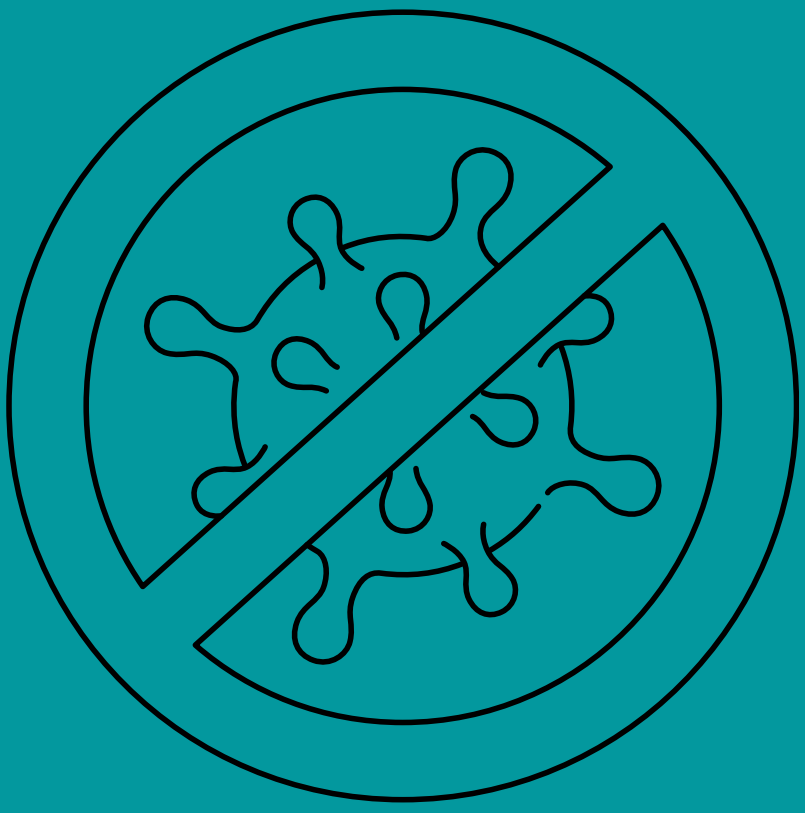

CENTRE FOR SOCIAL AND BEHAVIOUR CHANGE PRESENTS

SOCIAL NORMS SURROUNDING COVID-19 PROTECTIVE BEHAVIOURS

A TWO-PART STUDY EXPLORING SOCIAL NORMS AROUND PROTECTIVE BEHAVIOURS – A QUALITATIVE STUDY IN 2 LOW-INCOME URBAN SETTLEMENTS IN MUMBAI AND AN ONLINE SURVEY ACROSS DELHI, WEST BENGAL, TAMIL NADU, MAHARASHTRA

Centre for Social and Behaviour Change

TABLE OF CONTENTS

Centre for Social and Behaviour Change

SOCIAL NORMS PLAY AN INTEGRAL PART IN DETERMINING BEHAVIOUR

CONTEXT & OBJECTIVES

In the past, the world has witnessed a number of infectious disease pandemics. Some important ones are the Severe Acute Respiratory Syndrome (SARS), H1N1 Flu, and Spanish Flu pandemics because of their significant behavioural and economic impacts. The primary behavioural changes included increased adherence to the protective measures such as mask wearing, frequent hand washing, and social distancing (1). Economically, these pandemics had a greatly impacted the world's Gross Domestic Product (GDP) because, in order to reduce risk of infection, there was a decrease in domestic consumption of leisure activities, local and international transport, and tourism. For example, the SARS outbreak caused a 33 billion dollar reduction in our global GDP (2).

The impact of the current coronavirus disease (COVID-19) pandemic, both behaviourally and economically, has been unprecedented. COVID-19 emerged in humans in December of 2019, and is caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). This epidemic, which was centred in Wuhan, China spread to more than 114 countries within three months, leading the World Health Organization (WHO) to declare a global pandemic (3). As of September 2020, nearly 27 million people have been diagnosed with COVID-19, and more than 800,000 people have died across 216 countries, areas, or territories (4).

In India, the number of confirmed cases has risen to 2.65 million, making it the third most affected country in the world (5). This disease spreads primarily from person to person through small droplets from the nose and mouth, which are expelled when a person speaks, coughs, or sneezes. People can also contract the disease by touching surfaces that have been contaminated by infected persons (6). Therefore, in order to slow the spread of the virus, it has now become crucial for all people to wash their hands regularly, wear masks in public, and practice physical distancing.

The Government of India's (GoI's) first response to the pandemic was to impose a nationwide lockdown to restrict people's movement towards the end of March of 2020. This lockdown, which extended till June 2020, was supplemented by an emphasis on practicing protective behaviours such as handwashing and mask-wearing at the individual level. Due to the lockdown, these behaviours were adhered to by most people for several reasons including fear of government sanctions, and increased awareness and salience of the disease due to rigorous messaging (7).

