus. https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

[8] Jawerth, N. 2020. How is the Covid–19 virus detected using real time RT-PCR? *IAEA* (March 27). https://www.iaea.org/newscenter/news/how-is-the-covid-19-virus-detected-using-real-time-rt-pcr

most effective measures of preventing the spread of SARS-CoV-2 is the use of masks or other adequate face coverings, maintain physical distance of at least 6 feet between people (particularly symptomatic individuals), frequent hand washing with soap for at least 20 seconds, and avoid touching eyes and nose with unwashed hands.[9]

By January, SARS-CoV-2 had spread across several Chinese cities, which were put under strict lockdown to prevent the spread of the virus. At the same time, the disease was rapidly spreading through Europe, particularly Italy and Spain, and Iran. The WHO declared the outbreak a Public Health Emergency of International Concern on 30 January 2020 and a pandemic on 11 March.

2.2. India's response to the pandemic: The "harshest" lockdown in the world

In India, the first confirmed cases of Covid–19 were recorded in the state of Kerala in late January.[10] The infected individuals were students in Wuhan City. Next, a group of Italian tourists in the state of Rajasthan were tested positive. Other positive cases were found among individuals who had travel history to countries like Italy and China.[11] By mid-March, nearly 500 Covid–19 cases were recorded across various states. In the state of Maharashtra, the government issued work from home policies for public and private offices by the third week of March.[12] Meanwhile, the Central government issued orders to close school and higher educational institutions, as well.[13]

On 22 March 2020, Indian Prime Minister Narendra Modi issued a call for a 14-hour "Janta Curfew" (People's Curfew). With the exception of essential services like police and health personnel, all citizens were asked to remain indoors.[14] India officially initiated a nation-wide 21 day lockdown from 25 March to 14 April 2020. Under this, all non-essential activities and movements were prohibited. Road, air and rail transport services were suspended, with the exception of essential services like government employees, healthcare workers, police personnel, and other involved in food production and

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[9] Maragakis, L. L. 2020. Coronavirus, social and physical distancing and self-quarantine. *Johns Hopkins Medicine*. https://www.hopkinsmedicine.org/health/conditions-and-diseases/coronavirus/coronavirus-social-distancing-and-self-quarantine

[10] Reid, D. 2020. India confirms its first coronavirus case. *CNBC* (30 January). https://www.cnbc.com/2020/01/30/india-confirms-first-case-of-the-coronavirus.html

[11] Perappadan, B. S. 2020. 6 members of Delhi patient's family test positive for coronavirus. *The Hindu* (4 March). https://www.thehindu.com/news/cities/Delhi/covid-19-6-members-of-delhi-patients-family-test-positive-for-coronavirus/article30980724.ece

[12] Vyas, S. 2020. Maharashtra government orders private offices to go for 'work from home'. *The Hindu* (17 March). https://www.thehindu.com/news/states/coronavirus-maharashtra-government-orders-private-offices-to-go-for-work-from-home/article31086040.ece

[13] Sanyal, A. 2020. Schools closed, travel to be avoided, says Centre on coronavirus: 10 points. *NDTV* (17 March 2020). https://www.ndtv.com/india-news/mumbai-s-siddhivinayak-temple-to-close-entry-for-devotees-from-today-amid-coronavirus-outbreak-2195660

[14] Bureau Report. 2020. PM Modi calls for 'Janta Curfew' on March 22 from 7 AM-9 PM. *The Hindu Business Line* (20 March). https://www.thehindubusinessline.com/news/pm-modi-calls-for-janta-curfew-on-march-22-from-7-am-9-pm/article31110155.ece

distribution.[15] The lockdown was extended from 14 April to 3 May;[16] and once again from 4 May to 17 May.[17] By the end of May, some restrictions on shops and travel were being gradually lifted, with the nation entering subsequent "unlock" phases from 1 June to 31 July 2020.

The lockdown in India was one of the harshest in the world as it severely restricted the mobility of people, especially in dense urban areas. In particular, the lockdown adversely affected the estimated 139 million migrant workers in India.[18] Migrant workers are the backbone of India's informal economy, with majority of them migrating to cities like New Delhi, Mumbai, Bengaluru, Kolkata, Ahmedabad, and Pune, from villages in states like Uttar Pradesh, Bihar, West Bengal, Odisha, and Jharkhand. Most workers are seasonal migrants, and usually reside in rooms or settlements with other workers that are close to their places of work, like construction sites or workshops. Many of them are also daily wage earners. Thus, with the closure of shops and workspaces, millions of migrant workers faced existential uncertainties over their basic needs like food, shelter and employment. The closure of rail and road transport also severely crippled their mobility as they were unable to return to their villages—where many workers and families had access to support systems, or even alternatives to employment or income generation. As a result, India witnessed the "exodus" of millions of migrant workers who returned to their villages on foot, bicycles, or stowed into containers on trucks. As of June 2020, nearly 200 migrant workers were killed in road accidents during the lockdown.[19]

2.3. Coronavirus in Dharavi

Dharavi reported its first case of Covid–19 on 1 April 2020.[20] Considered to be one of the largest slums in India and Asia, Dharavi is spread across an area of 2.25 square kilometers

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[15] BBC. 2020. Coronavirus: India enters 'total lockdown' after spike in cases. *BBC News* (25 March). https://www.bbc.com/news/world-asia-india-52024239

[16] Bhaskar, U. 2020. India to remain closed till 3 May, economy to open gradually in lockdown 2.0. *LiveMint* (14 April). https://www.livemint.com/news/india/pm-modi-announces-extension-of-lockdown-till-3-may-11586839412073.html

[17] ET Online. 2020. Lockdown extended by 2 weeks, India split into red, green and orange zones. *Economic Times* (4 May). https://economictimes.indiatimes.com/news/politics-and-nation/govt-extends-lockdown-by-two-weeks-permits-considerable-relaxations-in-green-and-orange-zones/articleshow/75491935.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst

[18] Sharma, K. 2017. India has 139 million internal migrants. They must not be forgotten. *World Economic Forum* (1 October). https://www.weforum.org/agenda/2017/10/india-has-139-million-internal-migrants-we-must-not-forget-them/

[19] Datta, A. 2020. 198 migrant workers killed in road accidents during lockdown: Report. *Hindustan Times* (June 2). https://www.hindustantimes.com/india-news/198-migrant-workers-killed-in-road-accidents-during-lockdown-report/story-hTWzAWMYnokyycKw1dyKqL.html

[20] Shelar, J. & Mahale, A. 2020. When a virus finds space in India's largest slum. *The Hindu* (9 May). https://www.thehindu.com/news/cities/mumbai/when-a-virus-finds-space-in-indias-largest-slum/article31537623.ece

in the heart of Mumbai city. Dharavi consists of diverse residential neighborhoods and settlements along with small manufacturing workshops and factories which produce garments and clothing, food items, fashion accessories, medical equipment, traditional crafts like pottery, as well as housing recycling units. Dharavi is home to both, residents who migrated to the area several generations ago from northern and southern Indian states, and migrant workers and families who settled in the various neighborhoods over the last few decades.[21] It is estimated that the population of Dharavi is somewhere between 700,000 to 1 million—making it one of the most densely populated places in the world. Closely-built settlements, public toilets, lack of running water, and maintaining hygiene and sanitation facilities were some of the biggest challenges for containing the spread of the virus.[22]

Within weeks, the number of cases in Dharavi—as well as other informal communities—increased exponentially. By the end of April, there were 491 positive cases, which increased to 1,216 in May along with 56 deaths. However, MCGM's healthcare response was quick to adapt to the challenge. From early on, the civic body adopted the four Ts approach: *tracking*, *tracing*, *testing*, and *treating*. Healthcare workers set up "fever clinics" in the settlements to proactively screen residents, instead of only testing people with symptoms. By involving private doctors, the civic body covered nearly 50,000 households and screened over 15,000 individuals in mobile vans. The "Dharavi Model" even won praise from the WHO Director-General, Tedros Adhanom Ghebreysus.[23] As of 27 July 2020, Dharavi recorded 2,540 Covid–19 cases, of which only 98 were reported as active.[24]

In the next section, we examine the background, context and mechanisms through which SNEHA engaged in the distribution of fresh fruits and vegetables in Dharavi during the lockdown.

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[21] Sharma, K. 2000. Rediscovering Dharavi: Stories from Asia's Largest Slum. New Delhi: Penguin.
[22] M. S., Eeshanpriya. 2020. Inside Dharavi: India's largest slum and a major Covid hotspot. *Hindustan Times* (30 April). https://www.hindustantimes.com/india-news/inside-dharavi-india-s-largest-slum-and-a-major-covid-hotspot/story-ZbX5VOngcJImsK9F4ohBvM.html
[23] Pinto, R. 2020. WHO lauds Dharavi's model in Covid–19 fight. *Times of India* (11 July). https://timesofindia.indiatimes.com/india/who-lauds-dharavis-model-in-covid-19-fight/articleshow/76904931.cms
[24] Ahuja, P. 2020. Mumbai: Dharavi reports only 9 Covid–19 cases; 29 test positive in Dadar in the last 24 hours. *Mumbai Mirror* (27 July). https://mumbaimirror.indiatimes.com/coronavirus/news/mumbai-dharavi-reports-only-9-new-covid-19-cases-29-test-positive-in-dadar-in-the-last-24-hours/articleshow/77201675.cms

3. FOOD RELIEF IN DHARAVI: BACKGROUND, CONTEXT, AND MECHANISMS

3.1. Negotiating intervention work in a lockdown: From awareness to relief

SUB-SECTION SUMMARY

SNEHA programmes initially faced challenges in shifting to remote work

Teams focused on raising awareness about Covid–19

Community team members and local SNEHA volunteers undertook small-scale relief efforts with the help of MCGM and state officials and other NGOs

Volunteers and community team members also had to negotiate the lack of resources and constraints imposed by strict lockdown measures

Coordinating with states and civil society actors and food insecurity were significant challenges

By 18 March 2020, the Government of Maharashtra had already instructed workplaces to shift to remote working conditions, while the Indian Government had subsequently initiated the nation-wide lockdown on 25 March. Prior to shifting to remote work, most SNEHA programme team members conducted community mobilization exercises to ensure they collected and verified contact details of their beneficiaries and volunteers, particularly anemic adolescents (EHSAS), pregnant women and lactating mothers (MNH), children below 6 years of age (CHN), and clients seeking counselling services for domestic violence (PVWC).

One of the key activities undertaken by programmes while shifting to remote work was to disseminate best practices to prevent the spread of the virus. The staff created information, education and communication (IEC) materials in the form of PowerPoint slides and images to share with beneficiaries and volunteers via social media platforms like WhatsApp. As part of the transition to remote work, many community teams tried streamlining existing modules with such IEC materials to create awareness among people. Community teams were also given basic training on prevention and safety measures, as well.

Even though the programme teams were in continuous contact with volunteers and beneficiaries, they soon confronted peoples' needs to acquire food materials. By this time, the strict lockdown measures meant that many shops and stores were not open, or only open sporadically. Residents also found it difficult to access these shops due to restrictions on their movements. When community members and beneficiaries started raising these issues with SNEHA's programme team members, they faced challenges in terms of finding opportunities to provide food relief. Nevertheless, many programme team members and even volunteers coordinated with different actors to coordinate relief at the local level. These included actors like the state government, the MCGM, the public distribution system (PDS), and even local grocery shops and other NGOs.

