



## LENDING AN EAR, GAINING A VOICE, GIVING A HEART

A compilation of stories on supporting and empowering marginalised and vulnerable women to combat the ill effects of COVID-19

## Table of Content

# The ADB COVID Centre of Excellence

Progress Report 1  
January 2022

1	Executive Summary .....	3
2	Preface .....	8
3	Learnings From the COVIDActionCollab .....	12
4	Building a Collaborative .....	13
5	Working with Partners .....	17
6	Working with the Government .....	20
7	Working with Communities .....	24
8	Conclusion .....	31
9	Annexure .....	32
10	Abbreviations and Acronyms .....	52

# 1 EXECUTIVE SUMMARY

Swasti and ADB have joined hands to operate a **Centre of Excellence (CoE)** on COVID-19 response efforts for vulnerable women as a knowledge-management and learning platform for (1) connecting and collaborating with partners (2) working to bridge the gap between communities and services to combat COVID-19.

The CoE is **focused on women** due to the challenges they face on account of biological, socio-economic factors and gender norms. It generates learnings from COVID-19 response efforts targeted towards vulnerable and marginalised women with the intent to share the education and glean pointers for improved community engagement and impact in the COVID-19 context, in other humanitarian crises in different social development interventions. As a learning platform, the CoE focuses on **generating and widely disseminating learnings from the experience and initiatives of the #COVIDActionCollab<sup>1</sup> (CAC)**, a successful **collaboration of 350+ partners** that has been empowering vulnerable people to survive and thrive during COVID-19.

CAC has served to **orchestrate connections and achieve synergy among the vulnerable communities, civil society organisations and government departments** at multiple levels. It has **facilitated connections** of these entities to knowledge, people, materials, infrastructure and funds to help them increase the scale and effectiveness of their COVID-19 interventions. It has **designed or adapted multiple initiatives related to health, social protection and livelihoods** based on the needs from the ground and built capacities on its use. CAC's flagship interventions include:

- 1) High Impact Intervention (HII) packages - training modules and associated services related to health, livelihoods and social protection, customised to community needs identified by the implementers.
- 2) Call4Svasth - an integrated digital platform with hyper-localised, community-led, cost-effective helplines run by trained health and social protection personnel to enable access to these services during mobility restrictions and for communities that face mobility or stigma related access.
- 3) VaxNow - an initiative to connect communities, civil society organisations and local governments to vaccinate 50 million vulnerable people.

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<sup>1</sup> <https://covidactioncollab.org/>

Through these interventions, CAC has reached vulnerable people **with over 14 million service instances**. Based on the local context and inputs of its partners and advisors, CAC identified specific communities that were **some of the most vulnerable** on account of (a) social stigma and discrimination - such as women in sex work and trans persons; (b) livelihoods - such as health workers, small farmers, fisherfolk, construction workers, factory workers, migrants, street vendors, and informal workers; and, (c) life situations - such as the urban poor, survivors of gender-based violence (GBV) and child abuse, street children, persons with disabilities and people in homeless shelters.

Given this context of extensive outreach to multiple vulnerable groups, large numbers of collaborative partners, and diverse interventions, CAC's experience has been rich, providing valuable insights for efficient and impactful collaboration. Yet, its communication of learnings and designing products for scale has been limited. This limitation is an opportunity for the significant sectoral contribution the CoE makes through its knowledge management mandate.

Through primary data collection with key informants and secondary data analysis of case studies collected by the CAC team, CoE has generated learnings on (A) building a collaborative, (B) working with partners, (C) working with the government and (D) working with communities.

Presented in this document - "Lending Ear, Giving Voice, Gaining Heart", the learnings serve as a broad guide giving insights on the ins and outs of collaboration to other collaborators, organisations working with women, and those responding to humanitarian crises. A summary of these learnings follows here, with more detailed information in the subsequent sections. CoE will disseminate these learnings through different channels.

## SUMMARY OF LEARNINGS

### A. Building a collaborative:

Building a large, pan-India collaborative was possible because the founders - the Catalyst Group<sup>2</sup> - were able to **draw upon their long experience** working on social development issues and responding to humanitarian crises.

CAC articulated a **clear and focused cause** of enabling vulnerable people to survive the pandemic and thrive, aligning with the partners' plan. CAC further **focused the initiatives** on health, livelihoods, and social protection, themes that were the founders' strength

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<sup>2</sup> The Catalyst Group is a group of eight organisations working in the social development space since 1994. Learn more about the group at <https://catalysts.org/> or refer to the Box in the preface.

areas and the priority needs of communities. CAC reached partners through three phases, initially leveraging the solid social capital to bring together the **first 22 partners** they had close engagements with. They then **extended this reach to 350+** through snowballing and social media. Finally, they identified and approached organisations with ample space, networks, and association to enable scale and coverage to all identified communities. Partners included resource agencies, grassroots implementation agencies, service providers, social enterprises, private sector organisations, networks, associations and other collaboratives, academic and research institutes, and various health ecosystem stakeholders. The government and many donors opted for close engagement on specific initiatives.

CAC adeptly utilised **over 2,000 volunteers** in two years to augment the need for human resources at pivotal times during the implementation.

### **B. Working with partners:**

Bringing partners together to become members of the collaborative was the easy part. The challenge lay in securing member engagement and contribution to the collaborative mandate. CAC **clearly articulated the call for action** across the chosen themes of health, livelihoods and social protection. It designed HII packages targeting the needs of the communities, which were customisable to the partner's context. **One hundred thirty-six partners are implementing COVID and HII initiatives.**

**An engagement architecture with a well-resourced Secretariat** comprising value delivery, domain specialist and partner engagement teams also facilitated regular partner interactions. With this approach, nearly 50 per cent of partners were engaged in the collaboration.

Over the two years, CAC also **raised, shaped and leveraged funds to INR 1,080 Crores (USD 148 Million)** to support partners for CAC's initiatives. Overall, 89 donors provided funding and 180 partners, approximately 79% of implementing partners received support in cash/kind.

### **C. Working with the government:**

The CAC **government engagement was in 12 states/Union Territories and 23 government entities.** Given the pandemic's scale and effect and the unfamiliar territory, the government was challenged to mount a response and was busy on all fronts. CAC identified **social protection as an entry point**, a service that presented value-added to government efforts. It **subsequently layered other options for engagement** such as precision pandemic (early warning system through wastewater surveillance),



establishing a helpline, strengthening health facilities and material support, and NCD screening. Providing options of engagement showed the commitment of CAC to a long-term association with the government.

Government engagement at the local levels where implementation takes place requires **time and effort to secure buy-in** from the higher levels at the state and districts and the involvement of senior staff of the Secretariat and partner organisations. Planning the initiatives in detail with the administrative officials was an important step to clarify the tasks, timelines and roles. **Exceeding expectations** was a sure way to gain trust, which can be goodwill to carry into the future.

One critical learning in working with the government is that while they are willing to offer their resource teams for any intervention, they are **hesitant to provide funds**. This hesitation means that **funds have to be raised in advance**. For initiatives like VaxNow, funding was available through the private sector. Fundraising efforts are on for industries like precision pandemics, which are very resource-intensive.

#### **D. Working with the communities:**

Women's biological, socio-economic factors and gender norms prevent easy access to information, health and other welfare products and services, increasing their vulnerability to COVID-19. CAC's **HII intervention was focused on a strategy for gender equality and social inclusion (GESI)** to ensure that specific groups did not face discrimination or exclusion in access to services. Localised planning helps identify excluded groups and zone in on the causes of exclusion. It is the first step to designing customised strategies targeted to them, including mobilising funds for the plans.

**Partners and community-based organisations (CBO) consultations** are essential for strategising. They are attuned to the needs of communities, and the evolving CAC provides women-friendly health services such as telehealth, exceptional health and vaccination camps, material, food and nutrition support through this approach support. **They empower women** to bridge the periods of loss of livelihoods, whether temporary or more permanent, with vested confidence, hope and aspirations for the future.

The on-ground interventions also provide an **opportunity for building resilience** by creating service cadres of community members. Resilience is built as communities can access government schemes and entitlements, vesting in them the confidence to demand their rights. Ground interventions must ensure that the **links forged between civil society organisations and local governments remain strong** through regular engagement and championing of well-performing government officers.

## CONCLUSION

With the pandemic showing signs of becoming endemic, the way forward wrt to COVID response for the most vulnerable women is for collaboratives, civil society and districts to leverage the width and depth of its experience in the pandemic response, its recently-widened partner base, the knowledge and training assets built.

As it moves into the next phase, pertinent questions arise - How do we ensure that the interventions can be sustained and scaled beyond the pandemic? How do home-based and telecare systems incorporate and mount into the larger public health agenda? How are the health care resources (community care centres, oximeters and oxygen concentrators, telecare resources, capacitated health care workers, etc.) leveraged, maintained and updated/upskilled to be available for non-pandemic times? How does the social protection help desk model find a home in every district? How is the community's resilience built to tackle humanitarian emergencies, whether at a global or local scale? How can funders be engaged in a 'bigger picture' vision? And finally, how are the relationships developed during the pandemic. Between the community and their organisations, local administrations, public and private entities, funders and implementers, collaboratives like CAC, and many more, strengthened to work on addressing the many facets of vulnerabilities that women continue to face.

The CAC Secretariat discusses some of the questions with partners, advisors, and sectoral experts to design its transition from the COVIDActionCollab to a CommunityActionCollab. Common themes during these discussions have been around strengthening local capacities to promote localised/district level responses for building community resilience against health, climate and livelihood threats.

The CoE engagement is timely through its mandate with a strong focus on scaling interventions beyond the pandemics. It contributes to many aspects of sectoral knowledge and the CAC #ForwardTogether strategy relating to the protection and wellbeing of vulnerable women. In the upcoming reports, CoE will disseminate learning exchange and training and capacity building with a consultative approach toward the strategic design of community-based initiatives. The aim is to provide intersectoral insights on social protection, life skills development, gender integration and mainstreaming. Developing empowerment toolkits for marginalised women and working towards increasing inclusivity through capacity development initiatives will contribute to systems strengthening. CoE collaborates with local administration officials in these efforts, enabling them to create opportunities for community connections and private

and public participation in driving gender equality and social inclusion.

In summary, leveraging multi-stakeholder approaches, the ADB CoE creates a platform dedicated to knowledge and capacity building for women empowerment, promoting and advocating social inclusion and community resilience.