There are, however, people who still do not adhere to protective behaviours. This lack of adherence can be attributed to both psychological and socioeconomic factors. Some psychological factors that influence adherence to protective behaviours are (i) optimism bias i.e. the tendency to believe that one is less likely than others to experience a negative event, which causes people to underestimate their likelihood of contracting COVID-19 (8); and (ii) low risk perceptions of the disease (9). Socioeconomic factors include (i) age - younger people believe they are not likely to contract the disease; and (ii) geography - those living in rural areas tend to follow the protective behaviours less (10).

Another reason for this lack of adherence is that following the necessary precautions requires a significant shift in behaviour, which is difficult to achieve through policies alone. These shifts can be facilitated by a number of behavioural mechanisms, including tapping into social norms. Social norms are typically defined as "rules and standards that are understood by members of a group, and that guide or constrain social behaviors without the force of law" (11).

Social norms can be leveraged in several ways. The first is by leveraging descriptive norms i.e. perceptions of which behaviours are typically performed (12). These perceptions are often incorrect, especially when it comes to health behaviours, as people tend to underestimate the prevalence of health-promoting behaviours such as handwashing, and overestimate the prevalence of unhealthy behaviours (13). Correcting such misconceptions can be achieved by reinforcing positive norms. However, this is only effective if positive behaviours are common. If they are not common, tapping into social norms can, in fact, have a negative effect. For example, managers of a national park in the U.S.A. found that most of its visitors were stealing from the park. In order to curb this behaviour, they put up signs saying "Your heritage is being vandalized everyday by theft losses of petrified wood of 14 tons a year, mostly a small piece at a time". Researchers conducted a study in this park and found that this sign actually ended up encouraging theft, as that was the

established norm. In contrast, when researchers put up signs which alienated thieves instead of normalizing the thievery, cases of theft went down by 1.67% (14). In the event that positive health behaviours are not widely practiced, like in the example given above, the second way that social norms can be leveraged is by tapping into injunctive norms i.e. perceptions of which behaviours are acceptable. For example, using messages such as "90% of people believe that everyone should wash their hands".

The impact of both descriptive and injunctive norms can be increased by leveraging peer effects, and emphasising which behaviours are being performed, and are considered acceptable, by an in-group i.e. an exclusive, typically small, group of people with a shared interest or identity. This can be done by motivating members of a community to hold each other accountable for adhering to positive health behaviours through reminders and respectful reprimands.

In order to further understand how social norms and peer effects play out in the context of increasing adherence to COVID-19 protective behaviours, we conducted qualitative research in two low-socioeconomic settlements in Mumbai to explore:

- Norms around practicing protective behaviours in times of COVID-19.
- Challenges in adhering to these behaviours
- Norms around reminding and reprimanding others to adhere to these behaviours.

Through deep reading of this data, common themes were identified and the findings are organized around the following key areas:

- Overall understanding and perception of COVID-19, new practices adopted by the community, and sources of information
- Behavioural barriers including information about awareness, non-complying groups, and reasons for refraining
- Behavioural facilitators including positive deviants, and existing community interventions,
- Norms around reminding and reprimanding in the community

RESEARCH DESIGN

STUDY AREA

Shivajinagar
Population: 6,00,000 (approx.)
Population Density: 36,923 per sq. km
Average monthly income: < INR 4,000

Dharavi
Population: 15,00,000 (approx.)
Population Density: 2,70,000 per sq. km
Average monthly income: < INR 500

SAMPLE

A total of 12 respondents responded to the vignettes. We had a mix of residents (n = 8) and front line workers (n = 4) to understand the dynamics and challenges at the individual/familial and community levels.

METHODOLOGY

The sample was recruited through key stakeholders working and/or living in the area. Due to restrictions on travel, data was collected through vignettes using telephone as the medium. Four Vignettes were designed around the four prescribed behaviours under COVID-19.

Three calls were conducted with the sample to mitigate respondent fatigue:
a. Call 1: For rapport building, consent, and getting a time slot for the IDI.
b. Call 2: Two vignettes out of Four
c. Call 3: Remaining two vignettes

The data underwent thematic analysis to draw the main insights using the deductive approach. The data from the field was organised in a thematically. Data under each of the themes was examined to identify common themes - behaviors, patterns, and ideas, that came up repeatedly. We looked out for some striking variance from these common themes. Themes used in the analysis were in lieu with the framework with a set of sub-themes for each of these.

OVERALL UNDERSTANDING AND PERCEPTION OF COVID-19

Interviews with respondents investigated how community members perceive the ongoing COVID-19 pandemic, their own susceptibility to the disease, the experiences in adhering to the protective behaviours, prevalent social norms around these behaviours, and challenges faced in the communities.

Analysis of the interviews revealed that while community members had high levels of awareness about COVID-19 and the pandemic. They received information from community health workers, social media, TV and radio news, government mandated caller tunes, etc. Respondents were aware of the symptoms related to COVID-19 and of most of the protective behaviours that had been mandated by the government. The relationship between spitting and the spread of the virus was not salient among respondents. Infrastructural barriers like lack of space and resources often hindered the practice of protective behaviours. Additionally, social norms regarding these new behaviours also impacted how they were being practiced in the communities.