Dates	Activities and events
March 18	Shift to remote working
March 22	14-hour nationwide "Janta Curfew" imposed
March 25	Nationwide lockdown imposed until 14 April
April 1	First Covid–19 case in Dharavi
April 14	Extension of nationwide lockdown until 3 May
April 21	Beginning of Phase 1 FFVG distribution in Dharavi
May 3	Extension of nationwide lockdown until 17 May
May 15	End of Phase 1 FFVG distribution in Dharavi
May 21	Beginning of Phase 2 FFVG distribution in Dharavi
June 3	Cyclone Nisarga makes landfall in Raigad and Mumbai
June 8	Easing of lockdown restrictions begin
June 17	End of Phase 2 FFVG distribution in Dharavi

Table 1: Timeline of food relief efforts in Dharavi (March to June 2020)

During our interview, a programme director stated that it was a shock and surprise to learn that state agencies were unable to reach food to people. Even though India has done well in terms of food production and the systemic issues with distribution notwithstanding, vulnerable populations like the urban poor were still experiencing food insecurity. She said that even in cases where state and municipal agencies were able to coordinate and provide relief, they provided "dry ration" items like rice, wheat and lentils, and many relief packets did not include essential items like oil or fruits and vegetables—which were important to provide nourishment and immunity.

As SNEHA programmes had never encountered such challenging circumstances in terms of both a global pandemic and strict lockdown measures, she said that organizational responses were thrown "off gear." In such conditions, the organization's chief motivation in looking to engage in food relief work was based out of commitment to people and to respond to the situation. She said that many in the community teams faced these challenges more intimately. Much of SNEHA's community work is based on proximity and connection with beneficiaries and volunteers in the community. This helped establish trust and reciprocity. However, the risk of the pandemic and strict lockdown measures constrained—and effectively stopped—such work. Similarly, other forms of informal support that residents provided each other (e.g., arranging amenities or resources), as well as other forms of collective mobilizations and negotiations community members relied on (e.g., negotiating with local leaders) were also unavailable at the time. Many community workers recalled existential anxieties about resuming or continuing core programme work if community food insecurity was not directly addressed.

3.2. Preliminary relief efforts

SUB-SECTION SUMMARY

After the lockdown was imposed, communities struggled to arrange for food rations

SNEHA staff members and volunteers undertook personal initiative to arrange for food rations, particularly for those who were needy and vulnerable, like pregnant women, and daily wage workers

They coordinated with other local NGOs, MCGM officials, the PDS, as well as private shopkeepers to arrange for food kits

However, given resource constraints, staff and volunteers also faced challenges in providing relief to large groups of people

One of our interviewees, a member of the community team and a Dharavi resident herself, recounted her personal efforts in ensuring food relief to a few vulnerable families. After the lockdown started, one of her volunteers called her up and asked for help organize food relief for some daily wage earners and other vulnerable families in a nearby neighborhood. After contacting the MCGM ward office and other stakeholders, she finally contacted another local NGO in Dharavi which agreed to fund food relief packages for a small number of families. The NGO representative said that they would directly transfer the money to the account of the shopkeeper who would provide the items. After this, she contacted the volunteers in the neighborhood and asked them to provide a list of families who were "needy." The funding NGO had said they could provide 20 packets and had already defined the criteria: women receiving antenatal care, postnatal care, lactating mothers, and tuberculosis patients. She conveyed the information to other volunteers, as well.

However, one of the volunteers sent a list with 50 families. Even when she explained to the volunteer that the other NGO had already defined a criteria and the number of relief packets they could provide, she said she understood that the volunteer was "concerned about the whole community." She had told the volunteer, "If you write their names, people will believe that they will get something. If they don't get, who will take the responsibility?" Eventually, after negotiating with the other NGO, they agreed to fund 27 packets. But as they were also engaged in relief work in other others, there were delays in reaching these beneficiaries. She said that the volunteers were upset with the process and even expressed their anger, and she had to "make them understand."

Unfortunately they encountered yet another roadblock as the shopkeeper had provided account details from a non-functioning back account. After this was resolved, the interviewee recounted how she instructed the volunteers to undertake proper safety measures while collecting the packets and distributing them. She said, "So I made the volunteers understand, don't go out without wearing masks…go in groups of three, and follow each other after five minute intervals to the shop."

One the volunteers we interviewed recounted a similar experience in his community, as well, particularly as fear of the disease had gripped community members as Covid–19 cases had started rising rapidly. He recalled, "In the starting, there was a feeling of fear … when a few cases were identified, people in the area got frightened. They tried sealing entire areas by putting makeshift barricades; not let anyone in. In the beginning this happened." He then explained how he and some community members associated with their local *mandal* had arranged to sanitize their neighborhood. As the volunteer was already in the cleaning industry, he was able to arrange high pressure water jets as well as the disinfectant solution, sodium hypochlorite solution from some contact in the MCGM to sanitize their neighborhood. This played in important role in reducing peoples' fears as well. As he explained, "When we sanitize [the areas], the germs die, and fear is lessened … people are not afraid anymore."

By mid-April, when the nation-wide lockdown was extended from 14 April to 3 May 2020, Covid–19 cases in Dharavi and other slums in the city were on the rise. At the time, MCGM had initiated a plan to administer the controversial drug, hydroxychloroquine (HCQ), to slum dwellers in Dharavi and Worli Koliwada as a prophylaxis against exposure to the virus.[25] HCQ is a drug that is used to treat malaria as well as ailments like rheumatoid arthritis and autoimmune diseases like lupus. MCGM had reportedly been administering HCQ as a prophylaxis to frontline health workers and police personnel involved in providing help to Covid–19 containment zones in the city.[26] MCGM had approached SNEHA to facilitate a large-scale distribution of the drug in Dharavi by involving local volunteers alongside municipal community health volunteers (CHVs), Accredited Social Health Activists (ASHA) and Integrated Child and Development Services (ICDS) workers. As part of this mobilization effort, SNEHA's programme teams thus drew up lists of potential volunteers who could mobilize community members for distribution of the drug.