## 2 PREFACE

The COVID-19 virus has spared no life, and many of its detrimental effects will be felt across generations. The worst affected are the poor and vulnerable communities with little to no insurance to fall back regarding their health or livelihoods. Historically, those who face multiple forms of discrimination, such as women, migrants, transgender, people living with HIV (PLHIV), street vendors, and people with disabilities, have been more marginalised and vulnerable. These groups have needs specific to their conditions, which tend to be overlooked in the COVID-19 response and service delivery.

With the single purpose of ensuring that most vulnerable communities survive the pandemic and thrive, the Catalyst Group (See Box), of which Swasti is a part, co-founded the #COVIDActionCollab (CAC) in March 2020, around the time in March 2020 when the virus began to spread in India. CAC is a collaborative that provides a platform for partners to collaborate, convene, learn, share, and channel resources toward a comprehensive COVID-19 response for vulnerable communities.

Its 350+ partners include resource agencies, grassroots agencies, service providers, social enterprises, academic and research institutes, and other health ecosystem stakeholders. The collaborative engages closely with the government and private sector organisations and associations to augment its reach and impact. It has enabled over 14 million service instances in vulnerable communities. Through its partners, CAC has ensured that the voices of vulnerable communities are amplified and their needs addressed.

CAC's experience has been rich, yet communication of learnings and designing critical products to scale initiatives have been limited. This limitation is an opportunity that the Swasti-ADB Centre of Excellence (CoE) targets.

CoE is envisioned as a knowledge-management and learning platform for (1) connecting and collaborating with partners and (2) bridging the gap between communities and services to combat COVID-19.



CoE is focused on vulnerable and marginalised women due to the challenges they face due to biological, socio-economic, and cultural factors. It generates learnings from COVID-19 response efforts targeted towards vulnerable and marginalised women to share the education and glean pointers for improved community engagement and impact for COVID-19, health and non-health interventions.

The Catalyst Group of eight entities has deep experience in health, livelihoods and social protection. Through its initiatives, the group has worked with over 500,000 vulnerable groups that include women in sex work, trans women, MSM, smallholder farmers, artisanal fisherfolk, women in factories and micro, small, and medium scale entrepreneurs. Swasti, with the Catalyst Group behind it, collaborated with ADB in building and operating the CoE effectively and working with partners to strengthen communities and build their resilience in the long run.

## BOX: The Catalyst Group

The Catalyst Group, comprising eight organisations, is the founder of CAC and leads the collaborative operations. The Group organisations are:

- Catalyst Management Services, a social investment specialist partners with change agents, sharing a joint ambition to unlock and accelerate impact, scale, and sustainability of development initiatives.
- Swasti, a Health Catalyst, promotes everyday wellbeing for all poor and vulnerable communities.
- Vrutti a livelihood impact partner, builds the wealth and resilience of small producers through transformative livelihood solutions
- Fuzhio, an impact product marketing firm, deals with impact products for people prosperity and the planet
- The Genetic Resource, Ecology, Energy and Nutrition (GREEN) Foundation works to promote a well preserved ecosystem diversity for sustainable rural livelihood of the present generation, without eroding the resource base of the future
- Catalyst Foundation, a social enterprise platform promotes the health and wealth of vulnerable communities
- In addition, two more development impact organisations have recently been established by the Catalyst Group. The process of identifying their positioning and engagements is underway.

The group has a very deep experience in the themes of health, livelihoods and social protection and through its initiatives has worked with over 500,000 vulnerable groups that include women in sex work, trans women, MSM, small holder farmers, artisanal fisherfolk, women in factories and micro, small, medium scale entrepreneurs.



*A Swasti field staff sharing health information with women*

CoE, through primary data collection with key informants and secondary data analysis of case studies collected by the CAC team, has generated learnings from the CAC intervention<sup>3</sup>.

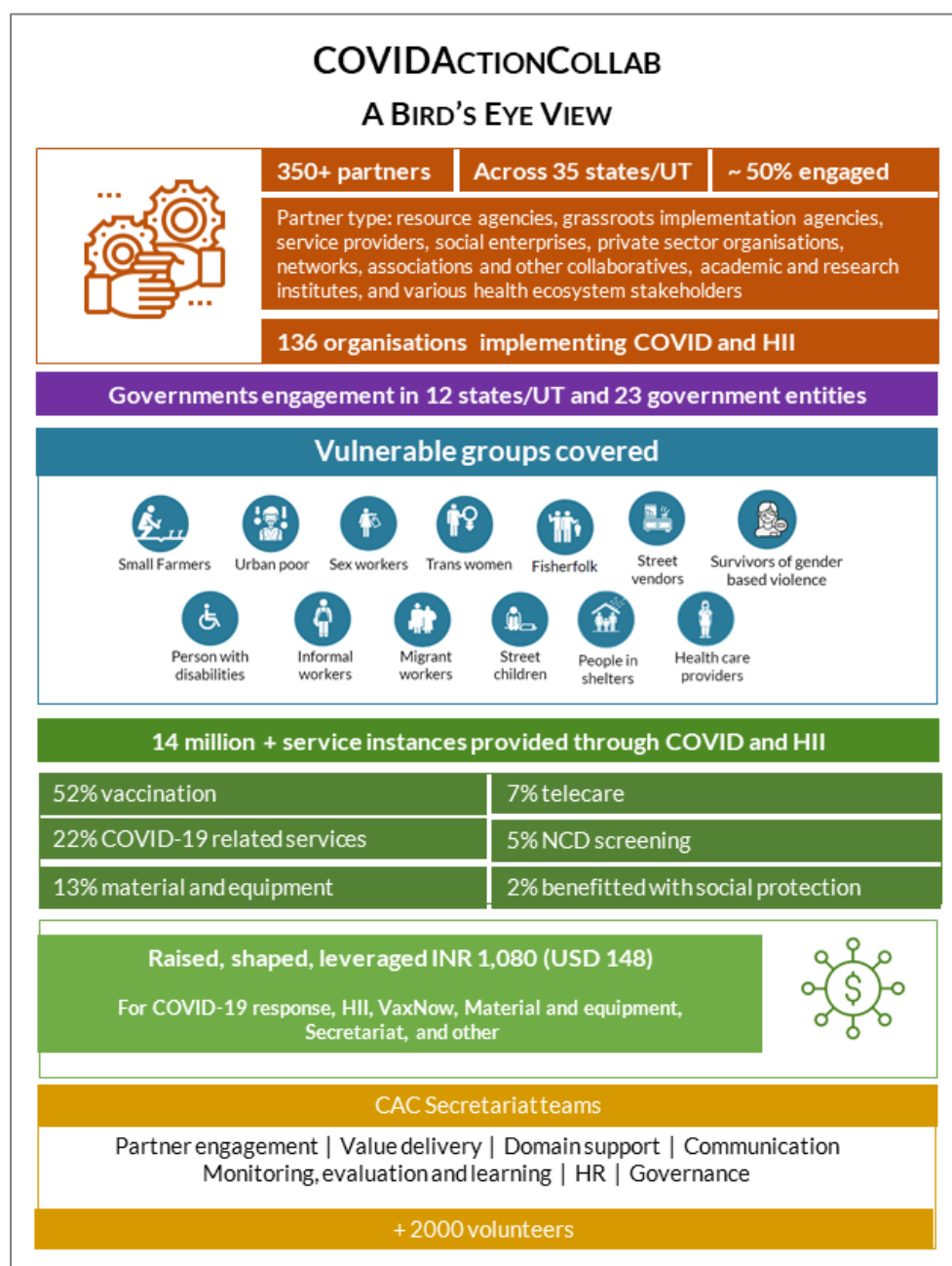
Presented in this document - “Lending Ear, Giving Voice, Gaining Heart”, the understandings serve as a quick guide on the ins and outs of collaboration for other collaborators, organisations working with women, and those responding to humanitarian crises. The document structures the insights and learnings from CAC in four categories: (a) building a collaborative, (b) working with partners, (c) working with the government and (d) working with communities. The annexure to this document captures some stories of women that illustrate and elucidate the learning.

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<sup>3</sup> Pl. note: All the data presented in this document is as of 1 March 2022

### 3. LEARNINGS FROM THE COVIDACTIONCOLLAB

Over the two years of the COVID-19 pandemic, CAC built a 350+ partner strong, pan India collaborative, present across 35 states. It reached vulnerable communities with over 14 million service instances. The size, scale and ground experiences make for valuable learnings.



## 4. BUILDING A COLLABORATIVE

### 4.1 Build collaboration on a solid and sure foundation

Swasti and the Catalyst Group, working on the health and well-being of vulnerable communities, recognised the potential negative impacts of COVID-19 on these groups and the urgency of designing a response. The group had extensive experience in the social sector and had supported vulnerable communities in past humanitarian crises. Given the scale of the problems, they knew that collaboration was the only way to reach across the country, reach diverse, vulnerable groups, and scale impact. They channelled their areas of strengths - the themes of health, livelihoods and social protection, the experience of running networks and collaborations, and the social capital built overtime to reach out to development partners to create an impactful partnership.

Building upon their work and reaching out to new opportunities, Swasti and the Catalyst Group offered critical interventions such as telehealth, vaccination, non-communicable diseases (NCD) screening health camps, social protection, and alternate livelihoods support.

### 4.2 Rally collaborative members around a common cause

CAC communicated a simple, straightforward, yet powerful message for collaboration that found interest among organisations wanting to join hands, i.e., to enable vulnerable communities to survive the pandemic and thrive. This person-centred approach was instrumental in drawing partners to collaborate.

#### **Types of partners rallied.**

The articulation of the endgame and the vulnerable community focus attracted several organisations and individuals committed to contributing to the response efforts, whether working with vulnerable communities. These included resource agencies, grassroots implementation agencies, service providers, social enterprises, private sector organisations, networks, associations and other collaboratives, academic and research institutes, and various health ecosystem stakeholders. The government and many donors opted for close engagement on specific initiatives. Each type of entity brought its strengths, enabling a vast expanse of interventions.