Apart from concerns surrounding health, there were other factors impacting how the community conceptualized the pandemic, and hence their behaviour. Firstly, the economic impact of the lockdown had a tremendous influence on the community, as most of their sources of income were impacted. Secondly, existing gender norms influenced how individuals perceived risks of contracting the disease and thereby how likely they were to follow the protective behaviours.

In the following section, these overall conceptualizations of the respondents surrounding the COVID-19 pandemic, the lockdown, and its impact on the community are discussed in detail.

RISK PERCEPTION

REASONS FOR LOW RISK PERCEPTION

The community members had high awareness about COVID-19. Respondents including both community residents and community health workers reported high awareness of the disease, symptoms, and some of the protective behaviours. Respondents also reported that conversations around COVID-19 and its impact on the community were very common and that they had been part of such conversations in their neighborhoods and other social circles. Sources of information included word of mouth in the community, social media, and television and radio news.

"People are well aware of the relationship effect of handwashing and mask usage in limiting the spread of COVID-19. Sources of information are from news, tv, NGOs, caller tunes etc."

In spite of the general level of awareness regarding the disease being high, community members did not believe that they were vulnerable to contracting the disease, or that the disease itself could be fatal to them.

"Everyone has heard about it, but many don't realise how big a problem this is. Many people are living in denial, they say someone died due to pneumonia and people are labelling it to death due to Corona. Some feel they are strong and nothing will happen to them"

This belief was expressed with different reasonings. First, where there were no positive cases in the immediate community, many felt that they were safe and not at risk of contracting the disease. This idea that their community is safe also translated into not strictly following all protective behaviours while inside the community. The community members reported maximum usage of masks when people stepped out of the community, especially on the roads.

Secondly, past efforts by government and non-government bodies aimed at providing healthcare services in the community have had an impact on the nature of the community's perception of the risk of COVID-19. Since these low-income urban settlements anyway had poor public health indicators and have been plagued with other diseases in the past, many respondents do not feel especially threatened by the COVID-19 pandemic. They believe that since they have survived other diseases in the past, they will survive this too.

"People in the core slum area don't follow the rules. They think that they have survived other more serious diseases/conditions/situations and won't be affected by this."

ROLE OF ADMINISTRATION & COMMUNITY ORGANISATIONS

In the context of the COVID-19 pandemic, the existing trust in the government machinery has also had an impact on how community members avail of healthcare services.

Since community members did not think of the disease as being threatening to their lives, the steps taken by the government to enforce a lockdown was seen as unnecessary and excessive. Many felt that this step by the government was especially oppressive for poor people and conveyed a lack of consideration of their realities. Additionally, many members who were religious minorities felt especially betrayed by the enforcement of the lockdown and felt that they were being targeted.

"Poverty is a big issue and fear in the community. Most of the people are daily wage workers - no money to buy essentials, people are frustrated because they are confined to their homes. People are not taking COVID-19 seriously as they have not seen any case around them. The government is conspiring and this lockdown is a strategy against the poor and COVID-19 is a rumour.

The promises made by the administration in the times of COVID were not fulfilled(essentials, money, sanitisation kits etc.). No government volunteers came to aid the people in the community. All the responsibility is taken up by the NGOs/CBOs and community stakeholders."

Community members also did not trust government health services like hospitals through the pandemic. Many respondents believed that if they visited government hospitals, they were likely to get infected with the disease. Moreover, people were also less likely to report any symptoms that they might be facing in fear of being taken to hospitals. Lack of strict protocols by government service providers also led to diminishing trust in the system. While on one hand, respondents did not believe that they were at risk of contracting the disease by themselves, low trust in the government machinery did influence how they perceived the risk of contracting the disease from government healthcare services. Respondents reported that many were scared to report symptoms in fear of being harassed by government officials. Thus, the government machinery was seen to signify high risk of the disease.

"There was negligence by the health system and not they were not following the protocol for patients with COVID. Their immediate/family members were living with them. This is responsible for the distrust by the people."

ANTICIPATED ECONOMIC IMPACT

While respondents did not report community members being scared of the disease per se, there was a lot of fear about the economic impact of the lockdown on the livelihoods. Since many community members work on daily wages, the lockdown has impacted many livelihoods and put a stop to their income for months. This has led to people relying only on their savings to meet daily expenses. Additionally, many migrants who live in these communities have been forced to go back to their villages because of a lack of employment in the city. The main fear that respondents expressed that this lack of employment and cash flow could prove to be devastating to them in the long run.

This lack of income and high degree of stress regarding future income has shifted the attention of the community on planning their finances for the future instead of taking steps to protect themselves from COVID-19. In other words, the priority of the community is on preserving their savings, seeking out new sources of income, and minimizing present expenditure. There have been report of people lending money from informal units within the community on an exponentially high interest rate. In the midst of this, engaging in protective behaviours which may not have any immediate, visible payoff is seen to be unnecessary and often wasteful of time and resources. For example, spending money on water for handwashing is seen to be extravagant given the lack of resources in the community.

"Sanitizer can't be used because they can't afford it. Daily wage earners are more concerned with daily food. Access to water in some areas is okay, but in some places, they have to pay for water (50rs/100

liters), so they try to save water as much as possible. People are trying to save money for the future and hence not spending on water."