However, the move to distribute HCQ was controversial because clinical evidence on its efficacy in preventing infection was sparse and insignificant. Indeed, in June 2020 the WHO Solidarity global clinical trial on Covid–19 treatments dropped HCQ as a potential drug.[27] Additionally, at the time there were also global pressures in the use of the drug, particularly as it was being advocated by U.S. President Donald Trump.[28] HCQ also had

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[25] Shelar, J. 2020. BMC to try out hydroxychloroquine as prophylaxis in Dharavi, Worli Koliwada. *The Hindu* (14 April). https://www.thehindu.com/news/cities/mumbai/bmc-to-try-out-hydroxychloroquine-as-prophylaxis-in-dharavi-worli-koliwada/article31335133.ece

[26] Iyer, M. & Pinto, R. 2020. Mumbai: In U-turn, BMC says won't use antimalarial as preventive drug. *Times of India* (16 April). https://timesofindia.indiatimes.com/city/mumbai/bmc-backtracks-on-use-of-anti-malarial-drug/articleshow/75171510.cms

[27] Bureau Report. 2020. Covid–19: WHO drops HCQ-HIV drugs combo from Solidarity Trial. *Hindu Business Line* (5 July). https://www.thehindubusinessline.com/news/covid-19-who-drops-hcq-hiv-drugs-combo-from-solidarity-trial/article31994488.ece

[28] Pandya, D. 2020. Trump-backed hydroxychloroquine drug may be taken by 15,000 Mumbai residents. *Live Mint* (21 April). https://www.livemint.com/news/india/trump-backed-hydroxychloroquine-drug-may-be-taken-by-15-000-mumbai-residents-11587479160869.html

risk of side-effects, especially on patients with preexisting heart conditions, and could cause side-effects like arrhythmia. In the end, the MCGM's plan to distribute HCQ was discontinued.[29]

Nevertheless, SNEHA's mobilization effort at drawing up a list of around 150 volunteers in Dharavi proved to be fortuitous as, by this time, SNEHA and ATECF begun their collaboration efforts of distributing FFVG in Dharavi. This initiative was jointly developed by Mr. Amit Chandra, and SNEHA CEO, Vanessa D'Souza. Around the same time, ATECF were already funding food relief efforts with Apnalaya, a non-governmental organization, in the M-East ward of Mumbai city—which has the lowest human development index of all the wards in the city, and recorded the highest Covid–19 fatality rate in Mumbai.[30] Thus, as a funding agency that had a comprehensive understanding of the ground realities of coordinating large-scale distribution of relief materials, ATECF provided the much-needed impetus for SNEHA to engage in food relief.

Requirement	Description
Location	Staying in and around the containment zones of Dharavi
Age	In the age group of 18 to 50 years
Time commitment	Willing to commit to a minimum of 5 hours for 3–4 days in a week based on the plan for the project
Consent	Have obtained family consent for participation in the relief work project

Table 2: Criteria for recruitment and selection of volunteers (Adapted from: SNEHA Fresh Food Distribution SOP and Policy Document)

3.3. The need for healthy food in a pandemic

SUB-SECTION SUMMARY

It was important for residents living in containment clusters to consume nutritious food items which could boost their immunity and lower the risk of infection

SNEHA and ATECF decided to distribute 30,000 boxes of FFVG to beneficiaries living in the containment clusters across two phases

The main supply-side issues were: procurement, packaging and distribution of large quantities of food items

[29] Iyer, M. & Pinto, R. 2020.
[30] Shelar, J. 2020. M East ward records highest Covid–19 fatality rate. *The Hindu* (14 May). https://www.thehindu.com/news/cities/mumbai/m-east-ward-records-highest-covid-19-fatality-rate/article31578172.ece

ATECF were able to coordinate with bulk suppliers in rural Maharashtra to meet these demands

Meanwhile, SNEHA worked closely with MCGM officials to identify beneficiaries living in containment clusters

Although MCGM and local politicians were involved in providing dry rations (e.g., wheat, rice, lentils, and sugar) at the ward level, both ATECF and SNEHA were of the firm belief that it was important to promote the distribution nutritious items which helped boost the immunity of recipients. It was decided that SNEHA would distribute FFVG boxes to 15,000 families in Dharavi across two phases—from 21 April to 15 May, and 21 May to 17 June 2020. The idea was for each box to suffice a family of four for one week to 10 days. Thus, SNEHA would distribute 30,000 boxes of FFVG in total.

The initial plan was for ATECF to partially fund the distribution of 15,000 FFVG boxes in Dharavi, while SNEHA submitted a more comprehensive funding proposal to the Bill and Melinda Gates Foundation (BMGF) to transition to engaging in Covid–19 relief work in the longer term. However, as a member of SNEHA's fundraising team explained in our interview, SNEHA was not a past donee of BMGF, and thus the process of acquiring initial funds was more prolonged than initially assumed. During this time, ATECF generously raised additional funds to cover the time period of the first phase of FFVG distribution. Eventually, SNEHA put forward a joint proposal with Give India Foundation, as the latter were a past donee of BMGF and already had an MOU (memorandum of understanding) with SNEHA.

One of the first challenges that SNEHA and ATECF had to manage was to streamline supply-side issues of acquiring large quantities of FFVG. In our interview with an independent volunteer associated with ATECF, he said that the initial challenge in the M-East ward was that they were unable to supply or handle large quantities of food. FFVG were being sourced from NGOs or farmers' collectives who were unable to provide a high volume of materials or quality packaging. Thus, the volunteer—who had a background in farming and retail distribution—connected with farming social organizations that were already involved in distributing to retail customers. These collectives were based in rural Maharashtra and had the capacity to provide large amounts of food (Figure 1).

