

# Safety and wellbeing of sanitation workers during COVID-19 in South Asia



A rapid assessment from Bangladesh, India, Pakistan and Nepal in the lockdown period

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**WaterAid**

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## Executive summary

The COVID-19 pandemic reached South Asia at the beginning of 2020 and by March most of the countries in the region had imposed lockdowns in an attempt to curb the rampant spread of the disease. Severe restrictions on movement were introduced and businesses were closed. Only the provision of essential services – including sanitation and waste management – were permitted to continue.

Sanitation workers have long been marginalised across South Asia due to stigma around the nature of their work and discrimination based on caste, ethnicity and religion. The COVID-19 pandemic magnified the considerable occupational and health hazards these workers already faced, leaving many of them to continue working with limited protection and almost no formal guidance or support structures.

In order to understand the nature and extent of the challenges faced by sanitation workers during the lockdown, WaterAid facilitated studies in Bangladesh, India, Nepal and Pakistan, through telephonic interviews with sanitation workers and key informants. The study, despite differences across the four countries, revealed important common insights:

**While workers were aware of the symptoms and risks posed by COVID-19, they were in many cases ill-equipped to manage these dangers due to lack of specific guidance or formal training, limited access to personal protective equipment (PPE), and inadequate handwashing and cleaning facilities.**

**The pandemic exacerbated existing vulnerabilities, such as the lack of health insurance or other forms of social protection. While there were examples in some countries of targeted support for sanitation workers, these were often sporadic and limited in scale, leaving most workers to manage any impacts on their health, income and rising expenses on their own.**

**While there was increased recognition of the importance of their work during this critical time, there were also cases of landlords and neighbours asking sanitation workers to leave due to the risk of contagion.**

**The informality of sanitation work – which is more prevalent among female workers – magnified the existing vulnerability of workers and was also a proxy for the absence of a safety net, regular income, insurance cover and access to PPE.**



There is a clear need for sanitation workers to receive immediate support in order for them to cope with the heightened risks as the pandemic continues. Regional actors, national governments, municipal authorities and non-government stakeholders need to:

- Recognise the vital role sanitation workers play and the risks they face carrying out this essential work.
- Provide emergency financing to support the safety and welfare of sanitation workers during the pandemic.
- Set up and implement the frameworks, protocols and guidelines for the safe provision of sanitation, waste and cleaning services, including training and regular supply of quality PPE.
- Strengthen social security schemes and access to health insurance targeted at sanitation workers to compensate for risks and protect workers from the high-risk situations they work in, ensuring the inclusion of informal workers.
- Ensure access to water, sanitation and hygiene (WASH) in workplaces and communities for decent and hygienic working and living conditions.

In addition to these urgent measures, long-term efforts are also required to improve the working and living conditions of sanitation workers, and to address the deep-rooted structural inequalities that have relegated them to the margins of society. These should include:

- Reviewing urban plans and investments to integrate considerations of sanitation workers.
- Supporting workers' representation and engagement with authorities.
- Supporting research and innovation on sanitation and waste work.
- Supporting the long-term formalisation of sanitation and waste work.
- Launching an awareness campaign that challenges the stigma and discrimination sanitation workers face.