IMPACT OF PREVAILING GENDER NORMS

Existing social norms surrounding gender were seen to have a large impact on how individuals perceived their vulnerability to the virus. In other words, gender norms had influence on the perception of risk, and thereby impacted how an individual engaged in protective behaviours, and reminding and reprimanding of peers for non-compliance.

Norms surrounding masculinity influenced how likely men were to view themselves as being vulnerable to contracting the disease. As men are traditionally socialized into viewing themselves as strong and brave, they were also less likely to believe that they were at a serious risk or under serious threat of contracting COVID-19. This in turn, made men less likely to engage in protective behaviours.

"Young men tend to be discriminated against amongst their peers when they are wearing masks. They are called them weaklings, and as a result of this the young people who wear masks also tend to stop using them."

Additionally, there was a high degree of social disapproval of those who did engage in behaviours that indicated that they are taking the disease seriously or are taking steps to protect themselves against it. Many reported that those who did engage in behaviours like mask wearing or social distancing were labelled "weak" or "easily scared" by their peers.

Protective behaviours like social distancing, staying at home, and avoiding going out was also typically not practiced by men as staying at home during the day is seen as a woman's responsibility. Additionally, while respondents reported that men would go out for leisure or to meet their peers, women were more likely to go out for buying groceries and other chores for the house..

"There are crowds in the market place and women take children along as there is no one to take care of them at home. The men do not help women in these times too."

PRACTICING THE PROTECTIVE BEHAVIOURS

With the interviews in the two settlements it has surfaced that there are some behaviours that are practiced more than the others. Across both the study communities, it is evident that mask wearing was practiced more than any other protective behaviour. When reasoned with the respondents for this, it was clear that the masks were readily available at a cheaper price and were reusable. Respondents also mentioned that a mask was more easily visible and the by-standers could easily remind each other of wearing it. In parallel to this these have been a number of challenges expressed in the study around mask wearing too.

In this sub-section of the report, we will look at the structural and behavioural challenges in practicing the protective behaviours as reported by respondents in the two study communities.

STRUCTURAL AND BEHAVIOURAL BARRIERS TO PROTECTIVE BEHAVIOURS

MASK WEARING

STRUCTURAL BARRIERS

A major structural barrier to the usage of masks at the beginning of the lockdown were the high prices of the product, which prevented people from the lower economic strata of the society from using masks as a preventative measure to guard their health. At the time, there was no mention of alternatives to masks (as advertised by the government). Therefore, those unable to afford masks, went without using any kind / form of cloth to cover their faces.

There were also some people that resisted adherence to mask wearing as a social norm as they were used to a previously mask-free way of living. Thus making it difficult for them to adapt to a new normal immediately. The usage of masks saw a difference with time, as people gradually became more accustomed to covering their mouths when stepping out of the house.

Furthermore, with time as masks became increasingly accessible (distributed by local NGOs) and affordable (i.e currently retailed at prices beginning INR 2-5), this structural barrier broke down, increasing the usage of masks significantly. With recent communication from the government regarding the possible substitution of masks with any two-fold piece of cloth, people began using handkerchiefs / dupattas (i.e readily available cloth pieces/material available at home) to cover their faces when stepping out.

BEHAVIOURAL BARRIERS

Some people don't believe mask wearing is an effective way to combat / prevent the transmission of COVID-19, especially if one is adhering to other preventive norms like social distancing, hand washing etc. Others have grown tired of the drawn-out duration of the lockdown, after having worn masks for many months are now reluctant to keep up this practice.

For most aged people, a significant behavioural barrier against the usage of masks is the discomfort of wearing restrictive masks for prolonged periods of time. They often face difficulty breathing, and don't like the restriction of having a mask on at all times when outside. The discomfort is especially pronounced during hot/humid weather, which often leads to many opting out of wearing a facial cover when stepping out.

People in these urban settlements live in small and cramped homes, often with large families. In such homes, family members are always in close contact with each other. Thus, there is a strong belief that if, when at home, they are safe in spite of being in close proximity to others - they will be safe in their communities as well and there is no need for a mask. There is a visibly low perception of risk in places of comfort. Furthermore, often when sitting outside their homes and talking to friends / neighbours casually - people tend to forget to wear their masks,

Non adherence to mask wearing is observed in men when they step out of the house for reasons ranging to socialization to chores. whereas with women in most of the Muslim dominated communities, it was observed that their faces were covered with burkha as this acted on their belief that the burkhas acted as a protect measure and secondly, did not give the chance to by-standers to learn if the women were wearing masks under the naquaab.

Some people in the community believe that if they 'have' to get the infection (if they are destined to get the infection?), they will contract it and there is no way to prevent it / nothing can be done to help them.

`Young men tend to engage in name-calling towards those that do wear masks outdoors. They call people that do adhere to these norms "weaklings". This has discouraged many from using masks.

"Young men relate the usage of masks to wearing hijab/burkhas"

SOCIAL DISTANCING

STRUCTURAL CHALLENGES

The houses in Baiganwadi and Dharavi are restricted in space. On an average the houses are constructed to have an area of 80-100 sq. ft to house a family of 5-8 members. In many of the instances, one house is shared by more than one family with a cardboard or a cloth partition.

