Guidelines on Inclusive COVID-19 Sensitisation Response Services for Vulnerable and Marginalised Communities

Progress Report 2
Table of contents

List of Abbreviations 3

1. Introduction 4

Summary of government efforts: 6
Response and Recovery 6

Figure 1: Geographic Spread of CAC Interventions (as on March 2022) 8

2. Vulnerable groups and their barriers 9

3. Contextual Guidance 13
   3.1 People-centred approach for vulnerable groups 13
   3.2 Collaborative Action 16
   3.3 Response and Recovery 18
   Awareness and information: 18
   C. Treatment 23
   Image 4 & 5. Raising awareness for Call4Swasth through banners and home visits 24
   D. Mitigation 25
       Surveillance - EWS (Environmental Water Surveillance) 25
       Social protection 27
       Economic Resilience 31

Key takeaways and concluding remarks 35

Contextual Guidelines Note: 37

A. Access and quality of healthcare 38
   1.1 Conduct vaccination camps for marginalised communities 38
   1.2 Co-locate NCD screening, regular health check-ups, counselling, and referrals with vaccination camps 39
   1.3 Provide sensitisation training to health and outreach workers 40
   1.5 Integrate mental wellbeing approaches within COVID-19 care 41
   1.6 Ensure safe and affordable transportation to access healthcare services, including vaccination 41
   1.7 Support access to identification/permission cards 42
   1.8 Provide a hybrid, remote and on-ground care option 43

B. Knowledge management and addressing information asymmetry 44
   1.9 Design an information strategy considering the community context 45
   1.10 Bridge the digital gap faced by marginalised communities 46

Annexe 48
### List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>BPL</td>
<td>Below Poverty Line</td>
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<td>CAC</td>
<td>COVID Action Collab</td>
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<td>CBO</td>
<td>Community Based Organisation</td>
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<td>CCC</td>
<td>COVID Care Centres</td>
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<td>CoE</td>
<td>Centre of Excellence</td>
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<td>CSO</td>
<td>Civil Society Organisation</td>
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<td>COVID-19</td>
<td>Coronavirus Disease 2019</td>
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<td>EWS</td>
<td>Environmental Water Surveillance</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HRT</td>
<td>Hormone Replacement Therapy</td>
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<td>MSM</td>
<td>Men who have sex with men</td>
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<td>NCD</td>
<td>Non-communicable disease</td>
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<tr>
<td>NGO</td>
<td>Non-governmental Organisation</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PLHIV</td>
<td>People living with HIV</td>
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<tr>
<td>PM-GKAY</td>
<td>Pradhan Mantri Garib Kalyan Anna Yojana</td>
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<tr>
<td>PPE</td>
<td>Personal Protective Equipment</td>
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<tr>
<td>PwD</td>
<td>Person with disabilities</td>
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<tr>
<td>SC</td>
<td>Scheduled Castes</td>
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<tr>
<td>SDH</td>
<td>Social Determinants of Health</td>
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<td>SHG</td>
<td>Self Help Group</td>
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<tr>
<td>ST</td>
<td>Scheduled Tribes</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Illness</td>
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<td>TGNB</td>
<td>Transgender and Non-Binary</td>
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<tr>
<td>UP</td>
<td>Urban Poor</td>
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<tr>
<td>VUCA</td>
<td>Volatility, Uncertainty, Complexity, and Ambiguity</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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1. Introduction

This document is the Progress Report 2 of the Centre of Excellence (CoE) on COVID-19 response efforts for vulnerable communities and women. In this report we acknowledge the government’s COVID response and highlight some guidelines that are context-specific toward an inclusive and equitable approach of service delivery to vulnerable people. These guidelines have directed interventions where over 12 million (and counting) vulnerable people have received COVID-19 vaccinations and nearly 19 million COVID-19 services instances have been received, pan-India, by some of the hardest to reach, most vulnerable communities.

Swasti and ADB have collaboratively established the 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 multi-layered challenges they face on account of biological, socio-economic factors and inequitable 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, and 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 (CAC), a successful collaboration of 350+ partners that has been empowering vulnerable people to survive and thrive during COVID-19. Of these, 159 partners, spread across 24 Indian states and union territories, work extensively with vulnerable populations. CAC since the start of COVID-19 till June 2022 has facilitated nearly 10 million services in health, livelihoods and social protection to vulnerable people. This provides a rich learning pool to CoE to spotlight lessons for government agencies, implementers and donors on effective intervention and collaboration; equity and inclusion of vulnerable women in service delivery; and building capacities of ground functionaries in the public and private spaces to extend critical services for vulnerable communities and women.

In this report, CoE draws from the experience of CAC in ensuring inclusive service delivery to vulnerable communities, especially women from marginalised communities including persons living with HIV (PLHIV), transgender and non-binary persons (TGNB), factory workers, unorganised labourers and migrant workers. There are vulnerabilities common to all marginalised women, but also specific ones faced by these communities that serve as barriers to inclusion. This report - gives an overview of some such common and specific vulnerabilities, while laying down the context and challenges, as well as pointers to inclusion. While some of the guidelines serve the

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1. [https://covidactioncollab.org/](https://covidactioncollab.org/)
general population and all vulnerable groups, some are stressed for the specific vulnerable groups mentioned earlier, or contextual to their specific circumstances.

This report first gives the rationale for the guidelines. It then highlights contextual guidance that is to be read in tandem with government guidelines and programmatic design documents. These guidance notes serve as a roadmap for planners, implementers, donors, and policymakers on important engagement features for constructing inclusive COVID-19 sensitisation response services for communities. The report includes links to important documents that complement the specific aspects being covered. A contextual guidelines note is provided towards the end of the document, offering guidance to CBOs/NGOs in the COVID-19 response sector on implementing inclusive interventions and solutions that address the unique roadblocks faced by marginalised communities in accessing COVID-19 support. An annexure is also provided as an extension of the empowerment toolkit that governments and civil society organisations (CSOs) can use in similar situations.

**Rationale for contextual guidelines**

The COVID-19 pandemic had multidimensional effects, including direct impacts on public health systems and population health, and indirect socio-economic effects causing disruptions by and creating unemployment.

The pandemic spread in a context where marginalized women and groups were already vulnerable to barriers derived from historical, socio-cultural, environmental, political, economic, and institutional biases that permeated all aspects of their lives (e.g. health-care, employment). For instance, access to healthcare is poor among vulnerable communities. During COVID-19 marginalised women faced an elevated risk of both, communicable diseases such as COVID-19, HIV, tuberculosis (TB) and non-communicable diseases (NCD) such as diabetes and blood pressure. Poor awareness and access to medical facilities that were otherwise diverted to, and focused on, COVID-19 services left a huge gap in the availability of healthcare. In addition, these groups also faced increased risk of contracting COVID-19 was due to poor sanitation facilities and overcrowding, which made social distancing impractical.

The primary objective of the Government of India (GoI) was to stop the spread of coronavirus and prevent massive loss of lives. It intervened to control the spread of the COVID-19 pandemic in a population of 1.4 billion people, and limit its health and economic impacts through the implementation of COVID-19 protection frameworks and policies, lockdowns, safe distancing measures, digital surveillance and telehealth technologies, nationwide vaccine roll-outs, social protection and emergency aid efforts. Its initiatives were focused on mitigation, response and recovery.
Summary of government efforts:

Response and Recovery

1. Awareness on COVID-19 and protection: through TV, radio, chatbots, mass media
2. Containment strategies: lockdown, geographic quarantines and cluster containment, restrictions on large gatherings
3. Testing: Laboratory testing and home test kits (approved for usage on 16th June, 2020), available in PHCs, hospitals and testing laboratories
4. Risk-stratified system of treatment:
   1. Hospital care: Tertiary and secondary facilities for severe and moderate COVID-19 cases
   2. COVID Care Centres (CCCs): Large facilities in educational and religious institutes, with residential facilities, for mild/moderate cases
   3. Home quarantine: Asymptomatic or mildly symptomatic case care

Mitigation:

1. Surveillance: Active case finding, passive/syndromic surveillance and serological surveys
2. Vaccination: Free vaccines in public sector, and market models in the private sector with digitised credentialing
3. Social protection: Advancing of existing entitlements including conditional cash transfers and expansion of health insurance for all healthcare workers. Introduction of new entitlements such as the Pradhan Mantri Garib Kalyan Anna Yojana (PM-GKAY) providing an additional quota of food free-of-cost to beneficiary households, and so on.

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However, many of these large-scale efforts were supply-driven and templatised in nature and did not adequately account for the varied realities and circumstances that negatively affect certain communities' ability to access or receive healthcare services and ensure social protection.