# Background

## Introduction

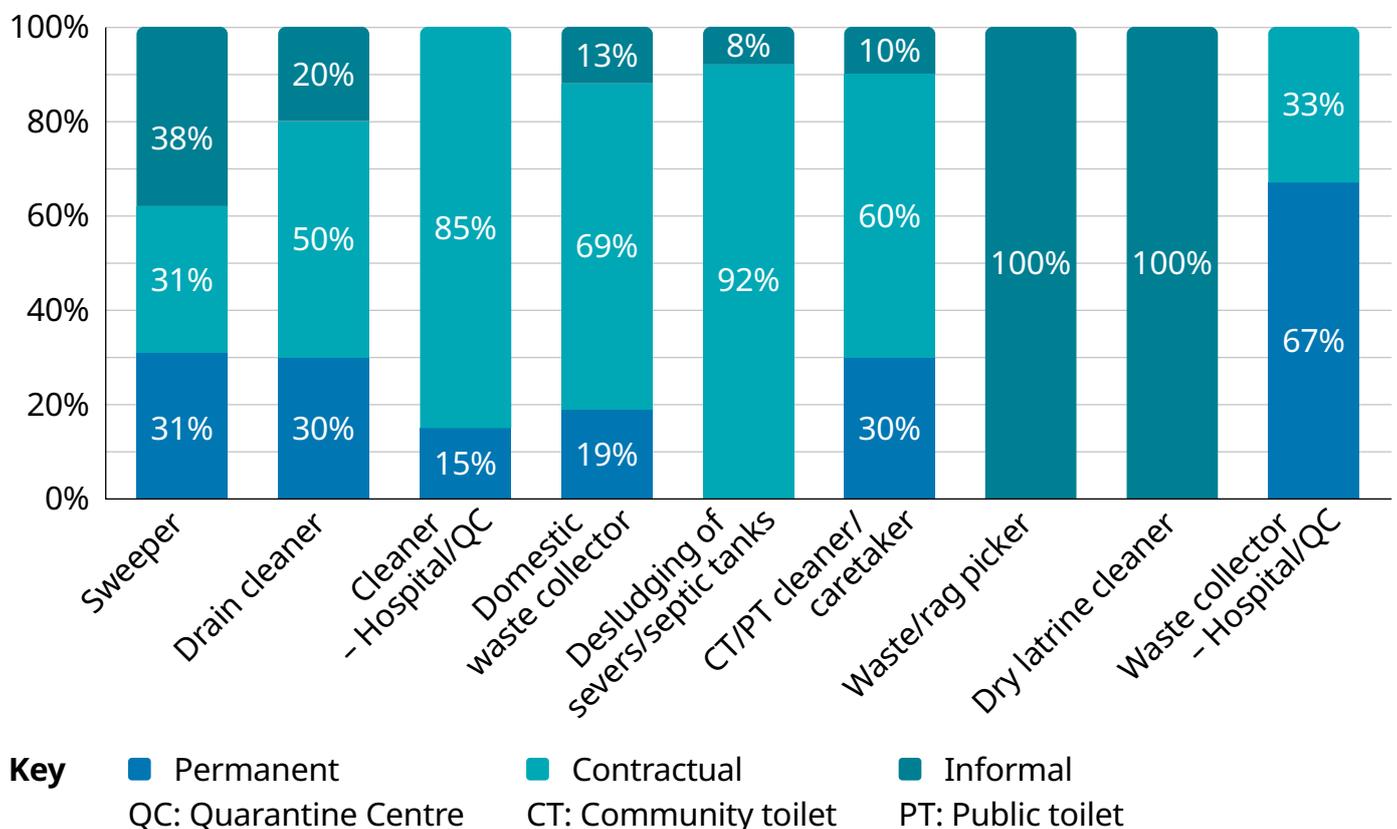
Sanitation workers provide an essential public service by keeping our cities, towns and villages running and clean – working on the frontline to ensure our sanitation services are continuing to function to protect the environment we live in.

Despite providing an essential public service, sanitation workers often operate in terrible conditions. They are exposed to multiple occupational and environmental hazards, suffering debilitating infections, injuries and even death whilst carrying out their work – which is tragically frequent, especially among sewer workers and septic tank cleaners. They also face low

pay and job insecurity, leading to financial challenges and poor living conditions – ironically including poor access to sanitation services. Another key factor is the social stigma and discrimination associated with this occupation – which is especially severe in South Asian countries as the occupation is assigned to those considered ‘lowest caste’ and to religious minorities.

These workers also have limited legal protection, which is compounded by the practice of sub-contracting municipal services, as well as high levels of informality within this work – including ghost employment where more vulnerable and minorities work on behalf of actually appointed workers.<sup>1</sup>

**Nature of engagement of sanitation workers’ sample from India**



The COVID-19 pandemic has been a time of heightened danger for sanitation workers. Most must carry on operating during lockdown periods, be it because of civic duty, or fear of losing their daily income or the job altogether. This can leave sanitation workers exposed to contracting the virus, which calls for concerted action from communities, employers and authorities.