People find it difficult to remain restricted in small houses/spaces (chawls) with large families. Habitually, families used to manage the space constraint by ensuring the male members of the family spend most of their time outside (at their workplace or some other public places inside or outside the community) while the female members spent time in the house with their chores and once free would sit outside the house, chatting with neighbours etc. This practice continues during the pandemic.

"[Social Distancing is] difficult to follow because houses are small, and [there are] too many people at home. This is the problem during the day. It is very hot, and people can't stay indoors for long. So people come out and sit together with others outside their home."

Social distancing has been particularly difficult to follow in the marketplace and in ration shops with large crowds that fail to be managed effectively in the absence of police authorities. Crowds tend to form at shops due to their limited working hours during which people visit to stock up on supplies.

BEHAVIOURAL CHALLENGES

People refrained from adhering to social norms largely due to stubbornness in following prescribed rules / norms. Most people deemed their community a safe place to socialise within since there were no positive cases detected close to the neighbourhood. Hence many saw social distancing an unnecessary measure inside the community, only to be relevant when visiting spaces outside the community. This was especially true for stubborn / egoistic men and young boys in the community, who tended to take reminders / reprimanding to maintain social distance in public lightly. This was largely because they didn't like being told what to do.

Often, despite knowing about the importance of social distancing through various media sources etc, people tend not to adhere to this norm due to old habits / ways of living that are difficult to alter. In the case of men that used to go to work regularly before the lockdown, staying home for prolonged periods of time has been difficult, often

leading to feelings like irritability and a longing to go outside. People cited the hot and humid weather in Mumbai as a hindrance to staying indoors. Some also claimed to be growing tired following the same norms for months now, and were bored of staying "caged". When sitting outside their homes to chat with neighbours etc. people were seen to have a tendency to cluster without maintaining social distance amongst themselves.

Failure to maintain social distance was seen especially amongst young people, who stepped out of their homes often to meet with friends and family due to the fear of "losing out on things" (i.e missing out on experiences, socialising etc.) When meeting friends in groups (usually in open public spaces), young people tended not to pay much attention to maintaining physical distance amongst themselves. Respondents said they were more likely to adhere to norms like mask wearing and social distancing when alone / out to complete chores/tasks as compared to when they step out to meet friends.

"They [the younger generation] lie to their families and leave the home and stay outside for hours. Younger people believe that only people above the age of 50/60 are susceptible to the virus, and believe they will not be affected."

Messages disseminated through social media sources have caused some young people to believe that they are not at risk of contracting COVID-19, and that the virus is only a threat to elder members of the community. Peer pressure and prevalent gender norms in the community have influenced the interpretation of COVID-19 related messaging. Young boys specifically tend to see themselves as 'stronger' than the rest of the population (especially their female counterparts, older residents etc.) and hence believe that they are not at risk of contracting the disease.

Lack of social distancing among individuals was also seen widely at grocery and ration shops.

"Because of Ramzan markets were crowded and people did not follow any preventive practices. Social Distancing is not followed in Market places & ration shops."

It was reported that it gets difficult to manage the crowd at times when the CBOs/NGOs have ration distribution in the community even when there is a stock of volunteers to distribute and manage the crowd. In the given situation of scarcity, community dwellers tend to fear missing on the distributed stocks and hence gradually dilute the social distancing practice and crowd around the source of distribution.

At the onset of the pandemic, a lot of people did not believe COVID-19 to be a real threat to their livelihoods. They had trouble accepting the fact that COVID-19 was a real, plausible threat because they were unable to relate it to anyone in their network / neighbourhood that had come in contact with / contracted the disease.

"Many think that Corona virus is fake, because they probably haven't seen a corona case around them."

Some believe that the threat was brought in from people coming in from outside the community, hence precautionary measures were unnecessary within the community if measures were taken to keep "outsiders" away. This gradually changed with time with the increase in awareness regarding the disease, and COVID-19 cases in many neighbourhoods.

Why? They forget, need to be reminded? Don't like being reminded, one respondent spoke back toa lady that pointed out to her that she was not maintaining distance from her friends when meeting them in a group. Reacted adversely.

HAND WASHING/USING SANITIZERS

STRUCTURAL BARRIERS

Most people were unable to use sanitizers and clean their hands frequently due to the lack of resources at their disposal. Sanitisers tend to be expensive to buy, and hence unaffordable to many. Daily wage labourers were keener on saving money to secure food. Sanitizers, being a newer concept and something that had to be paid for, wasn't welcomed in the community. Even after the NGOs/CBOs introduced the residents to the sanitizers, they did not know how to use it. With the Muslim population, learning that the sanitizers have a content of alcohol, refrained from using them.

Those living on unauthorised land without access to water pipelines are most likely to avoid following this norm. In areas with sparse access to water, people are forced to arrange for / buy their own supplies of water. Often, prices tend to go as high as at INR 50 / 100 litres, burdening households financially. Thus, given the scarcity and cost of resources, households tend to budget their usage of water and other expenses for essential purposes only, keeping in mind the size and requirements of their family.