Community-based organisations (CBOs) and non-governmental organisations (NGOs) work directly with marginalised communities, understand the local context, are privy to the special challenges these groups face in service access, and often serve to amplify their voice in corridors of decision making. They often liaise with local governments in their interventions. During the pandemic they brought to attention gaps in service delivery and barriers faced by vulnerable women towards enabling an efficient and inclusive COVID-19 service responses.

As a collaboration of ground level implementers and working closely with several state and local governments on COVID-19 interventions, CAC too had immense experiences in reaching services to the excluded and most vulnerable groups (Figure 1).

Drawing on these experiences, this report highlights the barriers faced by vulnerable groups, and then shows a way for civil society partners (CSOs) including the private sector, non-governmental organisations (NGOs) and community-based organisations (CBOs), to coalesce and unfurl the value of government services and ensure last-mile delivery. Such learning can lead to programme and policy shifts as required, for future pandemics and development initiatives.
Figure 1: Geographic Spread of CAC Interventions (as on March 2022)
2. Vulnerable groups and their barriers

Vulnerable populations often face barriers and challenges that are countenanced, and need to be overcome in order to access measures of service delivery. For instance, PLHIV access antiretroviral medication (ART) and counselling at ART centres. Mobility restrictions imposed during the pandemic were a barrier to medication access in its usual manner. Stigmatisation prevented many TGNB from accessing healthcare facilities, and created a hesitancy to access vaccination. Time and location of vaccination services were often deterrents to urban poor, street vendors, who could not afford a break to their livelihoods, and many elderly and persons with disabilities could not physically reach these centres. CAC in its COVID-19 intervention reached out to a number of such groups to enable their inclusion in COVID-19 services (Figure 2).

Figure 2: Some vulnerable groups covered in the CAC intervention

This section shares a framework of barriers faced by “unreached” communities on which the contextual guidelines are drawn. The framework, developed by Swasti on “Reaching the Unreached” for its learning4impact initiative guides the exploration of barriers related to specific groups while planning for their outreach and has been adapted for COVID-19 related intervention (Figure 3).
The framework of barriers to health, social protection and livelihood services for excluded and vulnerable communities cover six barrier types:

- **Material barriers** - Limited mobility on account of lockdowns, poor transportation services and/or poor road conditions for distant facilities and inaccessible infrastructure constrict access to service providers. Technological challenges through limited access to or knowledge of the use of mobile phones and the internet inhibit reach to initiatives with large technology components - such as CoWin for vaccination registration, or telehealth.

- **Financial barriers** - Inadequate economic resources as well as convivial support structures prevent the poor in general, and specific sub-categories such as women, PwDs and elderly to access services critical to their wellbeing. Material barriers intersect to further magnify affordability constraints by adding to the opportunity cost of accessing services.

- **Social barriers** - Linguistic, cultural and social norms barriers, exacerbated by low levels of educational attainment among marginalised women, restrict access to and the acceptability of services offered.

- **Systemic barriers** - Persistent and disproportionate poverty and displacement, co-existing with historic and systematic exclusion from policy making and service design, create barriers for intended beneficiaries. The design of service delivery, usually a top-down bureaucratic process, is unable to accommodate the varying and disparate needs of diverse constituents.

- **Knowledge barriers** - Insufficient awareness about available entitlements, a general distrust of services/service delivery mechanisms, lack of digital literacy and communication barriers restrict service access.

- **Institutional barriers** - The institution’s limited ability to understand and respond to divergent interests, hampered further by under-staffing, the lack of sensitisation among personnel and stigmatisation keep vulnerable communities at bay.
Figure 3: Barriers to health, livelihoods and social protection faced by some vulnerable groups

**Material Barriers**
- **Urban Poor (UP):** Risks from insecure and unsanitary housing are compounded by poor health service access outside registered slums.
- **Persons with Disability (PWD):** Inaccessible infrastructure and transport links make accessing health services a challenge.

**Social Barriers**
- **LGBTQ:** Homophobia and judgement from community and providers make health-seeking difficult.
- **UP:** Particular sub-groups, like the homeless, face discrimination when accessing services.
- **PWD:** PWD’s are often hidden or stigmatised by communities and providers, and their health remains untreated.

**Financial Barriers**
- **LGBTQ:** Not enough is known about the financial situation, beyond the trans community.
- **UP:** Unable to pay out-of-pocket or forego daily wages, the urban poor avoid or delay health-seeking.
- **PWD:** Located mainly in rural areas, the ‘earnings handicap’ and ‘literacy gap’ leave disabled people unable to pay for care.

**Systemic Barriers**
- **LGBTQ:** Discrimination still being recent, the discrimination faced is extreme, particularly for visibly minority populations like trans people.
- **UP:** The invisibility of the urban poor, especially those in insecure housing, makes their disadvantage persistent access restrictions.
- **PWD:** Diverse PWD perspectives are left out while designing institutions and services, which combined with discrimination, effectively exclude the group.

**Institutional Barriers**
- **LGBTQ:** Ignorance and discrimination of health professionals about this group leads to poor treatment, and even violence, faced by the group.
- **UP:** Identification requirements, need for financial and digital literacy, and the organisation of health facilities tend to exclude this group.
- **PWD:** The ‘40%’ benchmark for disability and un-sensitised providers combine to shut out most disabled people from supportive services.

**Knowledge Barriers**
- **UP:** Low awareness of rights and related low ability to advocate for services and social protection keep them away from health services.
- **PWD:** Social isolation, communication barriers, and poor community knowledge about disability keep disabled people from knowing their rights.
Contextual Guidance
3. Contextual Guidance

CoE draws from the experience of CAC in ensuring inclusive service delivery to vulnerable communities, especially women from marginalised communities including persons living with HIV (PLHIV), transgender and non-binary persons (TGNB), factory workers, unorganised labourers and migrant workers.

The CAC partners have supported vulnerable people on multiple fronts to enable them to tide the COVID-19 waves. This includes raising awareness on COVID-19 and its protection protocols, providing food, medication and health material and equipment, conducting NCD screening and vaccination camps, implementing telehealth initiatives, enabling access to social protection schemes and supporting vulnerable women to earn money when income flows had reduced or ceased altogether.

The contextual guidelines highlight some of the “complementary” and “supplementary” aspects required when helping vulnerable women respond to crises. They stress key approaches for inclusion and equity.

3.1 People-centred approach for vulnerable groups

The Challenge: The response to the COVID-19 pandemic was largely medicalized. However, this was neither fully relevant nor appropriate for vulnerable populations (especially women) who had different needs and barriers to navigate in access to services. While the focus was on response and mitigation, there were insufficient efforts even beyond the waves on recovery, and preparedness.

The Solution: A comprehensive people-centred framework that highlights intervention areas based on what is signalled from the ground, particularly during the response period and to a certain extent recovery period (which is ongoing). The framework for action will need to include besides the medical or health approach, food, livelihood and social protection. Exemplars in Global Health highlights this aspect. The people-centred approach also implies that the framework elements are customised to special needs of groups while planning interventions, as appropriate.
Figure 4: Building a COVID-19 framework with people at the centre

Key Considerations:

1. For every intervention, rapid consultation with local communities on aspects and barriers to access. Refer to Box 1 for examples of work
2. Adopting a district as a unit of action approach will lend to furthering a comprehensive approach and integrative action
BOX 1: Community consultations show the way

- Access to ART was one of the challenges identified by PLHIV groups. Since access was constrained due to the mobility restrictions imposed by the lockdown and aftermath, doorstep delivery of ART medicines was facilitated with the support of ART staff and the PLHIV community.

- COVID-19 workplace initiatives were developed in collaboration with factory leadership and management teams. These included awareness of beneficial social protection schemes, such as Employers’ State Insurance Corporation (ESIC) schemes, employee health benefits, NCD screening and medical counselling, and helplines to connect factory workers with nurses who could provide them with COVID-19 and general health support.

- Awareness building and education activities on COVID-19 in the community were implemented after consultations with local governments and community groups. These included safety practices of hand hygiene, masking, social distancing, and respiratory etiquette; COVID-19 symptoms; care and protection on testing positive, including home quarantine. These activities were conducted through a combination of home visits and outreach activities, such as WhatsApp campaigns, social media, signage, etc.

- Reaching out to community based organisations of women in sex work like Swati Mahila Sangha (SMS) and NGO Arogya Deepa helped identify, plan and deliver services such as screening, and addressing of cases of COVID-19, guiding women to register for vaccinations, conducting symptom screening, referring community members to vaccination centres (particularly elderly women), health care facilities, and quarantine centres, and delivering support packages that may include food, medicine, Personal Protection Equipment (PPE), sanitation supplies, etc. More than 3 crore (30 million) SMS and NGO Arogya Deepa as a means to render support to the women and their families.