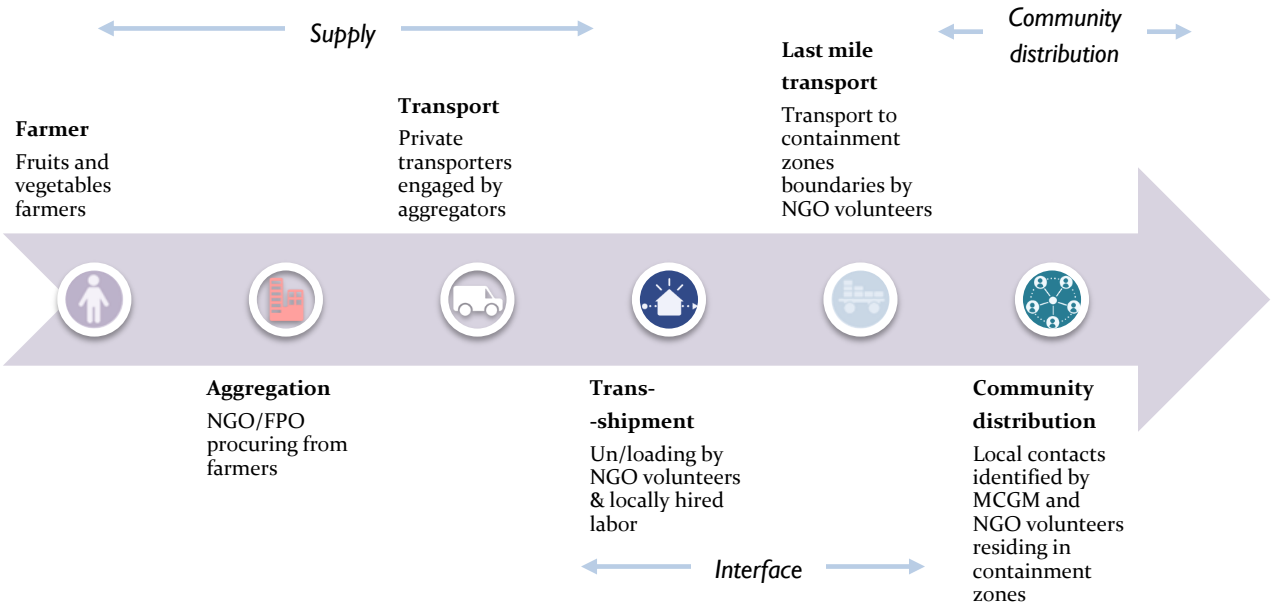

Figure 1: Chain of distribution of FFVG (Source: Adapted from ATECF)

FFVG were distributed in sturdy cardboard boxes which weighed approximate 11 kilograms (Figure 2). Each box included items like onions, potatoes, and tomatoes; assorted vegetables, like okra, cabbage, cucumber; leafy vegetables; condiments like green chilies, lime, ginger, garlic, and coriander and curry leaves; and fruits like bananas, papayas, grapes, watermelons, and oranges or sweet limes (Figure 3). Due to broken supply chains, such items were in short supply at the retail end, particularly in urban areas, and the increased prices also meant that many of these items were less accessible by the poor. For this reason, quality control and checks were also important (Figure 1) so the best possible and most nutritious items reached people—otherwise, poor quality produce might even cause illnesses, explained the independent volunteer.

Figure 2: Sturdy cardboard boxes in which FFVG were packed (Source: ATECF)

Figure 3: Assortment of FFVG contained in the boxes (Source: ATECF)

3.4. Planning for distribution

SUB-SECTION SUMMARY

Prior to distribution efforts, MCGM officials told SNEHA that their teams could not enter the containment clusters

Instead, MCGM provided both, lists of containment zones and beneficiaries, as well as list of community contacts who would coordinate the distribution of FFVG boxes within the zones

Instead, SNEHA teams—including staff members and volunteers—would distribute the boxes to the community locations at the containment zones boundary

The next stage was for SNEHA's programme teams in Dharavi to coordinate and plan the distribution of FFVG boxes. This meant identifying the names and addresses of beneficiaries who would receive the FFVG boxes. The initial plan was for SNEHA programme teams and volunteers to identify beneficiaries and distribute boxes. However, as key members of the programme staff coordinated with officials from MCGM's G-North ward office, they were informed that they could not enter containment zones. Instead, MCGM officials shared lists of containment zones and provided names of *community contacts* living in these zones. As a result, it was then decided SNEHA teams would deliver the FFVG boxes to designated sites outside the containment zones, and

the contacts would then distribute the boxes of the designated beneficiaries within the zones themselves.

SNEHA programme staff members then established contact with these contacts and discussed the requirements of beneficiaries—if there were home-quarantined patients, families of patients admitted to Covid–19 facilities, or families where individuals suffered from other illnesses or ailments. For instance, during the second phase of distributions, community contacts and volunteers identified tuberculosis patients in one cluster, and thus SNEHA was able to coordinate with contacts to ensure that FFVG boxes reached these families as well.