Given the general sense of uncertainty for the future, even those financially able to buy these resources are saving for contingencies and food and avoiding all kinds of 'unnecessary expenditure'.

Some respondents blamed the inefficiency of the Indian education system for failing to emphasise on teaching hygienic practices; such as regular hand washing and sanitation; to the population, something that is widely adhered to in western countries.

Due to this lack of knowledge / habit formation at an earlier stage, people find it difficult to adopt new healthy practices.

BEHAVIOURAL BARRIERS

Washing hands after coming home from outside is a cultural norm that has been around for ages amongst certain sections of the community. However, as reported by the locals, for some this is a newly learned habit (esp. Migrants coming in for work from outside states, "people from outside"), hence making it difficult for them to adopt easily.

While people have adequate knowledge regarding the connection between the spread of COVID-19 and hand washing from multiple sources (mainly caller tunes, media and news), they do not have adequate information / knowledge on when they must wash their hands (i.e under what circumstances, when is it necessary? How often? etc.). Most people are used to washing hands only at specific times - i.e before / after eating.

A lot of people are also unaware of the proper usage of sanitisers and tend to overuse it / use it incorrectly. This is especially relevant for children, since they tend to move around a lot and are difficult to teach these habits to. Parents often find it difficult to ensure young children wash their hands at regular intervals. Furthermore families tend to share resources, which makes them more likely to spread / contract the virus. In areas where water is easily available, people fail to adhere to regular hand washing norms due to negligence and carelessness.

This is also true for young people, who believe they are strong / immune to health threats. Young boys in particular are not used to being told what to do, and hence don't listen to advice / pay heed to reminders from elders.

NO SPITTING

STRUCTURAL BARRIERS

A major structural barrier to preventing people from spitting publicly, was the poor enforcement of laws and punishments concerning the practice of spitting in public spaces. This led to spitting (especially habitually for tobacco / gutkha consumers) becoming a socially accepted practice / norm amongst the people of the community.

BEHAVIOURAL BARRIERS

The most significant behavioural barrier in case of spitting in public places, was the lack of awareness amongst the people regarding the relationship between spitting and the transmission of COVID-19. This led them to continue living their lives as they had been, overlooking casual spitting in public spaces.

Spitting in public has developed as a habit for many people in the community. Thus, it has come to be accepted as normal behaviour. This is especially true of those that have grown accustomed to spitting in public spaces as a result of certain behaviours - eg. the consumption of gutka / tobacco.

"This is a very prevalent behaviour in the community".

These habits are difficult to overcome, and therefore despite there being laws against spitting in public in most public areas, they are seldom followed by most. This outlook has not changed with the spread of COVID-19. Furthermore, people in the community have also grown insensitive to such behaviour by fellow residents and tend not to reprimand / call it out in public as they believe such age-old habits are impossible to break / overcome. Even so, it is seen that people are more likely to spit in public when nobody is watching / monitoring them.

"Though people know about the law against spitting, there is no enforcement of the law and no one reprimanding them for spitting. People have never been told that they cannot spit in public."

Spitting is most prevalent in areas near dumping grounds. These areas are usually inhabited by migrant workers living alone (without their families). These people are already marginalised within the community they have moved to in search of work, and are forced to inhabit unhygienic areas owing to a lack of monetary resources. Because these spaces are unclean, residents in the area often lack incentive to maintain cleanliness and refrain from spitting in surrounding public spaces. While spitting is a widely prevalent practice amongst people living in the centre / interiors of the settlement as well, this practice is seen to be more widely prevalent specifically in these areas. Furthermore, living alone, they rarely have anyone reminding / reprimanding them / nudging them towards healthier behaviours.

"The general level of hygiene and sanitation in this area has always been poor."

A large portion of the population in Dharavi (not habitual of gutka/tobacco consumption), tend to spit in / when passing certain fixed places. These areas are usually dirty/unhygienic or foul smelling places (eg. near dumping groups, gutters etc.). They tend to do so from a sudden urge to expel saliva accumulated in their mouth / become increasingly conscious of the saliva in their mouths. This practice has continued during lockdown.

At the time of the study, it was also recorded that certain cultural and religious norms prevented people from swallowing saliva during Ramzan. This increased the number of cases of public spitting temporarily. However, such norms are only specific to certain religious periods / festivals and are not prevalent throughout the year.

As mentioned earlier, despite of the various structural and behavioral challenges, there are certain protective behaviors practiced more than the others. In this study we tried to explore if there was any reminding or reprimanding by the fellow dwellers for anyone who was not adhering to the suggested protective behaviours. This section provides an account of how and for what all behaviours people remind and/or reprimand others. An attempt was made to explore about the people who remind/reprimand others, the challenges they face in doing so, the people who are reminded/reprimanded and their reactions to the same. It was evident that reminding and reprimanding usually happened in case of protective behaviours that were more visible and there was a high level of awareness in the community about as compared to those that were more private (handwashing/using the senitizer) and lack awareness about the link to COVID-19 spread (spitting). These learning will help us in thinking about ways in which these practices can be standardised, made more effective, and scaled to include more stakeholders.