As of 1 March 2022, CAC had 354 partners, of which 64% were implementing organisations (NGOs, CBOs, private sector organisations), 20% were providers (HR,



materials, finance, knowledge, technology, communication), and 16% were enablers (Academia, industry associations, policy)

### **Vulnerable groups reached**

As the CAC design evolved through the on-ground context and the inputs of its partners and advisors, CAC identified categories of vulnerable communities to be reached. These communities were some of the most vulnerable on account of (a) social stigma and discrimination - such as women in sex work and trans persons; (b) livelihoods - such as health workers, small farmers, fisherfolk, construction workers, factory workers, migrants, street vendors, and informal workers; and, (c) life situations - such as the urban poor, survivors of gender-based violence (GBV) and child abuse, street children, persons with disabilities and people in homeless shelters.



*Women in sex work have faced a debilitating impact of COVID-19 on their livelihoods.*

Many of the identified groups or large segments within the groups were women and trans people, and gender norms and rights found a place at the forefront of planning and implementation processes.

### 4.3 Drive member identification with an eye on the collaborative purpose and evolving needs

Attaining the scale and goal set out by CAC necessitated broad-based partnerships with partners that:

- Worked on or had interest across the selected intervention themes
- Covered one or more of the identified communities
- Are involved in different engagements such as implementation, resource generation, service provision of technology, communication and media, etc.

#### Partner identification phases

The collaborative and partnership identification growth was deliberate and, at times, by default. It could essentially be broken down into three broad phases.

**Phase 1:** The Catalyst Group reached out to organisations with which it was already working or had close associations. Bringing these organisations on board was relatively easy since a shared vision of the commitment to community well-being already existed.

**Phase 2:** CAC designed a website where organisations could register to join. While this was easy for onboarding from a process point of view, the effort herein lay in getting to know these partners.

**Phase 3:** A few months following CAC's establishment, the process became purposeful to expedite the reach scale and reach some of the communities that had not been covered (like street vendors). The focus at this time turned to leverage the multiplier effects of large NGOs and networks and associations like healthcare provider associations, street vendors associations, National Hawkers Association, and local government networks. For instance, once CAC convinced the National Hawker's Association of its approach and value they could deliver to their constituents, they put CAC in touch with the state-level chapters through which the engagements flowed.

The Phase 3 engagements required a high degree of perspective building and value definition to convince the organisations of the need for collaboration.

### 4.4 Leverage volunteers to augment resources for the pandemic response

During the pandemic, volunteers, keen to do their part to support organisations

working on COVID-19 response, were available in large numbers, especially during lockdowns when people's routine work and travel were constrained. Over two years, CAC worked with over 2,000 volunteers.

A management plan that includes recruitment, deployment and follow-up for best results from engaging volunteers is required. CAC identified volunteers using online volunteering platforms - ConnectFor, iVolunteer, and Chezuba. CAC also shared the opportunities on its social media and circulated them on networks.

Volunteer engagement was high in the first two COVID-19 waves. In the first wave, between March-June 2020, volunteers helped design or translate IEC (Information Education and Communication) materials, health protocols related to COVID-19 care, social media posting, data management and analysis, and documented stories from the ground. Their support was instrumental in filling the language gap and translating material for communication into many Indian languages.

In the second wave of Covid in April-June 2021, the volunteer focused on supporting a virtual team that could reach for information support and connections to tide the scarcities of beds, oxygen, and medicines. Here again, language and vocational support enabled CAC to offer services widely.

The relatively mild third wave, in Dec-Jan 2022, did not see many requests for volunteer support.

In engaging volunteers, CAC learned the importance of matching skills to assignments. During the first wave, the pressing need for resources meant that all available volunteers were put to work without considering the volunteer skill sets. While this was not a problem for the IEC and translation work, quality issues arose in data analysis and story collections. In the second wave, CAC took adequate care to ensure that the people chosen for assignments had the requisite skills to produce the expected outputs, and their work was well guided and reviewed.

## 5. WORKING WITH PARTNERS

### 5.1 Create a dynamic engagement platform for partners to ‘give’ and ‘take.’

A collaborative is as strong and relevant as its member’s engagement. CAC was set up initially with about 22 partners and, over two years, grew to over 350 (Annexe 8.8). So, partner engagement was a tall ask.

A Secretariat team ran the collaborative with a Partner Engagement team at its core. The team’s role was to connect regularly with the partners to understand their interventions, share the ongoing interventions at CAC, record partners’ asks and offers, and support them on delivery as required. This group was christened Partner Results Accelerators to stress that the role was outcome-focused and not about task completion.

A robust back-end team served as the backbone of this engagement, providing value delivery, technical support, resource mobilisation, monitoring evaluation and learning, communication, HR, and governance.

Partner connects been in capacity building, materials and knowledge exchange, technology and resource mobilisation. CAC logged around 988 asks and offered through this engagement platform and delivered 71%. Of the remaining 29%, 7% are active, 16% dropped for multiple reasons, and 6% are idle.

**Around fifty per cent of partners have engaged and participated in the collaboratives’ activities through this architecture.**

#### **A High Impact Intervention (HII) package**

While a common cause attracts partners, action directs them. The CAC Secretariat focused on the three themes of health, social protection, and livelihoods. These themes identified specific high impact intervention services delivered to communities through partners. A High Impact Intervention (HII) package was designed after due consultations with organisations and domain experts and underwent three modifications based on the changing context and needs from the ground, available resources, and partners’ interests and bandwidth. The nuancing of the HII for each vulnerable group – for instance, how to resolve communication and access barriers - was done by the NGOs and CBOs.

Joint strategic plans were drawn to deliver the HII packages that included plans for capacity building, resources required, and timelines. The planning process provided a

clear indication of what partners could offer their communities. One hundred thirty-six partners are implementing COVID and HII initiatives.



*Partners reach out to communities with health and social protection information.*

Some specific activities included:

- Developing **information** products on COVID-19 guidelines and protocols, including COVID Appropriate Behaviours (CAB) and vaccination
- Providing persons living with HIV (PLHIV) and trans women access to life-saving drugs during lockdowns while ensuring confidentiality and dignity.
- **Distributing food provisions** to ensure households' nutrition was not compromised in the face of limited availability, restricted mobility and depleted funds.
- **Building capacities** of frontline workers for them to support communities, protect or respond to illness
- Supporting CAC partners and health officials reach communities with CAB messages, products and services - such as health and vaccine camps and COVID-19 protection kits.
- **Supporting factory owners create COVID-19 safe workspaces**
- Building resources and capacities for promoting demand and supply of social protection schemes
- Supporting partners offer **alternate earning channels** for those who lost their livelihoods.
- Resource mobilisation for CAC's engagements and supporting partners raise resources for their interventions

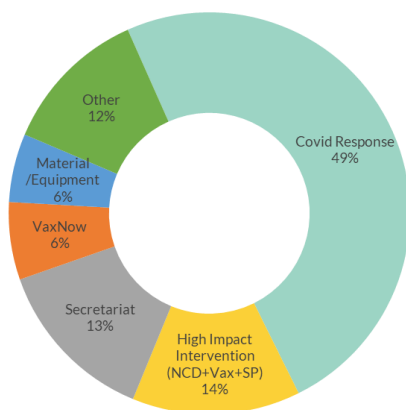


## 5.2 Raise and shape significant resources and channel them to the right place

Many partners were able to position their staff and project resources toward the expanded service delivery of the HII. The CAC resource mobilisation lent a hand to many organisations strapped for resources.

Over the two years, CAC has been instrumental in raising, shaping, and leveraging funds to INR 1,080 Crores (USD 148 Million).

Type	INR (Crores)	USD (Million)	Definition / notes
Raised	245	34	Where CAC is clear about the purpose and has mobilised resources from donors in cash and in-kind
Shaped	80	11	Where CAC has played a vital role in conceptualising, calibrating, connecting, facilitating resource mobilisation for specific / priority causes and partners
Leverage	755	103	Complementary & Supplementary Funding Channelised through Govt and Private sector programs and assets. Includes large part which is Social protection monies from Govt which has reached communities
<b>TOTAL</b>	<b>1080</b>	<b>148</b>	

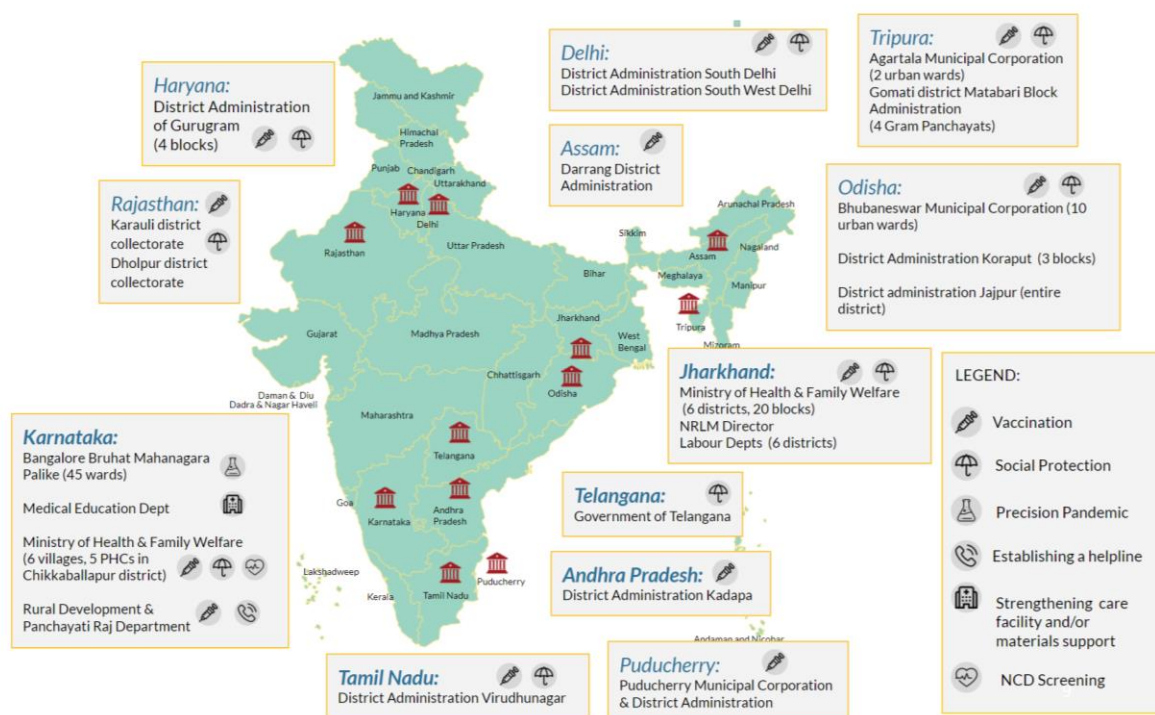


Nearly half of the resources raised (INR 245 Crores, USD 34 Million) went towards COVID response, 14% on the HII package, and 6% on the vaccine initiative and equipment. 13% of the resources raised was to build the team of the CAC Secretariat that operated the collaborative.