- Training leaders of CBOs of women in sex work, transgender persons and gay men on health, social protection, and livelihood. These leaders then took on the task of creating awareness among the community members through house visits, one-on-one interactions, group meetings and camps. They also coordinated with the local Primary Health Centres (PHCs) to organise health camps to screen community members for NCDs.

- Operating a telehealth initiative, named Call4Swasth, which is an integrated digital platform with hyper-localised, community-led, cost-effective helplines run by trained nurses, nurse-aide-callers, frontline community counsellors, and social protection officers. The tele-care solution provided holistic support that included COVID-19 screening for symptoms and management, virtual consultation with a nurse/doctor, information on vaccination, and on government social protection schemes and depression, trauma, and anxiety management. The initiative has reached more than 1,20,000 factory workers, urban slum dwellers, rural poor, sex workers, and transgender people.

- Training on mask production for women and trans persons whose income flows were disrupted due to lockdown and mobility restrictions, to enable them to have alternative means for their subsistence requirements.
3.2 Collaborative Action

**The Challenge:** COVID-19 is a large-scale and complex catastrophe and no single organisation can mount a response at scale, on time, and with quality. Due to the size of India's population and the socio-cultural and financial diversity that exists, it is difficult to craft an overarching approach when it comes to health equity. Large differences also exist between urban and rural areas in terms of digital and overall literacy that pose further challenges to disseminating accurate information.

**The Solution:** The diversity of India's population calls for collaborative action that addresses the multifaceted nature of a health problem. Receiving an array of multidimensional inputs and engagements - for information, resources, and action - will ensure that the action is a direct result of the community's needs while also being supported by clinical data. Examples of large collaborations that have achieved tremendous results include CAC, National Coalition of CSOs, Creative Dignity, National Association of Social Entrepreneurs, Rapid Rural Community Response to COVID. Refer to the report from the World Economic Forum on how collaboratives serve as the last-mile response in a pandemic and how their work is significant beyond the immediate crisis to build resilience and drive transformative change towards an inclusive economy. The Bridgespan report further highlights a critical aspect of a successful coordinated response, namely - coordinated financing.

Figure 5 - COVIDActionCollab Strategic Framework
The framework in Figure 5 illustrates the CAC collaborative approach, with the people-centric core. Multi-disciplinary partners are capacitated, connected with each other to leverage assets towards effective community interventions, by receiving and/or providing training, technical support and financing. Services are calibrated to the needs of the communities they serve. Collaborative partners offer solutions and learnings that improve the effectiveness of others’ interventions. New innovative solutions for more complex and intractable problems are designed, tested and scaled through the partnership. Together this collaborative machinery lends to outcomes at the community, institutional and ecosystem levels that build resilience for the sustained well-being of the vulnerable communities during the COVID-19 pandemic.

Key Considerations:

1. **Architect collective impact**
   - ✓ Focus on people - Not virus, sectors, components, money; Engage affected communities
   - ✓ Create multi-disciplinary design platform AND high impact implementation teams
   - ✓ Support partner initiatives AND promote key, well designed initiatives for partners to engage

2. **Orchestrate resources and initiatives**
   - ✓ Raise and shape significant resources, channel to the right priorities, communities and partners
   - ✓ Create a dynamic engagement platform where partner ‘gives’ and ‘takes’ are expressed and connected
   - ✓ Head on address reasons for non-collaboration (money, logos, egos, credit...)

3. **Act with urgency and agility**
   - ✓ Have bias and focus grounded and decentralised action and coordination
   - ✓ VUCA (volatility, uncertainty, complexity, and ambiguity) proof your actions; constantly listening, analysing, accelerating, pivoting, dropping - based on realities.
   - ✓ Measure the right things. Celebrate successes, Acknowledge and learn from failures

4. **Create/recognise spaces for integrative action and promote decision making and resourcing powers. Eg. empowering state and district units for crisis response**

5. **Include civil society and private sector representation in key multi-stakeholder coordination and governance mechanisms**

6. **Use already created partnerships and alliances to prioritise the agenda of the crises, then create new alliances towards scale and gap filling**
3.3 Response and Recovery

Response and recovery are critical during the crisis period. This includes prevention of infection, disease and death. This section nuances adaptations of COVID-19 response in the areas of (a) awareness, (b) vaccination, (c) treatment, and, (d) mitigation.

A. Awareness and information:

The Challenge: As a first of its kind in living memory, there were numerous gaps/misinformation/fear/stigma associated with the COVID-19 pandemic that had to be countered. Given the scale and nature of the pandemic it was necessary that government-issued guidelines on COVID-19 preventive and control measures reach all vulnerable people, with due considerations of the diversity of language and culture and access barriers. This information also had to rebut the numerous myths and misconceptions being aired and shared, that prevented vulnerable people from accessing critical services.

The Solution: Rapid dissemination of available guidelines among all population sub-groups in an easily accessible and comprehensible manner. Packaging information in the local language using both the digital infrastructure (interactive telecare services, including interactive voice response systems) as well as using community champions, religious leaders and peer groups.

Box 2: Different needs, different feeds:

Hesitancy to vaccination was addressed based on differing factors for different groups. For instance, for TGNB information around interaction of vaccines with alcohol and hormone replacement therapy was dispensed. Among persons with comorbidities, including PLHIV, fears related to vaccination exacerbating their existing health conditions, were addressed. Many elderly and persons with disability received the jab at their doorstep. Dissemination of tools and resources to grassroots and partners is also being done through CAC Newsletters. Moreover, CACs Knowledge Repository has a wealth of information for partner’s reference.

For adolescents technology paved the way for information sharing: Chatbot Yuwaah (https://wa.me/918071279671?text=Hello%20Swasti)
Key Considerations:

1. Invest in custom made awareness material with appropriate language, graphics and communication channels
2. Invest in building capacities of channel partners
3. Take testing to the communities and mobilise through community champions. Testing should be easily accessible, rapid turn around for results and non-stigmatizing
4. Enhance digital penetration, efficiency and effectiveness by using appropriate design, language and format like youth friendly chatbot
5. Enhance frontline worker’s resources with digital resources for uptake
6. Leverage digital tools for reminders, awareness etc for other conditions like non-communicable diseases, and seasonal afflictions like dengue etc.
B. Vaccination

The Challenge: While vaccines became available in a phased manner to the general public, beginning with high-risk populations, impediments towards attaining full coverage, particularly in remote locations and among vulnerable populations such as PwDs, unorganised workers remained. Perceived opportunity costs of immunisation due to fear of side-effects, even short-term, was a limiting factor, as was fear of stigma by the healthcare staff. Myths and misconception on the health impact of vaccines for those taking ART, HRT and pregnant women were also barriers.

The Solution: Centre the response based on the distinct factors for vaccine hesitancies of specific groups. Awareness campaigns (digital/in-person) to counter myths and fears associated with the vaccine, ensuring service availability at or closer to home (for PwDs) or at workplaces (for factory workers) mobility impediments and introducing flexible delivery timings to enable working class populations to avail services during off-duty hours.

Image 1. Frontline worker taking the blood pressure of patient at CAC organised vaccination camp (VaxNow Initiative)
Key Considerations:

1. Collaborate closely with local administrations and CSOs to identify appropriate locations and times for special camps
2. Help the government identify and fill gaps to increase uptakes on vaccinations - ex. Vaccines available, shortage of syringes
3. Layer vaccination campaigns with need-based support like food ration, health check-ups etc.
4. Ensure availability of doctors and counsellors to answer queries or address fears
5. Mobilised resources from the private sector and philanthropic donors for community outreach to spread awareness and bring people to vaccination centres or take vaccines to doorstep
6. Use the opportunity of people lining up for taking the jab to collect data or disseminate information
7. Use vaccine credentialing for other critical services like childhood immunisation, Antiretroviral therapy, etc

Box 3: VaxNow - A Big Shot

The VaxNow initiative, launched by CAC, is a response effort to the issue of vaccine inequity in India. The initiative is a solution to the last-mile delivery challenges that blocked vaccine access and equity for vulnerable communities through targeted domestic distribution and harnessing public, private and community partnerships.

Since its inception in October 2021 till the VaxNow initiative has enabled more than 6.5 million jabs across 24 states and union territories, for vulnerable communities including transgender persons, sex workers, migrant workers, people with disabilities, informal workers and street vendors, among others with the help of the partner network and in collaboration with local governments (Figure 1).