REMINDING

Almost all the respondents felt that awareness is not an issue when it came to preventive measures of mask wearing and social distancing. Handwashing was also a fairly well known protective behaviour but due to the limited availability of resources (water, soap, sanitiser) and it being a private and not easily observable act, people didn't remind others about handwashing as much as they did for mask wearing or social distancing.

For these behaviours, respondents reminded others by inducing a sense of responsibility towards their family and the community by using quotes and giving examples such as "If you are healthy, India will be healthy"; "if not for yourself, think about your family's safety". Some respondents reminded others by explaining to them all the facts and consequences of the infection (such as the need to maintain distance as no cure has been found for this disease; how painful death can be due to this virus). A respondent talked at length about how a known Corona infected person was cremated, separated from her family, and how even her family members were not allowed to bid final farewell. He narrated the same story to some of his friends and colleagues who were not actively following the measures prescribed by the government.

Others were reminded by being told that even if they don't believe in coronavirus, there are lots of other diseases that they can get infected with if they don't wear masks or don't wash their hands. Some respondents kept sanitisers at strategic / convenient / accessible places within the house/commercial establishments to remind others, while others claimed to individually approach and remind people to wash hands before entering their house. A set of people were using social media sites and apps to counsel people and another by telling examples of how people living in similar situations are practicing social distancing.

The study brings to surface that people in the community are not aware of the link between spitting and the spread of the infection. Even when reminded, many didn't even believe that not spitting is a prescribed behaviour for the coronavirus. For many it was the first time that they were hearing about such a correlation.

Many respondents agreed that spitting is an age old, socially acceptable and internalised behaviour in the community but still, nobody likes others spitting around their homes. It can be said that very low/no reminding with the intention to arrest the spread of the virus was happening for this behaviour.

While many respondents themselves claimed to have reminded members of the community, they also talked about the active role played by social, NGO, government, and health workers in reminding people about the practice of these behaviours.

Majority of people don't like being reminded about the practice of preventive behaviours. Such reminders have often turned into arguments and the fear of further harm/revenge prevails in the community. Some people are short tempered and will tell you to mind your own business ("tu apna kar"). A respondent's sister once told some young boys who were loitering near their door, but the boys would be rude to her and ask her "tere baap ka gali hai kya".

People may get offended depending on who reminds - especially in the case of young people or women reminding older members in the community. Many respondents felt that the youth are not ready to listen to others. As reported by one of the respondents,

"If you try to tell them, they ask if you're from the BMC, or what authority you have to tell us."

Another female respondent who tried to remind was told,

"You're a woman, you shouldn't be getting involved in all of this."

One respondent noted that strangers don't respond well to the reminding. They listen if they consider the person reminding them to be more powerful than self. So people in the community tend to remind those who are known to them. One of the respond narrates how it works for him,

"When the conversation starts, they don't like it but as I go into the details, they agree that I'm saying the right thing".

People who remind are seen as more privileged and elite within the community and not taken seriously. A female respondent was mocked and told she is more "advanced" because she has a job, which is why she is able to follow the protective measures. The respondent even claimed that a few people have not spoken to her for many weeks just because she reminded them. When reminded about washing hands, some say that they have just washed their hands, and why do they need to wash it again. They also say that they are trying to save water. A respondent narrate her experience,

"People laugh, and they say "you have the money to buy sanitizer but we don't so stop telling me to do this" when reminded about washing hands."

In one of the study areas, a respondent upon reminding was primarily told

"we don't have water and no money to buy water. How will we wash our hands?"

Many respondents said that very few people listen, most don't even respond or will ignore the advice when they are reminded for not spitting. Some however, felt that it may go either way, people can get into arguments or people may understand that spitting is not accepted. One respondent said youth get angry when they are told about these things as spitting (esp. tobacco) is a style statement for them. The usual response is, "don't try to be a leader" (netagiri mat karo) or "mind your own business".

REPRIMANDING

For mask wearing and social distancing, it was mostly the government authorities, especially the police which were actively reprimanding people. However, a few respondents did reprimand others by complaining to their families or by clicking their pictures and telling them that if they don't follow rules, they will forward the same to the police.

An NGO worker said that whenever there is overcrowding or violation of social distancing norms, he stops the relief distribution and asks people to go back to their houses. He then initiates the ration distribution at the doorsteps of people who listen. Another respondent talked about 'Kumharwada' a place where the local community was working proactively to sensitise people and reprimand offenders. Handwashing being a private act combined with difficulty in monitoring behaviour makes reprimanding more likely for known people and less likely for strangers. A respondent talked about reprimanding others by trying to increase the distance with the person so that they get a hint, instead of saying anything directly. Like reminding, very little or no reprimanding happened for spitting as people don't seem to connect spitting with increased spread of the infection.

Respondents claimed that they have experienced both positive and negative reactions while reprimanding others. Some respondents claimed that it's usually the strangers who react adversely and get aggressive, the known people on the other hand, just listen and leave. But some respondents claimed that people either get irritated when told what to do, or they laugh at you. They are also dismissive and say, "I already know everything so there's no need to teach me all this".

Another respondent claimed that anyone will listen to him only if they consider him more powerful than themselves. Like reminding, people who reprimand others are seen as more privileged and elite within the community and not taken seriously. A female respondent was mocked and told she is more "advanced" because she has a job, which is why she is able to follow the protective measures.