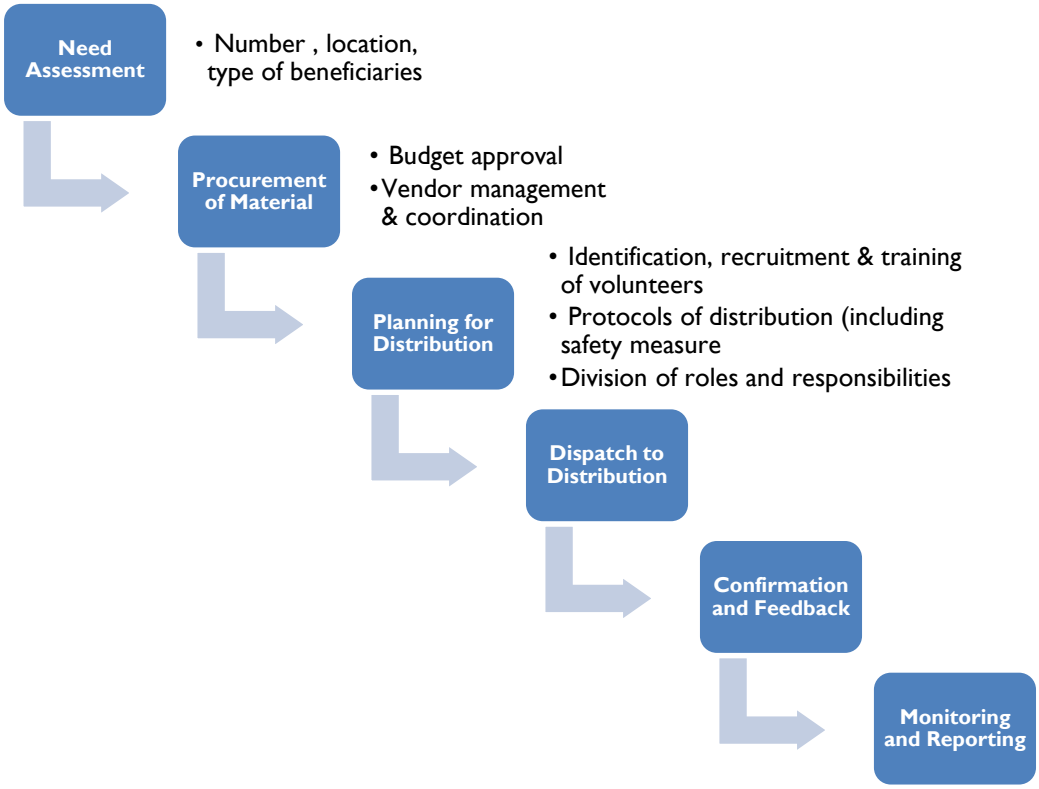

Figure 4: Steps involved in the fulfillment of food distribution project (Adapted from: SNEHA Fresh Food Distribution SOP and Policy Document)

Terminology	Explanation
Containment zone	MOHFW defines the containment zone as a specific geographical area where positive cases of coronavirus are found. Strict movement restrictions are put in place in such areas to prevent further spread of the virus.
Volunteers	A person who voluntarily offers himself or herself for undertaking the task of distribution of fresh food in the areas assigned by SNEHA. These volunteers have to be from the Dharavi community itself and living in the containment zones.
Beneficiary	Beneficiary typically refers to someone eligible to receive distributions from SNEHA. For this project, beneficiaries include individuals or households in the containment zones

	of Dharavi.
Drop-off location	Location where the food boxes will be delivered by the supplier and picked up by SNEHA volunteers.
Community location	Location where the food boxes will be dropped off by SNEHA volunteers and collected by the community contact.
Community contact	Contact person living in the containment zone and shared by MCGM.

Table 3: List of terms and stakeholders involved in FFVG distribution in Dharavi (Adapted from: SNEHA Fresh Food Distribution SOP and Policy Document)

Based on these consultations, the programme team would place orders with the vendors for the required number of boxes. Prior to the day of the distribution, programme staff members, MCGM staff, volunteers and community contacts would have conference calls to plan the logistics of delivering the boxes. MCGM provided electronic passes for the transportation vehicles which would deliver the FFVG boxes to select drop-off sites in Dharavi (e.g., near Lokmanya Tilak Municipal General Hospital or the T-Junction on Sion-Bandra Link Road), as well as for SNEHA staff members and volunteers who would be engaged in distribution. In addition, the SNEHA administration teams were responsible for procuring safety equipment like masks, face shields, hand sanitizer, and gloves for the teams. SNEHA programme staff and volunteers were part of the on-ground teams which eventually distributed the FFVG boxes.

3.5. Overcoming challenges, streamlining processes

SUB-SECTION SUMMARY

SNEHA teams faced numerous challenges towards the beginning of distribution efforts

Community members living outside the containment zones would also request FFVG boxes, at times confronting them and not observing physical distancing guidelines

There were complaints of misappropriation of FFVG boxes from within containment clusters, particularly when political party members were designated as community contacts

Team members and volunteers would draw on ideas of "needy" or "deserving" people to placate community concerns over distribution of boxes

Team members also experienced pressures from the summer heat, exhaustion, and had to constantly monitor safety protocols

In the end, the teams also distributed boxes to other service providers like police personnel, CHVs, and other beneficiaries who were identified at later stages

On the very first day of distribution, however, the teams encountered several problems. In the first place, it was difficult to estimate the volume of food and the resources required to move it. In our interview with one of the programme coordinators with the SNEHA community team, he said that while the initial plan was to employ laborers who operated hand-carts (*hath-gaadi*), this had proved to be insufficient and of the required number of workers, only a few of them showed up that day. Second, although the community contacts had suggested storing the boxes at a local Buddha Vihara—from where they would distribute it later—the community members who looked after the Vihara objected to this, and asked the team to remove the boxes from there. Third, once residents noticed the teams distributing FFVG boxes, crowds started gathering the vehicles. Even residents from the neighboring settlements gathered around the team and started asking questions. As the community team member recalled in our interview, "[We] had to explain things to them, make them understand ... [but] towards the end, there were conflicts (*jhagde*) ... People said they wanted food." Fourth, the team also encountered problems with the local CHVs. While the initial assumption was that CHVs would also distribute boxes in the entire containment area, that particular day the CHVs said that they would only cover their designated areas.