VaxNow continues to ensure that there is a continued focus on vaccinating the vulnerable communities. The supply and demand barriers are many, including limited last-mile delivery capacity, physical access barriers due to infrastructure, distance or the timing of the centres, high opportunity costs for daily wage earners, vaccine hesitancy, misinformation on vaccine redundancy with the pandemic ending, etc.

The initiative works on these demand and supply sides constraints. CAC works with the local administration to spread information on availability of vaccines and sets up camps for special groups as needed. Even though vaccines are given free of cost at government facilities, there is a
cost associated with improving awareness, generating demand and mobilising and supporting communities to reach vaccine sites, or taking vaccination to the door step through mobile interventions. These costs are raised from private institutions. Hesitancy on account of myths and misconceptions, where possible, is addressed through awareness drives, community champions and influencers.

Images 2 & 3. Frontline workers taking the COVID-19 vaccine to a person with disability and a woman worker
C. Treatment

**The Challenge**: Access to in-patient care for severe/moderate COVID-19 cases was marred by affordability constraints and limited resource availability - including facilities, and beds with ventilators and oxygen supplies. In rural and remote geographies, service delivery was even more scarce, with numerous patients receiving insufficient care or avoiding treatment altogether. For mildly symptomatic and asymptomatic cases, there was little clarity on home quarantine norms and care requirements. Avoidance of reporting was also observed, driven by fears of forced institutionalisation in hospitals and CCCs, and consequent separation from families.

**The Solution**: A service delivery intervention that covers awareness, infrastructure provision and medical support to vulnerable communities to receive self/home care, community care and institutional care, based on the severity of the infection.

Examples of customised service delivery:
- **Call4Swasth** and short and long-term considerations for improved tele-care service delivery and adaptation. Home Quarantine COVID Care kits were provided to priority individuals who were either symptomatic or COVID-19 positive but are unable to isolate at home. These kits included the following: Digital thermometer, Necessary medicines - Paracetamol, Sporlac DC, Vitamin C, Emeset, ORS sachets, and Becozinc Disposable masks, Soaps (hand wash) and Disinfectant (liquid).

Key Considerations:

1. Establish a digital backbone with appropriate reach using a phygital (physical + digital) strategy;
2. Accelerate telehealth use among tech savvy frontline community personnel (health, non-health, youth);
3. Empower low-income families and communities through effective triage and information and material resources to dispense self testing care for asymptomatic and mildly symptomatic cases by providing at-home quarantine kits and protocols;
4. Enable linkages to institutional care, including transportation, based on perceived need;
5. Support for coping with the anxiety associated with COVID-19 and institutional treatment;
6. Provide oxygen concentrators and pulse oximeters to local NGOs and CBOs, including imparting trainings on their use;
7. Re-assess roles and task shift including community members;
8. Re-purpose trusted community institutions like neighbourhood schools for vaccinations;
9. Deploy mobile testing units to individuals lacking access to transportation, physical mobility, or physical proximity to testing centres (e.g., inhabitants of informal areas, the elderly and disabled, rural residents).
10. Develop a handbook on treatment protocols and supply use
11. Improve relationships between PHCs and the communities especially in urban areas
12. Sustain and improve tele-health facilities so it is embedded in the mental model of preventive and promotive care

Box 4: Ringing in good health

Call4Svasth is an integrated digital platform with hyper-localised, community-led, and cost-effective helplines run by trained nurses, nurse-aide-callers, front-line counsellors, and social protection officers, built by Swasti and partners of CAC. This telecare platform hosts multiple community-led integrated programmes that use the telephonic model to address physical, emotional, and social determinants of health.

The programme includes services such as awareness about COVID-19, risk assessment, counselling services, vaccination onboarding and registration support, facilitation of government social protection schemes along with the provision of care materials for safe home quarantine, COVID-19 care management at home, and testing services to address the needs to vulnerable communities in a holistic manner.

The initiative has reached more than 1,20,000 factory workers, urban slum dwellers, rural poor, sex workers, and transgender people from October 2021.

*Image 4 & 5. Raising awareness for Call4Swasth through banners and home visits*
D. Mitigation

Surveillance - EWS (Environmental Water Surveillance)

The Challenge: Affordability and accessibility of COVID-19 tests makes it difficult for vulnerable communities to get tested and be aware of their medical status. Testing has entry barriers for the marginalised communities who are more susceptible to getting infected. These entry barriers include the high cost of Rapid Antigen Tests. The current public health surveillance system requires robust and comprehensive surveillance to address this inequity. It becomes a heavy burden on the health care system to conduct surveillance on the spread of COVID-19 due to lack of resources. Additionally, it would be a huge task to reach all people with different levels of digital literacy and education with how to access COVID-19 tests. Many people also do not exhibit high-functioning health-seeking behaviours because of economic and social barriers such as an unstable income source and stigma.

The Solution: Environmental surveillance of sewage systems and open sewage canals has the potential to represent a rapid and cost-effective method to support clinical surveillance, and can tap the areas and communities which are often missed due to lack/unavailability of resources, unaffordability. The surveillance system can detect symptomatic and asymptomatic cases within communities and serves as an early warning system to help identify and manage future COVID-19 outbreaks.

Box 5: Precision Pandemic Health Surveillance
Environmental Surveillance for SARS-CoV-2 in Bangalore, India

CAC launched the Precision Health platform which works on environmental (wastewater) surveillance and aims to support the local municipal governments of the city to understand the trends of new COVID infections.

Since April 2021 Swasti and its implementing partners have been conducting wastewater surveillance for SARS-CoV-2 in the city of Bangalore and supporting Bangalore’s Municipal Corporation, the Bruhat Bengaluru Mahanagara Palike (BBMP) in COVID-19 infection control and management by reporting early warning signals.

The Precision Pandemic Health Surveillance system in Bangalore regularly updates and communicates on the trends through public dashboards, social media and weekly reports shared with key city officials and administrators. As part of their learnings the platform is soon to release the playbook on how to conduct wastewater surveillance for COVID-19 in other cities and the same will be shared on their website.
The platform has been receiving prominence and was recently mentioned by [Exemplars in Global Health](#) as one of the BrightSpot for COVID response. The platform is further expanding the reach to replicate the initiative in 25 cities of the country across all the five regions in the next 2-3 years.

*Image 6 & 7. Collecting and testing wastewater samples for SARS-Cov-2*
Social protection

Image 8. Urban poor women in Bangalore participating in household budgeting exercise - Setting financial goals, managing savings and creating an emergency fund to be used in case of shocks.

**The Challenge:** Many marginalised women in India did not have social or financial safety nets to fall back upon during the period of the COVID-19 lockdowns. Efforts made by the government and other entities to curb both the health and economic impact of COVID-19 often did not, or could not account for the realities and circumstances that negatively impact urban poor communities’ ability to access services and ensure social protection.

**The Solution:** Accelerate activities to ensure that social protection benefits reach the most marginalised and hard to reach communities by actively involving district and local administrations, NGOs, CSOs, Panchayati Raj Institutions (PRIs) and frontline functionaries. Towards this CAC adapted Swsti’s social protection model where district level help desks are built as a one-stop shop for all needs to ensure social protection - raising awareness of eligible schemes, securing identification and other documentation, making applications and follow-up for receipt. It has set up 21 help desks spread across seven states that assist district administrators with SP facilitation.
Key Considerations:

1. Certain schemes have a window period. Build channels of communication to NGOs so that they can advocate for their use at the appropriate time.
2. Partner with CSOs to reach out to unreached vulnerable populations for awareness and access support.
3. Partner with local/district administrations to build ownership for long-term sustenance.
4. Strengthen awareness and build capacities of Panchayati Raj Institutions (PRIs) and front line workers on preventative safety measures.
5. Identify a resource pool of volunteers or champions to assist the government department in facilitating Social Protection.
6. Establish cluster-based resource centres to provide outreach for filling out government scheme applications, particularly for rural populations.

Box 6: Social Protection Facilitation in India with CAC partners

During COVID pandemic 1st April 2020 until June 2022, Social Protection as one of High Impact Intervention (HII) have been facilitated through CAC partners around 28 states and 2 Union Territories establishing 171 help desk and set up 21 help desk in district collectorate office consisting of various government line departments in the district, covering 7 states. The main objective to:

- To support the CAC partners in their efforts to address social protection (SP) needs of the communities across India. The planned interventions were on capacity development of local administrative and not-for-profit officials and extending technical support for:

Facilitation of COVID & Regular SP Schemes:

a. Awareness generation on COVID specific schemes and other existing government schemes
b. Facilitation of one or two COVID specific schemes

Accordingly, the engagement covered 28 states and 2 union territories to reach urban and rural communities, specifically the vulnerable populations. Over the reporting period the engagement has specifically included district departments of the government of States such as Health departments, Social Welfare department, Welfare of Differently abled persons Department, Food & Supplies Department, Revenue Department, Rural Development Department and Panchayati Raj Institutions. For the complete list of **CAC partners** who have been involved in
implementing and facilitating access to Social Protection schemes (as of June 2022), please refer to the link.