SUGGESTIONS

Many respondents talked about making the existing awareness generation programs more focussed and effective. For the same, they recommended the assistance of community based NGOs, volunteers, and social workers. Some respondents highlighted the urgent need to link the spread of drive COVID-19 with the practice of spitting.

People were willing to give more power to a group of individuals within the community or the authorities to ensure better compliance. Many respondents felt that the community should come together to make sure that everyone adheres to all the prescribed behaviours as reminding people individually can be risky. When a group of people from within the community come together, there is no risk and people do not tend to retaliate violently.

While some suggested roping in people who are respected / fearedin the community to speak to the offenders, others thought that employing volunteers to do the same job could produce better results. Volunteers could be trained to break down general guidelines into simple rules which groups/individuals can follow and women volunteers could be used to spread important messages to female members of the house.

Since spitting is an individual behavior, respondents felt that reminding and sanctioning should be mandated at an individual level besides having conversations around how spitting can impact the health of the family and children, calling each other out publicly, and encouraging people to spit in specific places (eg. gutters). One respondent suggested that people should be mandated to consume gutka / tobacco at the place of purchase so that they don't spit wherever they go.

Respondents felt that reprimanding should be done through active participation of the community and key community members, volunteers, social and government workers should take the lead on the same. Some felt that giving more power to Police - to fine / enforce punishment could work better. Boycotting or not talking to those households whose members repeatedly violated protective guidelines was another suggestion.

One respondent suggested the use of untested and unconventional methods such as barring repeated offenders from using their phones or punishment in the form of mandatory quarantine to increase compliance.

For handwashing there were suggestions for the provision of public hand washing stations at the community level and mandatory provision and usage of sanitisers at all private and public places.

REFERENCES

(1) Naing, C., Tan, R. Y. P., Soon, W. C., Parakh, J., & Sanggi, S. S. (2012). Preventive behaviours towards influenza A(H1N1)pdm09 and factors associated with the intention to take influenza A(H1N1)pdm09 vaccination. Journal of Infection and Public Health, 5(6), 412–419.

(2) https://www.reuters.com/article/us-reutersmagazine-davos-flu-economy/flu-conomics-the-next-pandemic-could-trigger-global-recession-idUSBRE90K0F820130121

(3) Bavel, J.J.V., Baicker, K., Boggio, P.S. et al. Using social and behavioural science to support COVID-19 pandemic response. Nature Human Behaviour 4, 460–471 (2020).

(4) https://www.who.int/emergencies/diseases/novel-coronavirus-2019

(5) https://news.google.com/covid19/maphl=en IN&mid=%2Fm%2F03rk0&gl=IN&ceid=IN%3Aen

(6) https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-coronaviruses

(7) Roy, D., Tripathy, S., Kar, S. K., Sharma, N., Verma, S. K., & Kaushal, V. (2020). Study of knowledge, attitude, anxiety & perceived mental healthcare need in Indian population during COVID-19 pandemic. Asian Journal of Psychiatry, 51, 102083. https://doi.org/10.1016/j.ajp.2020.102083

(8) https://blogs.bmj.com/bmj/2020/06/09/covid-19-and-cognitive-bias/

(9) https://www.popcouncil.org/uploads/pdfs/2020PGY_CovidIndiaKAPRiskPerceptionBrief.pdf

(10) Czeisler, M. É., Tynan, M. A., Howard, M. E., Honeycutt, S., Fulmer, E. B., Kidder, D. P., Robbins, R., Barger, L. K., Facer-Childs, E. R., Baldwin, G., Rajaratnam, S. M. W., & Czeisler, C. A. (2020). Public Attitudes, Behaviors, and Beliefs Related to COVID-19, Stay-at-Home Orders, Nonessential Business Closures, and Public Health Guidance—United States, New York City, and Los Angeles, May 5–12, 2020. MMWR. Morbidity and Mortality Weekly Report, 69(24), 751–758.

(11) Dempsey, R. C., McAlaney, J., & Bewick, B. M. (2018). A Critical Appraisal of the Social Norms Approach as an Interventional Strategy for Health-Related Behavior and Attitude Change. Frontiers in Psychology, 9.

(12) Borsari, B., & Carey, K. B. (2003). Descriptive and Injunctive Norms in College Drinking: A Meta-Analytic Integration. Journal of Studies on Alcohol, 64(3), 331.

(13) Bavel, J. J. V., Baicker, K., Boggio, P. S., Capraro, V., Cichocka, A., Cikara, M., Crockett, M. J., Crum, A. J., Douglas, K. M., Druckman, J. N., Drury, J., Dube, O., Ellemers, N., Finkel, E. J., Fowler, J. H., Gelfand, M., Han, S., Haslam, S. A., Jetten, J., ... Willer, R. (2020). Using social and behavioural science to support COVID-19 pandemic response. Nature Human Behaviour, 4(5), 460–471.

(14) https://www.influenceatwork.com/inside-influence-report/advice-for-reducing-undesirable-covid-19-behaviors/

Centre for Social and Behaviour Change