	Phase 1	**Phase 2**
Dates of distribution	21 April–15 May	21 May–17 June
Total days of distribution	14	18
No. of boxes distributed to beneficiaries	13,897	17,346
No. of boxes distributed to volunteers, police personnel, and CHVs	753	354
Total boxes distributed	14,650	17,700

Table 4: Overview of phase-wise distribution of FFVG boxes in Dharavi (Source: SNEHA)

Nonetheless, such challenges helped the team streamline the processes for the subsequent distributions. Instead of hand-drawn carts, the team arranged for tempos from local vendors which were more convenient to reach the smaller roads and lanes in the interior of Dharavi. Similarly, after the first few rounds of distribution, some community members reached out to the teams and raised objections about the FFVG boxes not reaching "deserving" families, and of political actors using their clout and influence to distribute boxes. Thus, in their subsequent preparations with community contacts, the teams ensured that the beneficiaries were from *chawls* or *bastis* (informal settlements), rather than buildings or housing societies. In such negotiations, team members would often draw on the idea of vulnerability and "neediness" (*zarooratmand*) to explain to people the rationale for distributing boxes. Similarly, the team would also invoke the authority of the MCGM and government to negotiate and manage increasing demands. As the volunteer explained in our interview,

> We had to explain ... that it is through the government. We received a list from the BMC.... [But] there were cases everywhere later on [unlike] in the

> starting.... People said later that there are Covid–19 cases here as well, but we had to tell that we are giving it to only those who received before....We cannot take care of everyone ....We had to tell them, those whose registration happened before, we are giving it to them; we cannot take care of others; we are taking care of people whose names are on the list....In the beginning, we were told we are giving it to those who are in need, but then we realized that everyone was needy—people were unable to work.

Engaging in distribution at the peak of summer was the other challenge that teams faced. Wearing face shields, masks and gloves took a physical toll. Although the teams were given safety trainings and briefings the day prior to distribution as well as during the day itself, programme staff had to continually remind the volunteers to observe safety, like keeping their masks on the entire time, properly disposing gloves, and not touching their eyes or noses. This was more difficult with community members, who would often not maintain physical distancing when they approached the tempos.

In one particular case, the community team member revealed that she had to repeatedly inform the tempo driver to wear his mask—which he repeatedly took off due to chewing tobacco. In another case, she recounted how an adolescent volunteer had fainted during the distribution due to the heat. Fortunately, one of the team members had a motorcycle and took her home. In the second phase of distributions, the teams had to contend with heavy rains and winds caused by Cyclone Nisarga, and decided to directly hand the boxes to community contacts rather than placing them on the ground for the risk of getting wet.

Figure 5: FFVG boxes being distributed at a community location outside a containment cluster (Source: SNEHA)

Apart from such challenges, many staff members would also face other expectations from community members—many of whom called them up at odd hours to enquire about possibilities of distributing FFVG boxes in their neighborhoods. Even though the initial plan was to provide FFVG boxes to the same families in the second phase, the teams found out other beneficiaries who required food aid but were not covered in the

first phase. They thus ensured the boxes reached them this time. For instance, when there were surplus boxes, the volunteer and the members of his *mandal* identified needy families and distributed the boxes, and diligently recorded their names and contacts. The teams were also able to provide boxes to CHVs who were involved in implementing other public health services.

Figure 6: FFVG boxes being distributed at a community location outside a containment cluster (Source: SNEHA)

The teams' overall experiences indicated that despite challenges and setbacks, communities were on the whole systematic and reasonable. Indeed, as the distribution efforts started gaining momentum and community contacts and volunteers had a better idea of how things were working, they would often make important recommendations and suggestions, like ensuring there were no overlaps or repetitions between areas. This also helped the teams to drop off the boxes as close to the containment zone boundaries as possible so that the eventual distances would reduce. An important factor that motivated both community contacts and volunteers was their commitment to Dharavi. As one volunteer had remarked to a SNEHA programme staff member we interviewed, "If Dharavi exists, then so do we!" (*Dharavi rahegi, toh hum rahenge*)

4. EMERGENT THEMES

4.1. Crisis and scale

Across all our interviews, one thing that emerged quite clearly was that there was simply no way for people—whether governments, civil society organizations and especially local communities—to realize the scale of the pandemic and the lockdowns. In our interview, the independent volunteer who helped coordinate the distribution efforts said that prior modes of disaster management and relief were simply not applicable due to the nature of the transmission of the virus. This was not a natural disaster like a flood or an earthquake, with localized impacts and unaffected individuals or communities who could mobilize to support them. Rather, large social entities like communities, cities, and even nations, were effectively limited.

This also had a political dimension. In democratic contexts, especially like India, the state is charged with responsibilities of caring for populations, of ensuring justice and equity. While much evidence has shown that such ideals are not always translated to actionable policies in the ground, the pandemic situation nonetheless showed how such crucial limits could be exacerbated. Nowhere is this more evident in the "exodus" of migrant workers from Indian cities—which was witnessed in Dharavi, as well.

This brings us to another insight relevant to the situation in Dharavi. For many decades, the lack of actionable state policies on housing, employment, and health—to name just a few—is precisely what enabled people and communities to come together and create new forms to make life possible. Indeed, this is precisely why "informal" neighborhoods exist, and why these are hubs of the "informal" economy. It is also pertinent to reflect on the role of NGOs here, as well, for it was also the lack of effective state policy and political will on matters such as health, nutrition and violence, which led to many organizations like SNEHA engage in working with both systems and communities, and even engage in reform and advocacy.