Overall, 89 donors provided funding and 180 partners, approximately 79% of implementing partners received support in cash/kind.

## 6 WORKING WITH THE GOVERNMENT

The CAC government engagement was in 12 states/Union Territories and 23 government entities.



### 6.1 Identify priority needs for government engagement

Given the pandemic's scale and effect and the unfamiliar territory, the government was challenged to mount a response and was busy on all fronts. Getting their time to inform them about CAC and piquing their interest to work with CAC was also a challenge.

CAC first pitched its social protection to many state governments. The model required setting up help desks in the districts to facilitate the uptake of public schemes. This engagement required support from the district administration that was readily available, and the value-added to their response was significant. As CAC built its credibility and demonstrated value through this channel, other engagement pieces followed.

### 6.2 A menu of packages reflects value and commitment

After getting a "foot in the door" with the government, CAC went with a menu of packages for building health resilience and disaster preparedness. This move

demonstrated CAC's commitment to working with the administration long-term and its flexibility in allowing the administration to choose based on its priorities. Vaccination was one package that was widely taken up since this was a strong mandate of the government.

Other interest packages were precision pandemic (early warning system through wastewater surveillance), establishing a helpline, strengthening health facilities and material support, and NCD screening.

As of March 2022, the complete package of services was taken up only in Karnataka. However, there has been engaging in many initiatives which the Secretariat is following upon.

### **6.3 Plan for intense engagement and high resource requirements for government engagement**

Working with the government for pandemic interventions is essential. The government has many social protection schemes and an extensive array of on-ground resources through the local administrations.

#### **Buy-in**

Usually, to secure the cooperation of local officials, it is essential to ensure buy-in from the district and state-level administrations. This endeavour requires the involvement of senior personnel and is expedited when partners have made inroads into the higher-level officials. The collaborative approach was instrumental as many CAC partners worked with the government on their development programs. Partners that did not connect with the local government in their interventions found the collaboration helpful to make inroads with the officials, complementing their current interventions and paving the way for future ones.

#### **Planning**

To begin with, in consultation with the local government (LG) officials, CAC identified the needs and gaps of the block/district. A demand generation process prioritised various LG needs and devised approaches to address these. This process employed a calculated, thorough, quick response catalogue of service packages that most LGs could adapt and deliver., which also included Technical Assistance (TA) needs and resource requirements. Further, CAC identified on-ground partners who would provide these services and involved them in the planning process.

CAC collaborated with the local administration and health delivery organisations and acted as an interface between them and the community to enhance access to services by the community and facilitate the outreach by the providers. Since many partners had no experience working on COVID-19 issues or other critical services such as social protection or livelihoods, CAC trained the local partner and administration teams to deliver these.



*A CAC team conducting planning workshops with district government officials*

## **Trust building**

Trust building by exceeding expectations and mutual respect is integral to successful government engagement. Several CAC partners - community-based organisations (CBOs) of sex workers or transgender - acknowledge that working hand in hand with CAC enabled the government to connect with and reach out to their communities that otherwise faced stigma from these channels. This trust enabled the community to access services where hesitancy prevailed. As these groups recognised the government's efforts and the media relayed it, the CBOs that were otherwise pariah to the government were now receiving calls and proactive support from the officials.

The linkages formed can serve as a sturdy foundation that the local institutions and influencers can leverage, nurture and build on for future social initiative engagements.

## 6.4 Identify funding connections in advance

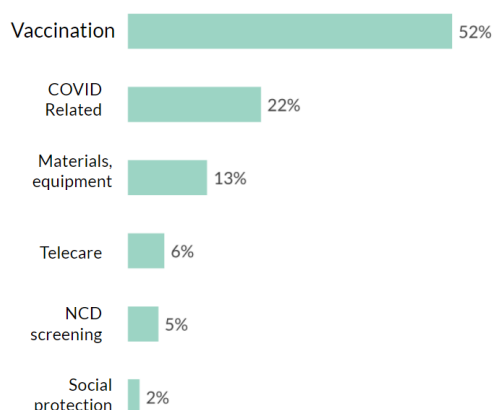
The local governments are willing to help mobilise their resource teams on the ground to support the implementation of the CAC initiatives; however, they are hesitant to deploy funds, often because of the multiple procedural requirements for giving money to civil society and private organisations. The CAC resource mobilisation team reached out to donors to raise funds to enable the initiatives to take root. For industries like vaccination, many private sector organisations offered their support. Fundraising efforts are on for industries like precision pandemics, which are very resource-intensive.



## 7 WORKING WITH COMMUNITIES

The CAC partners delivered over 14 million service instances to vulnerable communities. Vaccination was the service with the most significant uptake. Others included COVID awareness building and testing, material and equipment distribution, NCD screening and social protection.

*The proportion of service instances delivered by CAC, by type of service (N=14 million)*



### 7.1 Have a bias towards focused, grounded, localised action and coordination

The on-ground situation in any humanitarian crisis constantly evolves, and its effects vary across geographies and groups over time. A templated response would result in non-optimal solutions for communities and large pockets of exclusion.

To understand the local context and the perceptions and barriers of different groups, CAC conducted localised dipstick studies and needs mapping. This local information was instrumental in designing targeted service delivery strategies for vulnerable communities. It helped channel funds to bridge coverage gaps.

For instance, CAC held special vaccine camps for trans women who struggled with information deficits on the safety of vaccines for people on hormone replacement therapy. Special commands for other excluded groups helped them overcome the difficulties of registration and access. Vaccine camps required local administrations' engagement and private companies for vaccine supply. Funding was crucial for outreach, and the gap analysis formed the basis of the proposals to agencies such as Godrej, GiveIndia, Selco, and many philanthropic individuals and organisations to extend funding support.



*CAC partners organised special vaccine camps for trans women*

Rapid infrastructure mapping showed the location of local health and non-health infrastructures, such as community centres, health centres, schools, balwadis, and other structures, that could be commissioned as isolation or treatment centres, screening/vaccination camps, or distribution centres for food and material. It identified the presence of CBOs to be onboarded for on-ground support. This assessment noted the economic, geographical, social, and cultural context of the communities and locales for modelling the package of services to the community's context needs.

Close community engagement and identification of safe health spaces were instrumental in building trust and thereby easing community mobilisation and uptake of the health interventions.

## 7.2 Telehealth services for women promote health-seeking behaviour

Overall, poor and vulnerable women experience worse health outcomes and are more likely to acquire diseases. COVID-19 response efforts often do not account for the realities that marginalised women experience and are ill-equipped to address them. Targeting specific groups of women such as sex workers, trans women, PLHIV, factory workers, and rural and urban poor enables them to access knowledge and services in a safe and dignified manner that might otherwise not be accessible to them.

The telehealth model, Call4Svasth, designed by Swasti and implemented with CAC partners, is one such initiative that found significant interest during COVID-19. Call4Svasth is an integrated digital platform with hyper-localised, community-led, cost-effective helplines run by trained nurses, nurse-aide-callers, frontline counsellors, and social protection officers. The telecare solution has reached more than 1,20,000 factory workers, urban slum dwellers, rural poor, sex workers, and transgender people.

Due to their convenience and anonymity, women who often slip through the cracks in health systems have accessed telecare services. They have been reaching out for various health conditions, including sexual and reproductive health, infertility, etc.

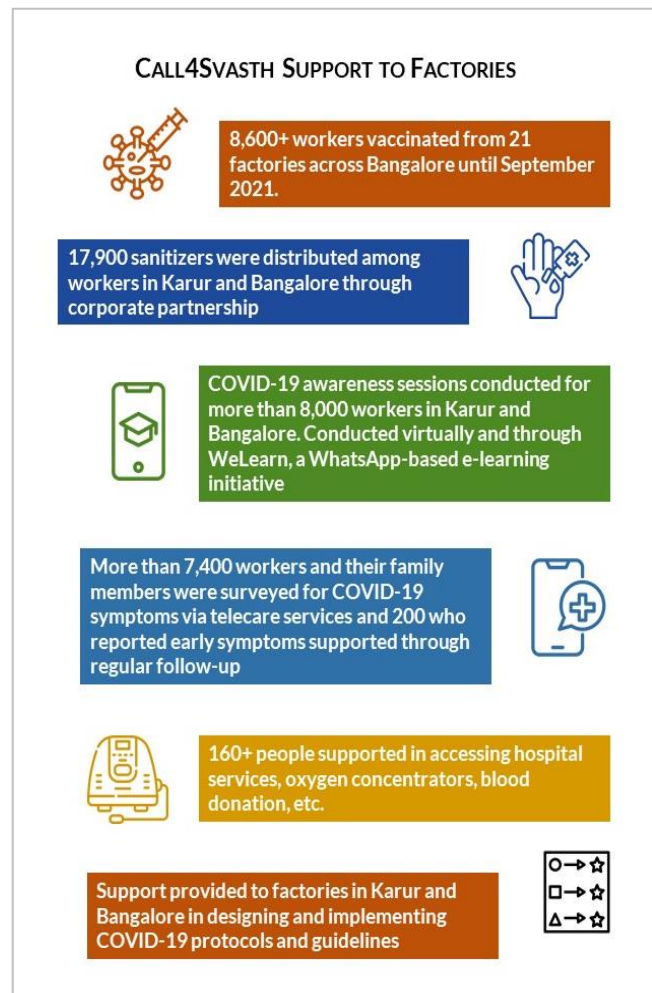
## Call4Svasth was founded on some key learnings:

1) Health is holistic and does not include physical health but also emotional and mental health. Call4Svasth has incorporated all these aspects in the intervention

2) Digital presence needs to be complemented with a strong ground force. Communities need to be oriented on the value and use of the service, which requires in-person engagement. The ground force also creates demand for the service and builds a relationship with the households to promote other health services.

3) Women do face digital challenges. Many do not own mobiles and give their husbands'/fathers' numbers to the field teams. During calls to provide information and seek their well-being, it is up to husbands to share the ring with their wives or not. This occurrence reiterates the need to have the ground force for the inclusion of women.