In order to understand the direct concerns and perceptions of the sanitation workers, how they are coping in this ever-changing situation and what action has been taken so far, we carried out a rapid assessment in four South Asian countries – Bangladesh, India, Nepal and Pakistan. This regional synthesis will highlight the key findings of this assessment, presenting common trends and differences, and putting forward a series of recommendations relevant to institutions operating in South Asia.

There has always been a strong, but neglected, moral and public health imperative to protect sanitation workers' rights. The COVID-19 pandemic not only strengthens that case, but also represents an opportunity to redress the historical neglect. This study hopes to make a contribution in that direction.



## The research

The research was carried out in Bangladesh, India, Nepal and Pakistan over a period of approximately six weeks from the end of April until mid-June.<sup>2,3,4,5</sup> At country level, studies were conducted either by the WaterAid team (Bangladesh), or through an external agency (Nepal and Pakistan), or the WaterAid team in collaboration with partner organisations (India).

Given the need for rapid and timely insights from the sanitation workers themselves, as well as an overview of the response of the utilities or local authorities, the assessments combined both the surveys of sanitation workers and the interviews

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- <sup>1</sup> The News on Sunday/Zeenia Shaukat (2020). *Faces of discrimination. Why is sanitation work reserved for non-Muslim minorities?* Available at: [thenews.com.pk/tns/detail/592949-faces-of-discrimination](https://thenews.com.pk/tns/detail/592949-faces-of-discrimination) (accessed 7 Aug 2020).
  - <sup>2</sup> WaterAid Bangladesh (2020). *Risk and vulnerability of sanitation and waste workers during COVID-19 pandemic in five major cities of Bangladesh.* Available at: [washmatters.wateraid.org/publications/safety-wellbeing-sanitation-workers-south-asia-covid](https://washmatters.wateraid.org/publications/safety-wellbeing-sanitation-workers-south-asia-covid)
  - <sup>3</sup> WaterAid India and Urban Management Centre (2020). *Health and Safety Challenges of Sanitation workers in India during the COVID-19 pandemic.* Available at: [washmatters.wateraid.org/publications/safety-wellbeing-sanitation-workers-south-asia-covid](https://washmatters.wateraid.org/publications/safety-wellbeing-sanitation-workers-south-asia-covid)
  - <sup>4</sup> WaterAid Nepal and MITRA Samaj (2020). *Rapid Assessment of Measures on Safety of Sanitation and Waste Workers during COVID-19 in Nepal.* Available at: [washmatters.wateraid.org/publications/safety-wellbeing-sanitation-workers-south-asia-covid](https://washmatters.wateraid.org/publications/safety-wellbeing-sanitation-workers-south-asia-covid)
  - <sup>5</sup> WaterAid Pakistan and APEX Consulting (2020). *Rapid Assessment of Measures on Safety of Sanitation and Waste Workers during Covid-19 in Pakistan.* Available at: [washmatters.wateraid.org/publications/safety-wellbeing-sanitation-workers-south-asia-covid](https://washmatters.wateraid.org/publications/safety-wellbeing-sanitation-workers-south-asia-covid)



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that were conducted with key informants. The survey sample size was small, ranging from 31 sanitation workers in Nepal to 123 sanitation workers in Bangladesh. The sample selection aimed to cover different types of workers and relied on existing contacts and networks. Contact details of respondents were obtained through employers (municipality or city authorities, private agencies, offices and healthcare facilities), as well as through networks and relationships built by WaterAid and our partners. Each country covered different types of workers, but these can broadly be clustered around three categories: solid waste workers, such as waste collectors, sweepers or landfill workers; sanitation workers such as pit emptiers, faecal sludge treatment workers and sewer or latrine cleaners; and cleaners working in homes, commercial set-ups and healthcare facilities. For the remainder of this regional synthesis, we will use the term ‘sanitation workers’ or ‘workers’ when referring to the three groups collectively.