The program systems of CAC Partners were strengthened with new efforts towards improved access of the communities to schemes and benefits and built capacities on operational planning. A total of 595 cr. raised in the hands of vulnerable communities through SP schemes provided by Central and State Governments.

Support to Transgender community on Central Schemes

The pandemic unearthed deep-set inequities in accessing basic healthcare facilities. This was especially so in the case of the Transgender and Non-Binary (TGNB) community. A strained relationship with the healthcare system and exclusion from social protection schemes, caused by a lack of gender-sensitive treatment protocols, low health literacy among transgender women and hijra persons, poor healthcare-seeking behaviors, socioeconomic barriers, and lack of health insurance, has driven transgender people away from availing essential healthcare necessities during the pandemic, such as vaccines, hormonal treatments, HIV medication, and nutritious food.

In view of the economic transgressions of the pandemic and subsequent nation-wide lockdown, the Government of India declared financial aid packages for all vulnerable groups, including daily wage workers, construction workers, garment workers, and migrant workers. However, the transgender community, which constitutes a 4.88 lakh population (Census 2011), were left out.

Swasti identified this gap in inclusivity and approached the National Institute of Social Defense (NISD), Delhi for providing monetary 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 the transgender community. Each selected transgender person under this intervention received a direct bank transfer of Rs. 1,500, expected to last for around a month. This financial contribution could be used to buy groceries that provide essential nutrients, especially 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 have been staying at home for days together. It was difficult for us to live our lives. During this time, Rs. 1,500 was deposited to our account. It was quite helpful and we are happy for the money provided. We are thankful to all of them involved in helping us get these funds”.

Box 7: Their pulse on their people
Alka Tai works as a wellness facilitator for Disha Mahila Bahu-Uddeshya Sansthan. She lost her job as a maid. Although her employers provided her with one month’s salary, the other maids in her locality were not as lucky. So Alka Tai took it upon herself to mobilise and distribute free groceries and masks to 150 families, and help 400 families access ration from the PDS including 30 widows and 15 People Living with HIV (PLHIV). She has inspired other Wellness Facilitators at DMBS to go above and beyond in their own communities.

“There are many leaders in Jhopadpatti (slum), but none came forward to support vulnerable families during this crisis, except for Alka Tai.” - a neighbour

In Pune, Maharashtra the Navchetna Yuva Vikas Samsthe (NYVS), a community organisation in rural Maharashtra is run by its 1,100 members who belong to MSM (Men who have sex with men) and Trans Communities. Their district faced a dire shortage of essential supplies in the pandemic. They held collection drives, collaborated with NGOs across the country (ex: Lions’ Club) and even made personal donations to procure and distribute food and groceries to the disadvantaged. NYVS distributed groceries and essential supplies to 2,000 people in the district. They continue to facilitate schemes for BPL.

Members of NYVS (MSM & TG), albeit marginalised in the Indian context, are demonstrating exemplary leadership to demonstrate that “Humanity is above all in this world.”
Economic Resilience

**The Challenge:** Poor and vulnerable households have been severely impacted by the pandemic due to factors like blocked income sources, loss of their breadwinner, and additional caregiving responsibilities.

**The Solution:** Building resilience means restoring a sense of hope and power in the hands of communities. Four key approaches i.e. Conservation, Diversification, Aggregation, and Risk Pooling (CDAR). Using this framework coupled with culture-building initiatives we hope to deepen community perspectives on resilience. Vulnerable communities need to be identified before future shocks.

Key Considerations:
1. Short term payment moratoriums in non-banking financial companies
2. Identify low income and informal localities to identify areas in most need of vital healthcare/testing, hygiene, food, and other supply relief to optimise distribution of emergency supplies
3. Collaborate with private sector to meet emergency labour demands by connecting unemployed, low-wage workers with high-demand logistics, manufacturing, agricultural, and other critical industry short-term employment opportunities
4. Work with informal worker associations and local trade unions to build-out formalisation plans to incorporate businesses and workers under societal protections, and provide input to help informal sector actors operate more efficiently and productively
5. Sustain health education and mainstream within public and popular media channels to familiarise the public with health crisis protocols
6. Expand public health and pandemic awareness via education systems, job trainings, televised advertisements, and other means, to instil public confidence in government and public health officials

Box 8: Resilient communities, empowered communities

CAC is implementing an economic resilience initiative to work with communities to explore available resources at community and household levels, and make a plan for conserving resources in order to reduce expenditure and amplify value. The initiative also looks at income diversification - including accessing relevant social protection schemes - as a means to reduce risk. Areas that have the potential for aggregation, and can result in risk pooling are explored, such as land, produce, people's institutions like self-help groups and farmer producer organisations. Such actions reap better rates from the market, and community-managed emergency funds. The economic resilience pilot is initiated in Karnataka, Madhya Pradesh, and Odisha with farmers, tribal youth, and artisanal fisherfolk, with approximately 2,000 households in each location in January 2022.
Images 11 & 12. Building resilience: Fisherwomen engaged in resilience planning exercises (left) and entrepreneurship management training by CAC partners (right)
Box 9: the cash counter

Cash was short during the lockdown. Determined women from Business Acceleration Units (BAUs) in Nallapareddy palli village, Bagepalli, in the Indian state of Karnataka provided financial services through a cash exchange facility. Srilakshmi alone serves 12 to 15 people everyday, benefitting over 100 family members spread across 10+ villages.

Image 13: Srilakshmi, a Business Correspondents Agent, providing financial services in the form of cash exchange to members from the community.
Key takeaways and concluding remarks

The COVID-19 pandemic hit the whole country hard but the vulnerable and marginalised communities were disproportionately impacted. These groups who face alienation on a regular basis on account of their marginalised status were further pushed into the periphery of society as they faced nuanced and intersectional barriers in access to essential services to tide over the detrimental effects of the pandemic. To address these barriers ADB CoE aimed to understand the barriers and challenges that are preventing communities from applying COVID-19 appropriate behaviour, and accessing and utilising services, especially COVID-19 vaccination. ADB CoE dissected these barriers that are categorised as material, financial, social, systemic, knowledge, and institutional in nature.

A largely medicalised COVID-19 response does not account for or benefit vulnerable groups who must overcome multiple barriers as mentioned above - this learning led to the ADB CoE building a COVID-19 framework with people at the centre. This framework for action includes food, livelihood and social protection interventions to ensure vulnerable groups achieve true resilience and access healthcare services. The people-centered approach also advocates consultation with target communities when planning interventions, to develop effective and customised solutions.

Progress report-1 "Lending Ear, Giving Voice, Gaining Heart"- Compilation of Case Studies” shared learnings that served as a broad guide giving insights on the ins and outs of collaboration to other collaborators, organisations working with vulnerable groups and women, and those responding to humanitarian crises. It was found that the way forward with relation to COVID-19 response for the most vulnerable groups is for collaboratives, civil societies and districts to leverage the width and depth of its experience in the pandemic response, its recently widened partner base, and the knowledge and training assets built. Lessons from this report gave valuable insights and points for further inquiry from which this progress report 2 on contextual guidelines was developed. This report highlights a few important lessons.

Since marginalised communities and women face multi-layered and multi-faceted barriers to health and other services, there is a greater urgency to ensure that their needs - on health, food, social protection, and livelihoods - are met in a large-scale pandemic like COVID-19. Gender and equity barriers and challenges persist throughout all stages of humanitarian response, and as a result, constant attention to the changing ground realities and listening posts can provide comprehensive insights for support.

Material and infrastructure provision is relatively simple because many delivery channels already exist and the resource flow - human, material, and financial - expands in a humanitarian crisis situation. As a way to open up opportunities for development in non-pandemic times, the focus should be on stigma reduction and community agency and trust in government services.

With regards to the response and ongoing recovery during the pandemic, there are overlapping aspects of targeting awareness, delivering vaccinations, and treatment which are vital to success.
While a fast response is preferred, it must simultaneously be easily accessible and comprehensible so as to reach the marginalised communities. These goals can be more attainable by taking advantage of digital infrastructure and community authorities whom the people have built trust with. Additionally, it is important that services are flexible especially when it comes to daily wage workers’ hours so as to reduce the opportunity cost of earning over taking care of their health.