4) The model is highly resource-intensive, but a crucial component of success







*Call4Svasth field teams create awareness about COVID-19, profile for risk and train people to use the service.*

### **7.3 Include targeted gender equality and social inclusion approaches within initiatives to enable significant impact for women**

Vulnerable communities have been at the centre of the CAC strategy. Understanding these groups based on their experiences of inequality and exclusion provides a more robust pathway toward attaining impact. Those amongst vulnerable groups who face discrimination and exclusion because of their gender and social status, geography, age, or education have been the most affected by the pandemic.



*Vaccination teams reach women in their places of work or in remote locations to get them jabbed.*

CAC's HII intervention was focused on a strategy for gender equality and social inclusion (GESI) to ensure that specific groups did not face discrimination or exclusion



in access to services. This targeted approach enabled CAC to identify these groups, understand the barriers they met, and work with partners to design interventions to facilitate these groups' inclusion. The GESI approach includes creating the GESI framework, training partners on the GESI constructs, building data and knowledge around GESI, financing and resource mobilisation, and advocacy to government and funders.

CAC's GESI approach was strengthened over time and is most visible in our vaccine initiative, VaxNow.

A difficulty in using this approach has been to enhance the understanding of field teams and implementing partners since not all partners work specifically on women's issues or communities like tribals who face inequalities. As such, gender and social disaggregated data and insights are hard to come by, limiting analysis of what works, what does not work, or specifics of some of the disadvantages these groups face.

#### **7.4 Direct the support to women through an empowerment approach for sustained impact**

Diversity presents opportunities. For CAC, one of the opportunities was to leverage the services provided and the systems, structures, and connections built toward women's long-term and sustained empowerment.

Several CAC partners provided services beyond their core area of focus and groups beyond their core community. For instance, Swathi Mahila Sangha (SMS), a community-based organisation of women (CBO) in sex work, provided services to women in sex work who were not members. They conducted health and vaccine camps where the general population could access services.

The pandemic was about health, but the impact on livelihoods was equally significant with lockdowns and mobility restriction, migration and death or morbidity of primary earners. Sri Lakshmi Pengal Munnetra Sangam (SLPMS), another sex worker CBO supported alternate livelihoods of tailoring to keep the earnings of some community members flowing.

CAC provided guidance and training to partners like SLPMS to enable them to support their communities in taking up new livelihoods to tide them over the pandemic, prepare for future waves, and build resilience. It empowered some vulnerable groups like sex workers and transgender people to take up alternate livelihoods, creating skills and aspirations for the future. For the organisation, such support was empowering and

improved engagements with their community members and sustainability of initiatives.



*A woman whose livelihood suffered during the lockdown earns money tailoring masks.*

The engagement further lowered the stigma women face in sex work, MSM, trans persons and PLHIV. Some CAC partners shared that district administrators opened up to actively working with these vulnerable groups when they realised the value they bring to reaching a large and excluded group. Leveraging these connections would be the way to sustain government engagement and service delivery.

## **7.5 Build capacities and confidence of communities and make champions out of local officials as levers for future resilience**

Many of CAC's interventions have led to building resilience for the community. CAC has created local cadres of community peers responsible for creating demand for health services and supporting access. It has trained health workers on COVID-19 care and protection. It has built an army of medical personnel available for digital consultations even in non-COVID times.

Strong connections have been made with local government officials and service providers like ART and ICTC centre teams. Acknowledging their support and offering thanks through public forums can strengthen bonds with local civil society organisations, facilitating future engagements.

Closing the loop on entitlements also promotes resilience. Awareness of schemes and entitlements and the ability to access these gives communities the confidence to

demand their rights and directions.

## 8 CONCLUSION

CAC has demonstrated how to build a **solid and engaged collaboration** that delivers critical service to vulnerable people in a humanitarian emergency. It has brought together partners of different types, providing cross-domain services and integrating community needs with donor and partner requirements.

Response to the COVID-19 pandemic focusing on the most vulnerable, excluded communities and women has paved the way for several opportunities with potential sectoral gains. For instance, **building capacities of NGOs and CBOs** to enable social protection access, in collaboration with local administrations, has vested the trust of these communities in the system in general and in their CBO's capacities. This is important for continuous demand generation and ensuring that eligible vulnerable groups receive their rights.

As it moves into the next phase, pertinent questions arise - How do we ensure that the interventions can be sustained and scaled beyond the pandemic? How do home-based and telecare systems incorporate and mount into the larger public health agenda? How are the health care resources (community care centres, oximeters and oxygen concentrators, telecare resources, capacitated health care workers, etc.) leveraged, maintained and updated/upskilled to be available for non-pandemic times? How does the social protection help desk model find a home in every district? How is the community's resilience built to tackle humanitarian emergencies, whether at a global or local scale? How can funders be engaged in a 'bigger picture' vision? And finally, how are the relationships developed during the pandemic. Between the community and their organisations, local administrations, public and private entities, funders and implementers, the CAC collaborative partners, and many more, strengthened to work on addressing the many facets of vulnerabilities that women continue to face.

The CAC Secretariat discusses some of the questions with partners, advisors, and sectoral experts to design its transition from the COVIDActionCollab to a CommunityActionCollab. Common themes during these discussions have been around strengthening local capacities to promote localised/district level responses for building community resilience against health, climate and livelihood threats.

Working together with stigmatised groups like sex workers and trans women has served to lower the stigma related to sex and sexuality and **amplify their voices**. Initiatives like **telecare** have connected women who otherwise would or could not seek health services to the health system. It has also brought issues **like mental health** to prominence. While

the actions and impacts might be localised, they create inroads for scaling the narratives and fostering the inclusion of people and themes.

In summary, as a knowledge centre dedicated to women's welfare, CoE is well placed to support this endeavour by generating and disseminating learnings, supporting the capacity development of partners working on the resilience of women in humanitarian crises, and supporting government engagement for a grander scale and sustainability.

## 9 ANNEXURE

During the pandemic, women faced many challenges in accessing health services. Pregnant women are at higher risk of experiencing maternal health problems due to the diversion of maternal health personnel and services, including ante and post-natal care, towards the COVID-19 response. Due to lockdown conditions, vulnerable and marginalised pregnant women could not access ANC and PNCs, and ICDS services were disrupted. Myths around vaccination of pregnant and lactating women on their health and the health of their foetus. Transgender persons faced enhanced stigma and discrimination, which hindered their access to health services and vaccination. Women living with HIV faced difficulty getting timely Antiretroviral Therapy (ART) or nutrition required to maintain good health while maintaining the confidentiality of their positive status. In many communities, women were likely to get a low priority in their family for vaccination and would not have access to information or support. Any nutritional challenges faced by the family on account of loss of livelihoods or lockdowns would disproportionately impact the women in the family. Challenges of women with disabilities, already facing stigma and access to health issues, were compounded in such a scenario of mobility and access restrictions.

In addition, even in non-pandemic times, people tend not to get regular check-ups without the drivers like ill health, health reports requirements for insurance, etc. Women and the poor communities are the least likely to get screened for comorbid health conditions that increase the risk of COVID-19 infections.

One of the most satisfying things about establishing and running a collaborative is hearing of women, many facing these very difficulties who have benefitted and grown from their support.

This annexure breathes some soul into the learnings through stories of women beneficiaries.

## 9.1 Empathetic Healthcare

### Responding to the unique needs of PLHIV

*The CBOs pulse the community's needs and understand their unique challenges. They must be engaged while planning interventions. Dhanalakshmi, a sex worker and PLHIV narrate how localised plans and collaboration are the best way to ensure empathetic inclusion of women in general and women in sex work and those living with PLHIV in particular. This approach includes enabling the doorstep provision of life-saving drugs and ensuring the continuation of medical treatment and counselling despite lockdowns by moving to digital platforms while ensuring confidentiality and dignity.*

*New modes of engagement, new networks, and collaborations with local administrations and service providers are assets that can be utilised for continued and improved service provision, leading to increased well-being.*

“The government is looking out for other labourers, but we have not received any help. No one shows any concern for our livelihoods. People like us need a permanent solution and support to make ends meet”. This is an oft-repeated lament echoing through the dingy alleys and shabby brothels of Bengaluru city.

PLHIV, women in sex work face substantial social, economic, physiological, and psychological barriers in accessing healthcare. The #COVIDActionCollab (CAC) has been working towards uplift and community representation of sex workers and PLHIV. CAC has made inroads into an otherwise cloistered community through its institutional partners. These partners, many of them CBOs of women in sex work, have their pulse on community needs through which CAC was able to prioritise the services for the community and rally the government's resources and other donors to arrange for support during the lockdown.

Sex work is characterized by its fragmented human rights, a highly mobile workforce, and livelihood fraught with numerous risks. Based on a recent study<sup>1</sup>, the ostracization and marginalization of sex workers on account of their livelihoods is further aggravated with the black mark of sexually transmitted diseases (STDs). HIV, a major epidemic affecting an estimated 2.1 million Indians at the end of 2020. There is a large concentration of HIV among “key populations”, comprising sex workers, gay men (MSM), transgender and injecting drug users. COVID-19 is affine towards weakened immunological defenses; and people with comorbidities, including HIV, find themselves more susceptible to COVID-19 related fatalities.

During the pandemic, CBOs and NGOs ensured doorstep delivery of ART medicines to the PLHIV community in collaboration with ART clinics. Access to ART was one of the challenges for many PLHIV, as access was constrained due to the mobility restrictions imposed by the lockdown and aftermath. PLHIV was unable to collect their monthly dosage from ART clinics. Many PLHIVs hide their positive status from their neighbours, friends, and even family due to fear of stigma and backlash. Maintaining the confidentiality of the PLHIV and their consent was of the utmost importance. “There are patients who are already on ART medicine secretly without letting their families know. We either surreptitiously delivered the ART medicine at their home ourselves or had taken help from the local NGO. Sometimes if they preferred and were able, we met them at their convenience and delivered the medicine. We provided medication sufficient for around three months instead of their usual monthly dose to restrict their travel requirements”, explained an Integrated Counseling and Testing Centre (ICTC) counsellor.

The complete or partial halt in care provision at the onset of the epidemic was unfortunate, given that healthcare frontline workers were as constrained as the beneficiaries. However, many providers went above and beyond to guarantee a better quality of care. There was a reported increase in providers' general commitment and empathy toward community members, as shown by greater outreach to PLHIV at their homes, with due precautions taken; or linkages they developed through the community networks to ensure care. Service providers also reached out to PLHIV, who were not registered with their ART clinics. These expanded linkages and outreach can be built upon to support future humanitarian crises and improve services to vulnerable women.