However, the crisis of the pandemic has deeply strained such efforts—at the individual, communitarian, and institutional level. The very act of a state-implemented lockdown, and the nature of contagion itself, precluded the possibilities of such engagements to provide relief. Nonetheless, the success of both distribution drives showed the value and persistence of social networks and desire and need to help others—both on part of individuals and institutional actors. At the same time, it is also important to reflect on the scale of the crisis and work towards more sustainable and scaled interventions—for instance, the relief efforts were able to reach 15,000 families out of the estimated 700,000 inhabitants of Dharavi.

4.2. Awareness about safety and best practices

In general, we found that both residents and other community members were aware of basic safety and precautionary measures, such as wearing masks and frequently washing

or sanitizing hands. Despite this, there were a few desperate situations during the distribution drives where such safety compliances were neglected, such as directly handing boxes to community contacts instead of placing them on the ground due to time constraints as well as rains.

Communities also gradually came to understand the relationship between safety and fear, which was exemplified in the narrative of the community volunteer we interviewed. Possessing information and awareness were important for people to manage the existential threats posed by the virus. Such negotiations were both intimate and collective. As the volunteered explained in our interview, "If we are afraid, the virus isn't going to go away…we have to find solutions…find out what works best, and use that."

4.3. Negotiating community needs and expectations

Related to the first point, one of the major challenges for SNEHA programmes were to continue their work with communities, including the provision of key services like crisis counselling, as well as find ways to address such existential issues. Indeed, in the early weeks of the lockdown, many community team members faced such constraints while engaging beneficiaries, who questioned them about whether they would provide food relief or not. One of our first interviews was with a director of one of SNEHA's programmes. During our conversation, she said that not engaging with the needs of the community was a situation that programme's staff and community team members "could not fathom." She said that some community organizers even expressed the sentiment that, they would "not be able to show [their] faces to them."

Needless to say, the food distribution efforts helped many programme staff members to eventually connect with their volunteers and other beneficiaries and also involve them in the process. Yet, other challenges that emerged from such exercises concerned issues like certain community contacts to distributing boxes to deserving beneficiaries, or others in the community putting forward their own lists and confronting the teams as they were unable to serve other such clusters. Such negotiations involved the teams to draw on the criteria of the "list" and the MCGM's authority to explain people (*samjhate the*), whilst still hearing them out. Teams also used notions of "deserving" or "needy" people to negotiate with community expectations.

For instance, when some residents in a building contacted her, she tried reasoning with them that families that lived in building at least had some resources or facilities, which people in "slums" or "*chawls*" did not. Despite this, many community members would use the very same logics to position themselves as needy, either by citing acting Covid–19 cases in their neighborhoods, or patients suffering from other ailments—which was how the team managed to distribute some boxes to families who were not on the original lists. Volunteers in neighborhoods also played a crucial role in negotiating with residents when they expressed such expectations.

4.4. An unanticipated convergence

Finally, the last theme we uncovered from this documentation exercise concerns the idea of "convergence"—itself a concept that SNEHA programmes have been working on over the last few years. Convergence, or a convergence approach, refers to organizational and institutional processes whereby the different objects and foci of each "vertical" programme would converge as a holistic intervention itself, in association with state and civic agencies. However, despite several years of collaboration, it was fortuitous that SNEHA programmes achieved some level of operational convergence insofar as the distribution of FFVG was concerned. The teams coordinating and planning distribution consisted of staff from across the programme—especially those who lived there. Admittedly, such a "convergence" was the result of responding to an immediate need, yet staff narratives highlighted how commitment to certain core ideas—like the need for criteria, inter-sectoral collaboration with systems, reasoning and negotiating with communities, the desire to help those in need—can form the basis of convergence, a framework from which subsequent efforts could draw inspiration.

5. RECOMMENDATIONS FOR ADVOCACY

In this section, we present some key recommendations that can be fruitful to guide discussions on advocating for constituting measures, responses and protocols for coordinating efforts at the distribution of food relief.

5.1. Inter-sectoral collaboration

From the outset, many civil society organizations and NGOs were involved in providing food relief, in Dharavi as well as other settlements in Mumbai, either by raising funds from donors, or in collaboration with civic and state agencies. Yet, the net effect was a fragmentation of efforts as organizations worked in in their "own silos." As the associate programme director had explained in our interview, even though there were limits in the MCGM's responses to food relief, the civic body had its "hands tied" with testing, tracing, and setting up isolation and quarantine wards. This was a moment when civic society organizations could have "come together," at least at the ward-level.

5.2. De/centralization of response

Another important theme that emerged from our interviews was regarding the need to calibrate both, centralization and decentralization of response, to ensure clarity in key sectors or areas. For instance, in our interview the independent volunteer noted a key difference between MCGM responses in the M-East ward and in Dharavi. Whereas lists of containment zones in M-East ward were detailed and differentiated between clusters—thus helping in food distribution efforts—this was not the case in Dharavi, where SNEHA was provided lists of individuals and their addresses, rather than the zone boundary. In such cases, standardized and centralized protocols on mapping containment zones could have helped streamline distribution efforts.

Similarly, the SNEHA volunteer felt that NGOs and other community organizations should curate lists of committed volunteers or activists who can be mobilized in such collaborative responses. He reasoned that since such individuals would be vetted by the organizations, they could be depended upon to ensure that food boxes were being delivered to the appropriate persons. Other community team members also reasoned similarly, and suggested that relief efforts should involve people with a background in voluntary work rather than political mobilizations—in the latter case, as one team member in particular noted, there is a tendency to take care of personal interests rather than the collective good.

5.3. Dedicated control rooms

Even though the Covid–19 pandemic threw into disarray the established modes of coordinating and implementing relief efforts, there are possibilities of adapting certain forms or repurposing certain structures. For instance, in our interview the independent volunteer likened the SNEHA team as a kind of "control room" that oversaw the

distribution efforts, drawing an analogy to similar to control rooms that state and civic agencies create to monitor situations like floods. Similar efforts could be undertaken between the civic body and civil society organizations, particularly over the use of big data.