While these communities are being delivered these resources, the overall situation should also be mitigated using multiple methods. The total infection rates also need to be kept in check with a rapid, cost-effective method such as EWS systems that can reach unreachable populations. Furthermore, people are informed on benefiting from social protection schemes which they are eligible for but did not have information on previously. Similar to COVID’s response, the knowledge shared on SP should be accessible, easily understandable and transparent. Last but not least, in times of suffering, a sense of hope must be restored to build resilience. Although, moving forward, these communities should be identified beforehand and shielded to avoid future shocks.

The government is best placed in mounting a standard response, however they cannot cater to specific needs of different groups. This is where the government must reach out to CSOs and NGOs, who know the pulse of the community can facilitate a targeted response. A specific guidance note for NGOs/CBO’s that are providing COVID-19 response services and solutions to vulnerable populations has been developed, based on Swasti’s on-the-ground experience and learnings from Progress Report 1.

The private sector also has an important role to play in filling the resource gap and sharing efficient procurement, delivery models as required. E.g. The private sector is able to provide the resources needed to spread awareness and bring people to vaccination centres or take vaccines to doorstep. In all, only a collaborative approach can truly produce a response that reaches the un reached. As an example, we found that collaboration with the private sector is an effective way to meet emergency labour demands; by connecting unemployed, low-wage workers with high-demand logistics, manufacturing, agricultural, and other critical industry short-term employment opportunities. In essence, collaboration ensures a more diverse look at the multi-faceted nature of the issues while also having access to a larger pool of resources to address the problems.

Scale is impossible without technology, and digital literacy, particularly for women, must be emphasised in order to achieve inclusive development. The government can provide ICT infrastructure, hardware, and software (such as CoWIN), but NGOs are best placed to build specialised apps (such as Call4Swasth), grow capacities, and encourage the use of digital services. Some of these lessons, will be provided in the next report on training and capacity building workshops organised with external partners. It will add to the repository of training guidelines and materials that can be replicated and scaled across Indian cities.
Contextual Guidelines Note:

This note offers guidelines to community-based organisations (CBOs) and non-governmental organisations (NGOs) on providing COVID-19 response services to underserved and marginalised groups such as TGNB, sex workers, migrant workers, marginalised women, or PLHIV, who face distinctive challenges both in and out of the COVID-19 context and whose unique circumstances and challenges must be taken into account when implementing COVID-19 interventions and services.

Guidelines for CBOs/NGOs on providing Inclusive COVID-19 Sensitisation Response Services for Vulnerable and Marginalised Communities

Contextual guidelines reflect and relate to a particular context. In the case of this document, the context is the characteristics and challenges unique to specific, marginalised communities. Guidelines created for a general (but heterogeneous) population may fail to account for the diverse and often complex circumstances of certain subsets of the population. Disability, socio-economic status, and societal conventions/stigma dictate the challenges that different communities face during public health emergencies. Guidelines that do not account for disadvantaged communities and their unique barriers fail to fulfil their purpose of boosting the population's resilience.

From Swasti’s on-ground experience, the following learnings emerged concerning the best and most effective responses to tackle the humanitarian crisis posed by COVID-19 for marginalised communities:

- A “one-size fits all” approach does not work. Community-centric and localised interventions and support must be a leading strategy, for which building an understanding of the context is essential.[1]
- The flow of resources (e.g., people, money and materials) must be directed where they are most required. This requires constant communication with community organisations and ongoing data collection and analysis, where available.
- A situation of a large-scale humanitarian crisis is that of extreme volatility, uncertainty, complexity and ambiguity (commonly referred to as VUCA), requiring constant attention to frequently changing ground scenarios for effective information management and coordination.

Based on these and other learnings, experiences, and experimentation on the ground, guidelines for planning and implementing inclusive and sensitised COVID-19 response services for marginalised communities are presented under the two segments of:

A. Access and quality of healthcare
B. Knowledge management and addressing information asymmetry

A. Access and quality of healthcare

To manage COVID-19 in the long run, the focus should be on prevention and mitigation, shielding the most vulnerable (elderly, children, those with comorbidities) from its effects, and providing humane, accessible, affordable and appropriate levels of care for those who are COVID-19 positive or showing symptoms of the virus, as well as those facing other healthcare needs. Each person, irrespective of caste, religion, socioeconomic status, gender identity and sexuality, has a fundamental right to high-quality healthcare services.

During COVID-19 the country’s health infrastructure and resources were ill-prepared to address the enormous health care needs posed by the pandemic. Most care provisions were diverted toward tackling the emergency, and medical care for “normal” medical problems was halted, increasing exclusion of women and trans persons. These guidelines on access to quality healthcare provide pointers on the additional services and precautions to take while providing health services to these marginalised groups.

1.1 Conduct vaccination camps for marginalised communities

Working to ensure that critical COVID-19 services like vaccination do not pass the vulnerable communities with a [blueprint designed by CAC for conducting COVID-19 vaccination drives for marginalised communities](#). Stakeholders set up pop-up vaccination drives, and CBOs facilitated the access to vaccines for the most marginalised. The pop-up vaccination drives were built up at locations frequently visited by community members. For a testimonial of how a TGNB community member received their vaccine, [click here](#).

Based on these learnings from organising vaccination camps, it is advised that in addition to the basic logistics, technical and medical attention care must be afforded to:

1. **Ensure the vaccination camps are strategically located at places frequented by community members.** For example, if community members often visit a CBO’s office, vaccines should be made available there. If factory workers are required to be vaccinated in order to continue working, the employer should organise a vaccination camp at the place of work. They should also provide paid time off in case a person needs to recover from side effects.

2. **Work with CBOs to spread awareness and help gain the community’s trust.** CBOs have the pulse on the community needs during the pandemic and due to past engagements, the community knows that their organisation has their welfare in mind. Communities are more likely to listen and follow directives on COVID-19 protocols, access to services and the importance of getting vaccinated when suggested by their own members and leaders. Community leaders can also guide the local administration and NGOs to organise special
health and vaccination camps located and scheduled to the community’s convenience and ensure privacy if required.

3. **Consider flexible camp timings** to ensure that services are available for groups for whom standard times are inconvenient. For instance, women engaged in sex work or begging prefer afternoon hours because they need the mornings to rest and to take care of domestic chores, especially if they work all night.

4. **Provide safe and respectful spaces for vulnerable community members to address their concerns.** Vaccination and health check-up camps should be kept small in order to avoid crowding and diversion of efforts towards non-target people. Additionally, TGNB, PLHIV, and women with disabilities have experience with discriminatory and stigmatising healthcare service provision and the health and outreach workers at the camps should be gender and context-sensitised and trained to provide holistic care (e.g.: gender-affirming care).

5. **Use mobile apps and mobile clinics to actively track, support and monitor those at risk.** Trusted community champions can help identify individuals for active screening and testing and subsequently mobile vans should be used for assessment, sample collection and testing, and vaccination of the vulnerable. Transportation was increasingly difficult during lockdown for the poor, which is why the use of mobile vans can take vaccination and medical care to the communities.

### 1.2 Co-locate NCD screening, regular health check-ups, counselling, and referrals with vaccination camps

The impact of COVID-19 on healthcare services exacerbated NCDs among marginalised communities. It was difficult to seek testing and medical care for conditions such as diabetes, high blood pressure, depression and anxiety. Some people reported refusal of care due to logistical and capacity constraints, resulting in an increased risk of severe morbidity or mortality from the virus.

Co-locating ancillary services like counselling, NCD and CD screening, regular health check-ups, and referrals at vaccination camps benefit marginalised communities who can address a number of different health concerns at one time and location. The NCD/CD screening setup must adhere to national guidelines (NHM, MoHFW, ICMR). Additionally, the following points can guide the centres/clinics (more in Section 2 of the annexure).

1. **Use vaccination camps as an opportunity to dispel vaccine hesitancy and educate the community on the proper healthcare requirements** for COVID-19 to address their concerns on vaccination effects regarding their health for HIV, hormone therapy and the associated medications.

2. **Make available specialised healthcare providers at the centre/camp** to cater to the specific needs of individuals with various types of healthcare concerns. This should include psychiatrists and psychologists for mental health; endocrinologists for TGNB undergoing HRT; gynaecologists and social workers for SRHR problems (e.g.: birth-control, STI testing
and treatment, pre-and ante-natal care), emergency medicine specialists for other medical problems (e.g: checking bumps, old wounds, etc.). Refer them for further care where necessary, and teach them how to integrate lifestyle changes that benefit their NCD (change in diet, exercise, etc.).