“For better quality, we need to work harder. For instance, there is a patient who lives far away from the ART clinic and was monetarily stretched to travel for medication, so we send a helper from either the local NGO VIHAN or the PLHIV network, which goes to their home for the check-up and provides them with timely medicines”, an ART



counsellor shared. Further, counsellors have shifted from face-to-face outreach to tele calling to minimise direct contact in COVID times and ensure health service provision.

Despite this, some PLHIVs did report experiences of increased prejudice and a flippant attitude toward their caregivers. One PLHIV, who requested anonymity, says, “Before COVID-19, they (caregivers) would at least sit and counsel us for 15 minutes, but now, they don’t even let us stand. They just asked us to take the medicines and leave and not crowd around. Now the way they treat us is not good.” This is the mixed bag that is life.

Yet, these experiences, whether good or not so good, show that vulnerable women like sex workers with HIV can continue their medical treatments through COVID-19 mobility restrictions when they have their community organisations and focused service providers on their side.

## 9.2 Knowledge Empowers

### Addressing Information Deficit, Transparently and Accurately

*Clear, correct information from trustworthy sources is the most critical input that can drive people to protect themselves and was the input in large deficit during the pandemic. In this story, Dhanalakshmi continues her narrative on how people living with a chronic condition like HIV received confusing, often fake messages concerning the safety of vaccinations for people on ART. They were reluctant to approach the health services for fear of stigma. They had no one to turn to for advice. The community-based organisations with whom these groups had close connections and a bond of trust made it their priority to provide correct information and support them to make the right choices regarding their health. They further ensured that access barriers such as digital illiteracy were removed by organising special vaccination camps for women and supporting them through registration. The CBOs could keep the communities based on the solid trust capital built. Their engagement further strengthened that trust.*

SMS and its extensive grassroots level network played a pivotal role in reaching out to 6,000 members via telecare to deliver telehealth consultations, counselling, medicine, and social protection services. A highlight of their work during COVID-19 was distributing medication for diabetes, hypertension, cardiac-related issues, thyroid, etc., to women living with chronic conditions. Community leaders would catch up daily to discuss and brainstorm actions on real issues and provide expeditious support to people in need.

During discussions post the vaccine’s approval for adults, the leaders recognised that

PLHIV was hesitant to get jabbed because of the absence of clear information on the safety of vaccines for those on ART. Fake news from sources like WhatsApp and Facebook and conversations with unaware community members fanned their hesitancy. The stigma and silence of PLHIV prevented them from reaching out for information. The urgent need was to facilitate credible information to the community about their condition through reliable information sources.

Dhanalakshmi recalls, “I only got to know of my HIV-positive status when I got a blood test during my pregnancy. My medical counsellor at the time connected me to SMS, with whom I’ve been in touch ever since.” For many women like her, the telephonic and face-to-face group sessions conducted by SMS were their go-to platform for COVID-19 related information. “The news on TV covered daily death tolls and vaccine supply. But no one spoke about how the vaccine would affect someone like me who is HIV-positive. There was a lot of confusion in our community, and people were worried about the risk of the vaccine’s side effects. But the team at SMS was very informative and helpful. Their support was the sole reason I felt confident about getting vaccinated,” she states.

Convinced by the knowledge and trust of SMS volunteers, Dhanalakshmi was finally able to take the life-saving vaccine shot from an SMS-organised camp in June 2021. “I will get my children vaccinated as soon as vaccines are available for that age group,” she commits.

A pivotal hindrance to vaccine accessibility was the inability of the women to use the mobile platforms to register and book slots. Sathyaprema, a woman in sex work, reported that her biggest challenge was getting herself registered despite taking the vaccine. She overcame that barrier with the support of SMS. Recognising the frequency of this complaint among community members, SMS conducted vaccination camps where the registration of the beneficiary was handled by SMS. They ensured that women who did not have access to vaccine registration or digital infrastructure know-how were not left out.

Instances like these highlight the gaps in communication regarding critical medical information, particularly when conveying it to at-risk and marginalised communities like PLHIV. SMS leveraged its connection to the community via its prior work to build on its formidable trust capital, allowing them to address the community’s concerns.

## 9.3 All Gain, No Loss

### Switching on the earning tap

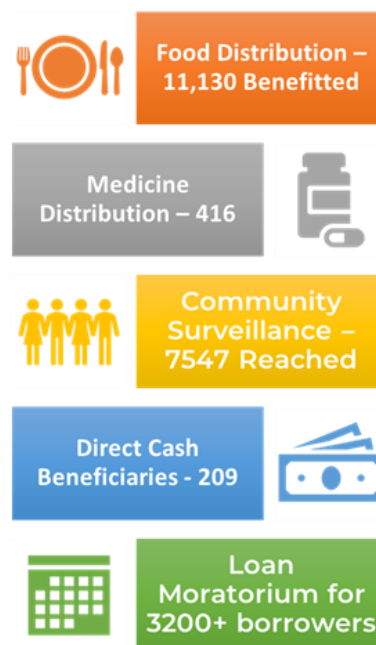
*The pandemic led to the loss of livelihoods, and with the lockdown, sex workers, unable to practice their livelihood, suffered. Community-based organisations connected women in sex work to government programs and facilitated the distribution of rations, which was immense to women struggling to make ends meet.*

Dhanalakshmi found her family in dire straits and lost her livelihood during the pandemic. The need to reach out to her and others from the PLHIV community and connect them with aid tailored around their peculiar context was never more urgent than during the pandemic.

For one, women in sex work have seen a drastic loss of livelihood from the COVID-19 situation in the country. In Bengaluru city alone, nearly 25,000 sex workers and their children were affected during the lockdown. Business slackened. And there was a fear of contracting COVID-19 and the extant social distancing norms.

Dhanalakshmi, a sex worker, earned around ₹2000-3000 per day before the pandemic. With the pandemic, her clientele reduced to a trickle, and she took up a part-time job as domestic help. The sole breadwinner of her family, consisting of her two children, and her mother-in-law, Dhanalakshmi's meagre income of ₹500-1000 per day from domestic work was not sufficient. While high volume sex workers (typically servicing more than ten clients per week) may be lucky to find a client or two in these uncertain times, the young sex workers and new entrants in the job are distraught: "We do not have any other means to earn our daily bread."

The community outreach offered by SMS has been tremendous. For instance, Dhanalakshmi was unaware of government programs supporting marginal communities, but she received COVID-19 protection kits from SMS-supported camps or local police stations and dry ration kits from SMS. PLHIV members who don't have ration cards have been provided dry ration kits through Bruhat Bengaluru Mahanagara Palike (BBMP).



SMS also helped women aspiring to diversify their livelihoods to become financially independent by giving top-up loans (worth INR1.3 crores) over and above their existing loans.

Sathyaprema, an SMS member working as a dog breeder, says, “the lockdown period was very tough for me as my own dog breeding business had encountered a full stop. Thanks to SMS’s business loan, I could keep it afloat and support my family.”

## 9.4 Myth Busting

### Protecting Pregnant Women

*Pregnant women, for instance, struggle to get information and support to help them through pregnancy, lactation, and early childcare. The struggle may be compounded by the need to continue their livelihoods through pregnancy. Facilitating focused action for pregnant women - knowledge on health, nutrition and entitlements, and medical and counselling services sets the stage for the women to get the adequate rest and nourishment required for the health of the mother and child and have safe deliveries. The easy availability of information availability of good leave without affecting their earnings gives them peace of mind. Such focused action also builds trust in women in the systems that design and deploy entitlements and the community organisations that facilitate access. The effects of safe motherhood live on for the future.*

Vulnerable populations often find themselves at the intersection of several deprived categories: whether due to their choice of livelihood, their socio-economic status, their immediate living situations, or even their pre-eminent health status.

One of Swasti’s critical impact areas has been garment factories, where workers are susceptible to health risks, livelihood uncertainties, and workplace discrimination. These issues become more pronounced for migrants and women, a significant proportion of the garment industry workforce. Swasti has had a role in influencing policies and implementing interventions focused on garment workers’ holistic well-being and development, directly reaching over 230,000 workers (majority of whom are women) across 334+ factories in India.

In March 2020, COVID-19 was officially classified as a Global Pandemic and health crisis. The public health emergency it posed had dramatic spillover effects on people’s lives and livelihoods. Manasa, a product quality checker for a garment factory in the Bengaluru

industrial cluster, is one of the many garment workers caught in the pandemic wave. Hailing from Ramanagara district in Karnataka, she has been employed in the factory since 2017-18. Her husband works in the same factory. Having migrated away from an agriculturist family in her home village, the garment factory became Manasa's family's only source of livelihood. Manasa and her husband were to welcome their first baby in January 2022; their tiny single-room-house is stacked with essential utilities, a television, and two large almirahs, but not much for their eagerly awaited newborn.

When the Karnataka State government declared a lockdown in July 2020 with the raging second wave of the dangerous Delta variant of COVID-19, the factory, Manasa's singular pillar of livelihood support, was shut for two months. It was challenging for Manasa and her husband to get decent jobs during this period. The only resort was to return to their native village in Ramanagara. Her family and extended family lived under one roof, subsisting on essential groceries provided through the household ration card and vegetables grown on their farm.

This lockdown was a delicate phase for Manasa, as she was in her first trimester of pregnancy, and the COVID-19 pandemic was in full force. Manasa acknowledges, "the travel from Bengaluru to my native place was as risky as undergoing a full health check-up at the nearby ESI hospital" since Karnataka showed a daily count of more than the usual 2,000 positive COVID-19 cases. Moreover, the risk of Manasa contracting the infection was exponentially higher, considering that pregnancy lowers the immunological defences in the mother's body. The doctor she consulted advised her against taking the COVID-19 vaccine, citing the risk of fever and COVID-19 like symptoms due to her decreased immunity.

When the COVID-19 situation improved and the lockdown was lifted, Manasa returned to her job, another risk she chose to take. She mentions, "it was important for me to be able to contribute to the household income, so taking leaves for extended periods was not an option for me." She was concerned about meeting medical costs if someone from her family contracted a severe bout of COVID-19.