Key informants who were interviewed included local authorities, utility operators and civil society organisations who work closely with sanitation workers. Most of the country studies also captured case studies of individual workers.

Both the survey and the interviews were conducted via the telephone, using semi-structured and structured questionnaires respectively. The questions covered five topics:

- Knowledge and awareness of COVID-19 causes.
- Symptoms and treatment measures.
- Occupational health and safety, including access to PPE and training.
- Handwashing practice at work and home.
- Impact of the lockdown on livelihoods.
- Social and personal implications.

Primary data was supplemented by secondary data where it was available and relevant.

## Findings

### Impacts on livelihoods, discrimination and health

#### Loss of livelihoods and economic distress

As it is an essential public service, sanitation and waste work did not stop, even during the country-wide lockdowns in the four focus countries. The workers continued working, as the fear of losing jobs and income outweighed the health risks. Two in three sanitation workers in Bangladesh mentioned that they do not have alternative job opportunities and over one-third feared losing their jobs if they stopped working during the pandemic. In Pakistan, respondents also feared losing their jobs, except for the permanent government workers who were interviewed. In India, one in four sanitation workers were interested in alternative sources of livelihoods, but faced issues of sufficient capital and resource – which forced them to continue with this work. In all four

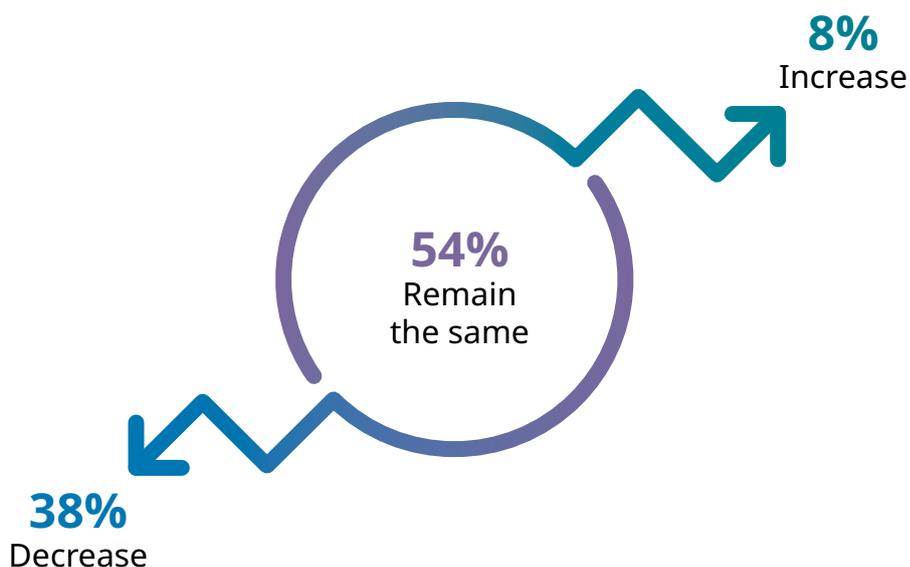
countries, many workers reported financial distress due to loss of parallel and part-time work opportunities due to lockdown, such as washing cars, and cleaning homes and hospitals etc. Workers also feared falling ill with the virus, which would result in additional loss of income. With schools closed, female workers had no choice but to leave their children home alone or instead face a loss of income. A case was reported in a town in Gujarat (India), where sanitation workers' groups had negotiated reduced working hours for women during the lockdown to help them cope with childcare and additional responsibilities that often fall to women.

Around half of the respondents (66% in Bangladesh; 44% in India; 50% in Pakistan; 61% in Nepal) reported challenges in meeting their daily expenses. Loss of income during the lockdown was compounded by a rise in food prices, additional expenses for safety gear

**“Before, I would get overtime tips, but not now. So it has been difficult for me to survive. I do not have a single penny for buying vegetables and other basic needs.”**

**Household waste collector, private, Lalitpur, Nepal.**

**Figure 1: Changes in income due to lockdown in Pakistan.**



and hygiene supplies, and cost of transportation, especially in India and Bangladesh. To address this, a municipal government in Telangana (India) provided transportation arrangements for workers.