3. **Provide information** to those coming to the camp on the health and social security schemes available to them.

### 1.3 Provide sensitisation training to health and outreach workers

Women of marginalised groups, such as PLHIV and TGNB, encounter stigmatising and discriminatory behaviour by health workers at hospitals and clinics, as well as outreach workers. Such behaviour, whether intentional or unintentional, can be reduced through sensitisation training that focuses on community-specific health and psychosocial needs (especially for PLHIV and TGNB patients), and the intersectional oppressions faced by vulnerable and marginalised communities. Additionally, providers should be trained in COVID-19 vaccination and treatment delivery according to the specific needs of the communities for COVID-19 treatment, vaccination and other health-service uptake. TGNB community members reported that they have noticed an improvement in how they are treated at hospitals that have staff members that have undergone sensitisation training. To build a welcoming environment at healthcare service points:

1. **Ensure that caregivers are aware of norms** around respecting the names and pronouns of TGNB individuals. Recognition of their strong association with their “Gharana” can help caregivers appreciate the gender behaviour, expressions, attitudes and emotions of the TGNB community (COVID Vaccination Playbook, 2021) (Watch: [How to address a transgender person respectfully](#)).

2. **Develop tools and protocols** so that providers can address issues of TGNB individuals, such as the non-availability of IDs and visual and name differences between IDs.

3. **Ensure the training covers caregiving for the additional health needs** a member of specific communities may have when they come to the sites and centres (e.g., gender-affirming care, care for HIV).

4. **Invite members/leaders of the marginalised communities** to be trained on caregiving for their community members so that they can then be integrated into any health activities to support their community.

5. **Ensure that sensitisation training during an emergency is provided in a hybrid learning environment** (offline and online lessons) so that caregivers can have an effective upward learning curve, with adequate hands-on training and easy-to-access learning material. Offline tasks need to be based on putting theories learned in online classes into practice under the guidance of senior health and outreach workers. Online lessons must provide knowledge and information. For training, use simple language so that individuals with no prior medical or outreach training can follow and understand the content.
Go here to access our COVID-19 self-learning modules designed for and used by Frontline Health Workers and Community Workers alike.

1.4 Ensure availability of equitable healthcare, medicines, and vaccines:

Ensuring equitable healthcare access, including general health services, SRH services, HIV treatment and medicines, COVID-19 vaccine, and mental health care for vulnerable women through outreach programmes is effective in the following manner:

1. Provide tests and medication free of cost, or at a subsidised rate in order to cater to the economically disadvantaged communities, e.g. those below the poverty line, having informal source of income, or incomplete identification documents.
2. Actively disseminate information on where the community can receive or purchase the medicines they need. To further support the community’s continued access to medicines for NCDs, map the Jana Aushadhi Kendras in the area and share their details with the community.
3. Ensure the provision of COVID-19 protection kits, either at vaccination camps, health centres, NGO and CBO offices, or provide these through at-home delivery.

1.5 Integrate mental wellbeing approaches within COVID-19 care

Psycho-social support is necessary to tackle psychological challenges (e.g. trauma, anxiety, depression, suicidal ideation) that marginalised individuals may face due to intersectional lived experiences of different levels of oppression (stigma, marginalisation, discrimination, violence etc.); and due to increased risk factors for poor mental health related to the pandemic, such as unemployment and financial uncertainty and fear relating to health of self and family. To integrate mental wellbeing within COVID-19 care:

1. Place mental health providers at health centres that provide multiple services (e.g. vaccination centres, general health check-ups and treatment centres, CBO offices etc.)
2. Ensure that counselling and therapy are available to marginalised community members through Tele-Health initiatives.

1.6 Ensure safe and affordable transportation to access healthcare services, including vaccination

Lockdowns and night curfews, intended to stop the spread of COVID-19, restricted mobility and completely stopped public transportation services, the lifeline for marginalised people to access health-care services and medicines (insulin, ART, HRT, etc.) Marginalised community members reported incidences of violent encounters with the police if they stepped out. If community
members did manage to get permission cards for movement, the cost of travel was an additional barrier as auto-rickshaws/tuk-tuks, cycle rickshaws, etc. were unaffordable for them. Moreover, communities in rural areas particularly faced difficulties accessing healthcare facilities. To overcome access barriers due to distance and transportation:

1. **Ensure that the centres set up for the purpose of COVID-19 services are reachable at the lowest possible cost.** This may involve looking at local transport solutions such as shared autos/tuk-tuks, cycle rickshaws, tempo traveller vehicles, etc. It may also require systems to make transportation available to the community. Towards this:
   1. Identify coordinators to plan and operate travel schedules, pick up and drop locations and timing suitable to the community.
   2. Share contact details of coordinators with the community representatives to ensure efficient communication.
   3. Book vaccine slots at preferred timings (pending availability) via the CoWin portal or the Aarogya Setu mobile app, which ensures that travel schedules can be accurately planned, and time taken away from work can be minimised or even eliminated.

2. **NGOs and CBOs to inform members of vulnerable communities on how to find affordable and safe transportation.** In case of situations such as lock downs or curfews, or the event of any violence or altercation, local government entities, democratic representatives (such as Members of the Legislative Assembly elected from the constituency), and police personnel might need to be involved. This involvement could look like the following:
   1. Special transport arrangements when public transport is unavailable.
   2. Involvement of police to address any possible untoward incidents of abuse and violence that vulnerable communities may encounter in transit.
   3. Heightened deployment of security personnel / liaising with police at the healthcare sites.

3. **Ensure that both the transport and health centre are accessible for people with disabilities.** If that is not possible, alternative arrangements need to be made - this may involve discussing with the Medical Officer at the vaccination centre to provide mobile vans or home visits.

4. **Initiate product design innovations for safe public and private transport.** For example, Swasti helped innovators design and mass-produce plastic shield separators between passengers and auto-rickshaw drivers in Bengaluru. Additionally, TGNB community members learned how to make their own masks.

Please find more information on Swasti’s efforts to ensure safe transportation to health institutions in the annexure ([Section 9](#)).

### 1.7 Support access to identification/permission cards
During lockdown, restrictions were put in place to stop the spread of COVID-19, and some of these restrictions limited mobility and completely stopped public transportation services. Without a permission card issued by the local administration, going out of the home during lockdown was difficult, if not near impossible. The inability to move around, especially to seek care or to get medicines, lead to strategic partners providing at-home medical visits and medicine delivery. This required them to have identification cards and/or permission cards. Many people were not able to obtain permission cards during lockdown because their need was not considered a priority. Not having ownership of these cards significantly contributed to the challenge of accessing health care.

Many marginalised groups also find themselves excluded from social schemes because they do not have the appropriate identification.

To ensure those reaching out to marginalised communities for health and other services are able to guarantee service delivery:

1. **Sensitise the police on** the need for mobility of social workers and marginalised groups and train them to be able to provide them support with healthcare needs access to or delivery of services.

2. **Assist marginalised communities in filing for documentation:** For instance, migrant women often lack the correct identification documents to be eligible for social protection schemes. The process for TGNB to obtain identification cards with their correct name and gender identity is difficult and many have a card with their “dead” name and wrong gender identity. Swasti has a social protection-based help-desk model which includes enabling vulnerable people to get documentation such as Aadhar, BPL cards, birth and death certificates, bank documents, etc. which are a prerequisite to applying for social protection schemes.

3. **Employers ensure that the migrant employees in their firm have access to all these documents** as and when required for their safe and unrestricted passage to their domicile.

### 1.8 Provide a hybrid, remote and on-ground care option

The interruption of primary healthcare services due to the reallocation of efforts and supplies towards COVID-19 relief and aid forced health centres, CBOs and NGOs to adopt different service delivery modalities. Tele-care has been one such adaptation.

**Tele-care is a hybrid (online, telephonic and physical) and remote care option via community actors.** It supports prevention efforts by ensuring that verified information and health services reach the last mile. Swasti’s tele-care model, Cali4Swasth is layered on trusted service providers and networks of the community. In addition to verified information, it helps monitor and support low-income families who have tested positive or are experiencing symptoms; provides at-home quarantine kits and protocols; provides support for coping with the current situation, anxiety and panic around COVID-19; helps ascertain whether the caller needs a teleconsultation or a doctor
visit for COVID-19; supports transportation to health facilities, if required; and, in the process, reduces the burden on existing healthcare facilities and streamline the process of health care consultations. All of this together helps contain COVID-19.