It was back at work that Manasa contacted Swasti, associated with the factory, for quite some time. Swasti helped the factory management design workplace guidelines for COVID-appropriate behaviour to ensure the safety of the workers. Swasti and their partner's frontline program facilitators, through its CAC initiative, had disseminated information on the virus, prevention, and mitigation strategies, and even organised vaccination camps targeted at the vulnerable women communities. When asked about safety guidelines, Manasa was fully aware of them, mentioning training sessions

conducted for sanitation and hygiene practices in the workplace.

Manasa also learned some vital information on entitlements for pregnant women through Swasti and their partner's healthcare facilitators. She had limited awareness of the Employers' State Insurance Corporation (ESIC) scheme's employee health benefits, knowing that it included six months of fully paid maternity leave; but being unsure about the prerequisites or phase of pregnancy during which the scheme could be availed. She was not aware of other livelihood security benefits under the plan. Her lack of complete information prevented her from taking leave during most of her pregnancy. Thanks to the direct counselling by the health facilitators, she was happy to avail these benefits postpartum. "The factory has a maternity leave policy that I now know, allowing me to take sufficient leaves during my pregnancy. I also appreciate that they (the factory) did not push or pressure me to do the strenuous work expected in my job line."

Manasa had saved up some money for medical expenses, and the company also provided some financial assistance for pregnancy.

Manasa shares how in-person counselling and free blood tests made her aware of the importance of healthy blood haemoglobin levels, especially during the initial stages of pregnancy. "In the tests, I found out that I was anaemic. The health facilitator helped me plan my diet and nutritional requirements during pregnancy and lactation. She explained the vegetables and iron supplements I need to build my immune system. Because of this counselling, I followed the diet regularly and improved my haemoglobin levels from 6.5 to 12.8". This experience has built her trust in Swasti's healthcare facilitators and nurses.

Manasa also received reliable guidance about the COVID-19 situation in the city, affordable healthcare facilities, and the risk of the infection itself. Her regular information source, WhatsApp, proved unreliable and confusing. Manasa appreciates the healthcare facilitators' very approachable and prompt response: "I can immediately call up the nurse to get instant information on many health issues such as fever and weakness I might be facing. In COVID times, where we are always facing the risk of contracting the virus from amongst the factory workers, the Swasti staff's approachability has helped me stay safe and be aware of COVID-like symptoms, as it may affect my child's health too."

Manasa's story shows the vast difference entitlements and services can make to a pregnant woman's well-being. Closing the entitlement loops necessitates that eligible people know about the availability of schemes and services and are also supported in accessing these.





*A factory worker back to work at a COVID safe workplace*

## 9.5 Safety Paramount

### Creating a Safe and COVID-Informed Workplace for Women Migrant Workers

*Many garment factory workers count among the urban poor. They live in nearby slum colonies with high population densities and unhygienic conditions. These conditions are grounds for the rapid spread of illnesses. Despite knowledge about the importance of vaccination to protect against serious illness, and a willingness to be vaccinated, many vulnerable communities found challenges in accessing the job.*

*Many workers can engage for services during work hours in a factory setting. An integrated workspace safety strategy that looks at protecting workers from COVID-19 through awareness generation, myth-busting, vaccination, and provides other health information, health services, and counselling is a win-win. The workers - who remain safe and healthy - and the management can keep the shop floor operational for more extended periods and have*

*lower absenteeism. Such an approach also builds the capacity of a cadre of women who get trained on essential health. This boosts their confidence amongst their peers. It further erases the stigma around women's health issues like menstruation, making for open dialogue and access to services. Finally, it promotes resilience by creating grassroots service providers and leaders.*

Workers across the nation felt the debilitating effects of lockdown as their lives and livelihoods went into a tailspin. Millions of daily wage workers and factory workers were stranded without a livelihood to meet their basic needs. One such vulnerable person was Vijayashanthi, a tailor at a garment factory in Bengaluru.

Having worked at the same factory for the past ten years, Vijayashanthi had come to rely on this job to support her household. Despite the high labour turnover rate in this industry, it still serves as a steady income source for many migrant workers like herself. Thus, the nationwide lockdown imposed on 24 March 2020 was a huge shock for her. The factory would be closed for two months, putting a full stop on her only reliable source of income. Furthermore, she recalls, “It was challenging to get travel permits during the lockdown. The government officials had placed very stringent rules for travelling; I could not even freely go back to my native village!”

The reopening of factories post lockdown did not immediately resolve her woes; public transport was still closed for use. The daily 10-km commute between her home and the factory added a significant burden on her household budget.

As television kept Vijayashanthi updated on the COVID-19 situation back in her home state, she felt apprehensive about her and her family's safety, considering the high population density and unhygienic conditions of the locality. Her overcrowded two-room home could not have provided quarantining isolation. Being at increased risk of getting infected due to the nature of her job, she was constantly worried about how they would manage if even one of them got infected. Vijayashanthi recalls, “Online learning mode was becoming a serious challenge for my children. I want them to secure a good education, but what use is online learning if my kids are not healthy enough to study?”

One of the main issues Vijayashanthi faced on returning to work was the compulsion placed by her factory to get vaccinated. In Bengaluru, it was challenging to get vaccination slots immediately at government hospitals. People had to shell out a fair bit of money to book a space and get vaccinated in other places. Further, while people did have information to prevent COVID-19, there was a lot of misconception about COVID-19 like symptoms. The side effects of vaccination, including fever, body aches, and sore

throat, had planted a staunch hesitancy against vaccines. She also mentions that the hesitation and mistrust for vaccines is not something new; it is the same for all medical interventions such as health check-ups.

A community-based organisation of women in sex work, SMS, saw the opportunity to support vulnerable women in Bengaluru's nooks and crannies through its health and vaccination camps. These camps proved to be a very reasonable boon for Vijayashanthi and many others in her position.

SMS's vaccination camps were organised in localities with distressed populations and garment factories. The health facilitators imparted awareness and education to dispel myths and misinformation, leading to vaccine hesitancy. They organised free vaccination drives for factory workers and their family members. When she attended these COVID-19 awareness sessions on protecting herself and her family from being infected, she gradually felt confident in going to work. The factory also had made an effort to create a COVID-19 safe working environment. She says, "the factory provided workers with masks and hand sanitisers. They had ensured social distancing at each workstation. When one's employers make such efforts, I'm sure every worker will feel valued by their company."

The SMS health camp volunteers were also ready to offer technical support for workers who did not have access to their mobile phones, where the OTP for vaccine registration would be received. "We have young children and our ageing parents and other adults in our homes. Even if we continued coming to factories, it would have been tough if they became COVID-19 positive because of us," another factory worker noted. Vijayashanthi and others expressed their relief at getting such easy access to the vaccine, "Calling all the workers to the factory to SMS's vaccination camps is greatly appreciated. We are now confident about the safety of our family".

Vijayashanthi's association with SMS did not just end at this vaccine camp. SMS established many such interventions associated with the factory, including regular health check-up camps. In one such centre, she was diagnosed with acute anaemia. The SMS health facilitators gave her ample information about this health condition, explaining the importance of nutritious and wholesome food and basic hygiene. The counselling and appropriate guidance of SMS is helping her recover quickly.

The experience with SMS has instilled courage in Vijayashanthi. She wants to empower and educate migrant women like her, who have faced various forms of social and economic barriers in accessing healthcare facilities. She has converted the relationship

between herself and SMS from a provider-beneficiary form into a partnership; “I was very impressed with SMS volunteers’ work in the camps and thought of how I could give back to the community. With the support of SMS and CAC, I underwent basic training in healthcare practices and first-aid. Today I am one of SMS’s facilitators at my workplace”, she concludes with a bright smile.

SMS, supported by Swasti and CAC, has created such grassroots leaders through its extensive network and outreach programs. These “Social Sahelis” have proactively disseminated good healthcare practices to underserved communities.

Rekha is one such Saheli who is proud of being able to help other women through this role. Rekha underwent a three-day Foundational and Advanced training to improve communication and build leadership skills. This training led her to be selected as ToT (Trainer of Trainers); she had to teach her coworkers everything she had learned at the training. Her coworkers, who would earlier liken her to a strict “army officer,” were now pleasantly surprised at her openness, friendliness, and approachable nature. These attributes have helped her break through the thick hesitancy and discomfort in publicly discussing reproductive and menstrual health topics. How does she deal with this hush-hush attitude? Rekha says, “Our trainers explained that we should not be ashamed as it was essential for us to be trained on this topic and train other workers. They told us that whenever we go to a doctor, we need to openly discuss reproductive and menstrual health concerns to prevent any health risks and fatalities”. Identifying such dynamic community leaders and equipping them with the sensitivity and right set of informational guidelines is the heart of the CAC mandate.

Vijayalakshmi and Rekha’s stories are testament to how people’s institutions can respond to crises, expand the scale of their work, and reach out to non-community members, gaining confidence and acceptance in the process.

## 9.6 Turning Times

### Alternate Livelihood Opportunities for Marginalised Women

*The pandemic has shown that community groups have a strong support structure for vulnerable women. Through needs assessment and training by the CBO, women were able to cultivate new skills and remain financially independent, even with the loss of their primary livelihood, giving them a sense of pride and empowerment. Their entrepreneurial capabilities have come to the fore as the enterprises have made money and have scaled. The support of*

*an orchestration mechanism like CAC enables the conditions to rally funders for small grants to kick start enterprises. Together these are individual ingredients that are critical for success.*

The CAC initiative has teamed up with several community-based organisations to address the socio-economic barriers and gaps in availing healthcare and support during the pandemic. Since its inception, the collaborative has experienced an upward learning curve, helping it design better interventions to reach vulnerable women populations.

Amidst the myriad and unique challenges faced by marginalised women, a common thread emerged more prominently with the backdrop of the COVID-19 pandemic, i.e., loss of livelihood. Several success stories in CAC's repertoire speak of livelihood support, employment generation, and community service. One such story is of Rathnamma, a 35-year-old garment worker from Kandavara Village in the Chikkaballapur district of Karnataka. Rathnamma faced the brunt of the lockdown much more severely, as both she and her husband, a manual labourer, had lost their daily wages.

Rathnamma has been an active member of the Pragathi Arogya group and the Soukhya Sanjeevini Samsthe, a CBO of sex workers, for the last two years. Her enthusiastic participation has helped her benefit from the group's health, financial, and computer literacy sessions. It has also connected her with the CBO to share her difficulties since the onset of the COVID-19 restrictions.

Meanwhile, the CBOs were facing their own set of challenges. While distributing essential supplies to marginalised communities, they quickly realised that surgical masks, with their short lifespan, were not sustainable for distribution. They, therefore, requested Rathnamma to stitch 500 washable and reusable cloth masks. Out of the 500 masks that Rathnamma produced for Soukhya Sanjeevini Samsthe, 300 were distributed to marginalised community members by facilitators, the board of directors, peer educators, and volunteers. Local donors from the Chikkaballapur block agreed to financially support Rathnamma's venture by transferring INR 5,000 directly into her bank account to fund the manufacturing process.

This project supported Rathnamma's family and provided crucial protective equipment to vulnerable communities during the pandemic. The mantra of the community is "Stay safe, spread love." This has never been more relevant than now.

"Being a member of the Soukhya Sanjeevini Samsthe helped me acquire and cultivate new skills to become financially independent. During COVID-19, I was able to utilise my skills to save my family's livelihood."

A similar story comes from Sri Lakshmi Pengal Munnetra Sangam (SLPMS), a CBO working with 2,300 individuals from various vulnerable communities-such as sex workers and people living with HIV (PLHIV), Transgenders (TGs), Gay Men (MSM), etc. SLPMS created a forum for these communities to voice their problems and jointly mobilise to come together and work on a solution.

For the communities that SLPMS worked with, the pandemic completely altered their way of life. A majority of the 2,300 individuals depended on sex work for their daily income. The pandemic drastically affected them, leaving many community members without food or shelter. In the early days of the pandemic, CAC, Godrej, and Give India supported the community by donating food kits, but that wasn't enough. They needed jobs to enable them to earn even INR 100 a day.

The SLPMS team knew that some community members learned how to tailor and had fair experience in sewing. SLPMS saw this as an opportunity to create jobs for community members. Noticing an increase in the demand for masks, a Tailoring Unit was set up in September 2020 in Madurai. SLPMS faced several challenges when setting this up. One of them was that the individuals who had previously owned sewing machines had been forced to sell them during the lockdown as their regular source of income abated. SLPMS themselves didn't have the capital to invest in the infrastructure needed to set up the unit.

Priya Babu, a Program Manager at Swasti and a well-respected writer from Tamil Nadu, initially approached a local women's association and told them about SLPMS and their work. The association donated INR 40,000, which was used to purchase machines. Community members were willing to take this on, but there wasn't any space to work in. Priya Babu shared the communities on social media, and soon they found a room at a local playschool that they could rent at a minimal cost. Once again, through Priya Babu, SLPMS's tailoring unit got its first client, who ordered 11,000 masks.

The unit currently has 18 individuals working on the production, of which 13 work from their homes as they own sewing machines; they earn anywhere between Rs. 100 to Rs. 200 a day. Two types of masks are being made, i.e., an essential everyday mask and a herbal mask. On average, each individual can make 100 masks daily and earns Rs. 1 per essential mask and Rs. 5 per herbal mask. The unit will also be venturing into creating more products, such as cloth bags, pouches, women's nightwear, etc., and receiving orders. Since its start in September 2020, the unit has produced 1.6 Lakh masks, with an income of INR 1.2 Lakhs and a profit of INR 90,000.



With CAC's support, SPLMS was introduced to Godrej and Give India, assisting with providing grocery kits to the communities they work with. They were also connected to Selco Foundation, which provided them with solar panels to power the sewing machines at the tailoring unit, further reducing their operational costs. SLPMS hopes that they will provide more employment opportunities to these groups.

Supporting the trans community members with alternative livelihoods has been critical to their well-being. Success in new ventures has given them the confidence and aspirations to scale and support more community members.

## 9.7 Righting the Wrongs

### Assuring Entitlements

*Vulnerable communities are guaranteed certain rights and entitlements that they are often unaware of or face barriers in access. Community collectives with solid leadership and support structures can serve as a vital force for advocacy and the attainment of rights. When trans women were excluded from financial aid, community institutions rallied the power of the people, and CAC and partners provided the framework to make a case for the community and won. Such victories amplify community voices that carry to the future attaining the attainment of rights.*

The COVID-19 health crisis was deemed “the great equaliser,” affecting everyone without discrimination. However, in reality, this was not quite so! The pandemic unearthed deep-set inequities in accessing primary healthcare facilities, pronounced in the Transgender and Non-Binary (TGNB) community.

The trans community remains estranged from mainstream society. Transphobia leads to extreme forms of physical and mental abuse from every corner, including public and private healthcare systems, alienation from the family, and deadnaming. A strained relationship with the healthcare system, caused by a lack of gender-sensitive treatment protocols, low health literacy among transgender women and hijra persons, poor healthcare-seeking behaviours, socio-economic barriers, lack of health insurance, and exclusion from social protection schemes, has driven them away from availing essential healthcare services, such as vaccines, hormonal treatments, and HIV medication during the pandemic.

Jeevika, a 27-year-old “Mangalamuki” or trans-woman based in Chikkaballapur, Karnataka, has faced such indignations multiple times. Facing social aversion and lack of support from her own family, she had to beg at traffic signals and solicited sex work; the transphobia, appallingly, has prevented her from actively seeking a decent livelihood. So, when the city came under strict lockdown, she found herself helpless with no transportation facilities to the vaccination centres; discriminatory glances and rude remarks were thrown at her, making her very uncomfortable. On the other hand, despite the general awareness about vaccination and information received through mobile, rumours spread in her community like wildfire: “some people said that they lost their family members after taking the vaccination; others got fever and body pain. Even though I don't have a family to take care of, I am fearful if I take the vaccine and get the fever; who will care for me then?”

This fear and mistrust about COVID-19 vaccines are not entirely unfounded. For one, the TGNB community is highly at risk of contracting HIV. At 3.14% of affected people, trans and hijras have the second-highest HIV prevalence rates across all most-at-risk population groups (i.e., people injecting drugs, female sex workers, and MSM). They remain higher than all adults in India (0.22%) as per data from the National AIDS Control Organization and ICMR-National Institute of Medical Statistics. It is unclear how vaccines affect people undergoing hormone therapy or antiretroviral treatment for HIV. Thus, it becomes an essential factor for vaccine hesitancy in the TGNB community.



*Trans women receiving health information*

Even as the country rolls out large vaccination camps, the TGNB community has been isolated in a sea of information deficits or misinformation. Jeevika says, “We are engaged in sex work, and we didn’t know what the situation was like about vaccination for us. For information on HIV, I would go to the doctors and directly ask them because they are the only right person to clarify our doubts. If doctors told us it was safe and would not cause any trouble, we would be willing to take the vaccination. But in the pandemic, doctors and counsellors did not reach out to us.”

Past experiences in her community have made her bitter against approaching hospitals for vaccines: “In hospitals they make us stand in the line to get the vaccine. Sometimes after seeing us, they tell us that vaccination is not available”.

Swasti and Samara, an NGO working with trans communities for decades, also recognised that trans people need a safe space within their comfort zone. They are treated with respect and dignity and have their concerns addressed by trusted healthcare providers. In 2020, they collaboratively organised webinars for the community to discuss their concerns with the doctors. Other organisations in Bengaluru collectivised trans women to facilitate vaccination campaigns and counselling that were explicitly targeted at the TGNB community. More than 200 trans people were served in this camp.

Given the economic transgressions of the pandemic and subsequent nationwide lockdown, the Government of India declared financial aid packages for all vulnerable groups, including daily wage workers, construction workers, garment workers, and migrant workers. The transgender community, which constitutes a 4.88 lakh population (Census 2011), was left out. This exclusion came as a shock considering that in 2014, the Supreme Court of India recognised the transgender as “third gender” entitled to reservation in education and jobs and eligible for many social security programs at the central and state levels. However, the fact remains that their gender is neither recognised nor accepted in various formal registrations. Many State governments have constituted Transgender Welfare Boards (TWB). Still, these have not yet yielded concrete actions in addressing the social protection needs of transgender people, including health care, housing, education, and employment in the State. Moreover, TWB’s work during the time of the pandemic remains unknown.

Most TGNB members like Jeevika subsist by begging on the streets or as sex workers. Thus the exclusion of the community from centrally-sanctioned monetary support was devastating. Swasti realised this need and approached the National Institute of Social Defence (NISD), Delhi, to provide financial relief to the transgender community in

Karnataka, Maharashtra, and Tamil Nadu. Through the collaborative efforts of Swasti and district CBOs, vulnerable groups eligible for receiving financial aid were identified. Factors like comorbidities, homelessness, old age, and people living with HIV were considered for determining the vulnerability of transgender people. The number of beneficiaries of the relief fund was set at roughly 10% to 15% of the total transgender population residing in that district.

Each selected transgender person received a direct bank transfer of Rs under this intervention—1,500, expected to last for around a month. While vulnerable groups were supplied with basics such as cereals, pulses, and oil under government or NGO relief programs, this financial contribution could be used to buy groceries that provide essential nutrients significantly since the cost of food had increased because of the pandemic. A beneficiary of the intervention expressed her gratitude, “We have been earning a livelihood by begging in shops. Due to the outbreak, we stayed at home for days together. It was difficult for us to live our lives. During this time, Rs. 1,500 was deposited into our account. It was quite helpful, and we are happy with the money provided. We are thankful for all of them involved in helping us get these funds”.

Jeevika’s story and that of other trans people who found support during the pandemic represent the title of this collection of stories - they found an ear willing to listen to their difficulties, with the help, they were able to voice these at the correct forums, leading to steps towards its redressal.

## 9.8 Partner list

Please find the complete list of partners at the [link](#).

## 10 ABBREVIATIONS AND ACRONYMS

ART	Antiretroviral Therapy
CAC	COVIDActionCollab
CBOs	Community-Based Organisations
CoE	Canter of Excellence
COVID-19	Coronavirus Disease 2019
EPIC	Employers' State Insurance Corporation
GBV	Gender-Based violence
GUEST	Gender Equality Social inclusion
HII	High impact Interventions
HIV	Human immunodeficiency virus
ICTC	Integrated Counseling and Testing Centre
MSM	Men having Sex with Men
NCDs	non-communicable diseases
NEED	National Institute of Social Defence
PLHIV	persons living with HIV
SMS	Swathi Mahila Sangha
SLPMS	Sri Lakshmi Pengal Munnetra Sangam
TWB	Transgender Welfare Boards
WASH	Water Sanitation and Hygiene