Tele-care is a solution so that the community can access healthcare easily, quickly and in an affordable manner. By picking up the phone and talking to a nurse, up to about 80% of the health issues faced by a household can be addressed and prescriptions availed. Call4Swast also provides emotional wellbeing services and information on social protection schemes.

Tele-Care is combined with on-ground community interventions by volunteers and community champions. The following six things should be remembered when setting up tele-care for marginalised communities:

a. **Prioritising**: It is essential to spend time understanding specific constraints of marginalised individuals and their families to tailor their access to health care services.

b. **Communication**: It is important to explain that tele-care is not an emergency line; clarify what the service can do, and not do; where and how the service is available; and what the community health entitlements are. Language skills are crucial for tele-care.

c. **Understanding**: Often, people have rational reasons and legitimate concerns for why they are not able to use certain services. It should not be assumed that they have a bad or difficult attitude. Their limitations may require exploring options for changing the way COVID-19 services are being provided.

d. **Counselling**: It is important to listen to people's problems, build a relationship of trust, and work with them to find solutions. Perceptive listening and empathy are at the core of an effective tele-care system.

e. **Persistence**: Changing behaviours is not easy. Poor and marginalised people may not perceive the immediate risks or gains, have other more important priorities, carry the baggage of past unpleasant experiences, or may find changes with respect to COVID appropriate behaviours difficult to make. This may require repeated visits and counselling to households before it is accepted, or its value understood.

f. **Coordinating**: For Tele-Care to be effective, coordination is an essential requirement. This means regular communication and bridging any gaps between ground teams, volunteers, networks and community institutions to get the individual/family the help they need.

**B. Knowledge management and addressing information asymmetry**

During each COVID-19 wave and lockdown there was a mass amount of information on social media and on the news, some of which was completely inaccurate and dangerous. Misinformation about how to treat the disease at home, the efficacy and safety of the vaccine increased the sense of panic among the communities and contributed to treatment and/or vaccine uptake hesitancy or avoidance. The timeliness and accuracy of knowledge dissemination on COVID-19 are critical factors in influencing people to act in an appropriate manner in response to the pandemic and its various shifts. A better understanding of COVID-19 health risks, safe health and hygiene practices,
workplace protections, and availability of COVID-19 response services and resources can lead to improved self-protection and significantly support transmission control. It is also important that health service providers, for whom the virus is also new, have the correct information to share with the people they come in contact with.

1.9 Design an information strategy considering the community context

The government and many agencies working with communities designed COVID-19 awareness and service delivery material (flyers, posters, WhatsApp messages, audio-visual messages, training material, etc). For engaging with specific marginalised groups, these products need to be adapted to their special socio-cultural context for better effectiveness. The knowledge dissemination strategies also need to amplify the voices of the community who have experienced COVID-19 (infection, recovery and vaccine).

Towards this:

1. Contextualise the product types to the audience it is for. That is, make sure that illiterate women receive audio-visual or well-designed posters with pictures rather than a flyer with text.
2. Adapt available products for specific communities through alterations in language, content and images. For instance, use the appropriate pronouns for TGNB groups, and show images of women in factory settings or street vending for factory workers or the informal workforce.
3. Identify a population-specific multimedia communications strategy for creating an informed discourse on COVID-19 appropriate behaviour. For instance, Swasti set up community radio stations, for example, Radio Active 90.4 MHz for the TGNB community-based in the Bengaluru suburbs. For easy understanding, information on hygiene and safe sexual health practices was disseminated in the local language.
4. Enable healthy employers-employee communication and accurate healthcare information with women workers. During times of crisis, open channels of communication and dialogue between all relevant parties, including workers and recruiters, are vital. Ensure the employer can be a credible source of information about nutrition, sanitation, COVID-19-related safeguards, social security and government notifications, etc., for women workers (more in section. 5.2 of the annexure).
5. Identify and involve community leaders (e.g., gurus/leaders of gharanas for transgender women, employers at factories, sarpanch, etc.) in these clusters, which would create awareness of health campaigns/government programmes at a grassroot level to ensure that information reaches many “hard-to-reach members through their networks and by word of mouth” (Reza-Paul et al., 2020, p. 105) (more in section. 5.3 of the annexure). Use pictures/videos of community leaders or influencers in communication products as appropriate.
6. Leverage social media (Instagram, Whatsapp, Facebook) for accurate information dissemination and debunking of myths. Use platforms such as Arist, which has courses about menstrual hygiene, water and sanitation hygiene (WASH) and COVID-19 care to name a few. Identify social influencers that are popular and trusted among the communities for disseminating vetted information through a targeted social media campaign, including - but not limited to - Instagram Live, Reels and Posts (e.g., Myth Busting session, Q&A with health specialists, Go shopping with me during COVID-19). Ensure each post has links to additional resources.

7. Place posters at locations that the target group often visit or pass by. Make information materials available at supermarkets, pharmacies, vaccination and quarantine centres, CBO and NGO offices and outreach centres, especially in locations frequented by the community members.

1.10 Bridge the digital gap faced by marginalised communities

Financially or socially disadvantaged, marginalised women are likely to have lower rates of digital illiteracy and are often reliant on their partners or male relatives for (smart) phone access. Due to the digital authentication mode for COVID-19 testing, vaccination, and contact tracing (through the Co-WIN and Aarogya Setu app) and other COVID-19 related information such as the live status of vaccination/testing centres, downloading vaccination certificates, and COVID-19 test results available online, women often find their lack of familiarity with technology and unequal access to digital devices a barrier in access to care. Low decision-making power coupled with gender norms restricting equitable access to technology has exacerbated the barriers that women face in accessing a rapidly evolving, unorthodox healthcare delivery system.

The digitalisation of India’s COVID-19 response has also added a layer of exclusion for senior citizens. Age-related health and cognitive challenges deter the elderly from easily adapting to ever-evolving digital technologies; they are ‘digital immigrants’. Senior citizens from rural areas and poor/marginalised communities also lack access to digital devices and internet connectivity. Thus, many older people could not navigate or benefit from the technological solutions to the pandemic.

However, the advent of Aarogya Setu and CoWin can incentivise digital illiterate groups such as marginalised women and the elderly to pick up digital skills. Male relatives may also be motivated to provide the women in households with digital devices. It provides an opportunity for greater investment in digital literacy programmes, as well as boosting digital access.

An increase in digital familiarity means that new digital health infrastructures then have the potential to make healthcare and critical health-related information more accessible. Current government guidelines do not address this digital exclusion. When dealing with future pandemics or other public health emergencies, government guidelines should account for and address the challenges faced by groups with no or low digital avenues and literacy in accessing interventions.
Box 2: Enabling digital literacy

The UN Development Programme (UNDP), in partnership with the Odisha State Government’s Department of Social Security & Empowerment of Persons with Disabilities Department (SSEPD), conducted a digital and financial literacy initiative that helped more than 20,000 senior citizens (including elderly with disabilities) become digitally literate in three Odisha districts during the pandemic. With the help of local volunteers and NGOs, the initiative departed digital skills through training sessions, including information on how to apply for government benefits and social protection schemes, how to access disability aids and old-age pensions, and how to communicate with loved ones through Whatsapp and social media [2].

Contextual guidelines should prescribe the promotion of digital literacy and accessibility amongst the elderly and marginalised women, including engendering their trust in digital technology and creating awareness of how the digital world can benefit them.

For instance, vaccination has been one service where these guidelines are important.

1. Assess the expected footfall and ensure the presence of an adequate number of supporters to register people on CoWIN quickly. A bulk of people are likely to arrive at the beginning of a vaccination camp (or there might be surges in people at a given time), so take care that more people are assigned to the registration at peak times so this service is not a bottleneck.

2. Include a team at registration and a few roving volunteers outside the venue registering people as they wait.

3. Ensure healthcare workers guide the women who might not have mobile phones or don’t know how to use one to check for OTP messages for Co-WIN authentication on the mobile device used for registration. They also need to ask the device owner to share any associated notes.

4. Ensure that visual material like posters and advertisements indicate the availability of vaccination certificates and COVID-19 test results on government-notified web portals.

5. Ensure that community-based testing results are disseminated to people with low digital literacy rates through simple channels, such as WhatsApp direct messaging. Moreover, ensure that the COVID-19 status is not made public since it may cause chaos and community isolation of the afflicted person.
Swasti conducted a survey with PLHIV and their care providers in 5 states of India to understand the experiences of disruptions while accessing and delivering ART and other SRH services during the pandemic and subsequent lockdown to gather insights for programming. The research findings are available through a video on COVID-19 & Sexual and Reproductive Health services for the HIV community in India.


Annexe