Loss of livelihood was more prevalent amongst informal workers – which has gender-specific implications as most workers who are part of the informal workforce are female. For instance, in India where dry latrine cleaners are almost invariably women, one in four of the respondents in this category were completely out of work during the lockdown while others were only able to resume work partially. Similar issues and gendered imbalances were also observed among waste pickers.

Some workers also faced increased workloads – specifically workers in healthcare facilities who reported longer shifts and increased working hours across all four of the assessment countries – which in the most part was not compensated for. In contrast, domestic waste collectors, office cleaners and those working in trucks carrying waste reported a reduced workload.

**“We have faced challenge of increase in prices – everything is expensive especially food items.”**

**Sanitation worker, public,  
Sindh, Pakistan.**

**“Hunger is more dangerous than the coronavirus. Our situation is very bad.”**

**Dry latrine cleaner, India.**

## **Discrimination vs recognition**

Sanitation workers are frequently subjected to stigma and discrimination, however the consequences of COVID-19 on these workers were mixed across the countries. In some cases, the workers received more recognition from the public and employers, along with self-pride for providing essential services during the pandemic. In other cases, workers reported concern and pressure from neighbours not to return to home after work (Bangladesh) and even demands from landlords for them to vacate their homes (Nepal).

**“People used to throw our fees/wage or service charge from their windows or terrace. It used to hurt me. But ever since the social distancing has been adopted in this outbreak of COVID-19, I have started to take it positively.”**

**Sewer and manhole cleaner,  
Kathmandu, Nepal.**

**“People’s perspectives have changed now. They have started to realise that sanitation and waste workers are working for the public good. Thus, they have started treating us well.”**

**Household waste collector, private,  
Kathmandu, Nepal.**

**“I and other sanitation workers are the reason people can live at home during the lockdown without worrying about their waste disposal. If we don’t work during this pandemic, people do not know what to do with this waste. We are continuing our job under great risk only to give the public some level of comfort. But it is very unfortunate that people do not value our sacrifice.”**

**Female sanitation worker,  
Khulna, Bangladesh.**

Face-to-face interaction between workers and clients had reportedly reduced, which is primarily linked to the need for physical distancing – for example, people not opening their doors and talking to waste pickers from inside their homes. Various officials at state and ULB officials in India reported initiatives taken to change social perception by recognition of the efforts of sanitation workers during pandemic through awards and ceremonies.

### **Health, infection and loss of life**

In India, several of the municipal authorities who were interviewed reported cases of sanitation workers contracting the virus in their cities. There have been several deaths covered in the media in May (see Figure 2). However, there were no cases of contagion or deaths reported in the media in Pakistan, Nepal and Bangladesh.

This pandemic has also had unseen health impacts for the female sanitation workers on the frontline. Many have reported difficulties carrying out this essential work, especially during menstruation, as many public toilets have been closed during lockdown.

**Figure 2: News clips of sanitation worker injuries and deaths in India.**

### ***Sanitation workers holding the Fort Against COVID-19 have no protective equipment***

thewire.in  
30 March 2020

### ***Sweeper faints, dies after fogging in Uttar Pradesh***

telegraphindia.com  
8 April 2020

### ***Coronavirus: Sanitation worker forced to drink disinfectant in UP’s Rampur, dies***

india.com  
19 April 2020

### ***SDMC’s sanitation worker who tested positive for coronavirus dies at AIIMS***

timesofindia.indiatimes.com  
26 April 2020

### ***‘Stigmatised, ostracised’: Sanitation workers in Tamil Nadu battle COVID-19***

thenewsminute.com  
6 May 2020

### ***AIIMS sanitation supervisor dies due to COVID-19***

hindustantimes.com  
26 May 2020

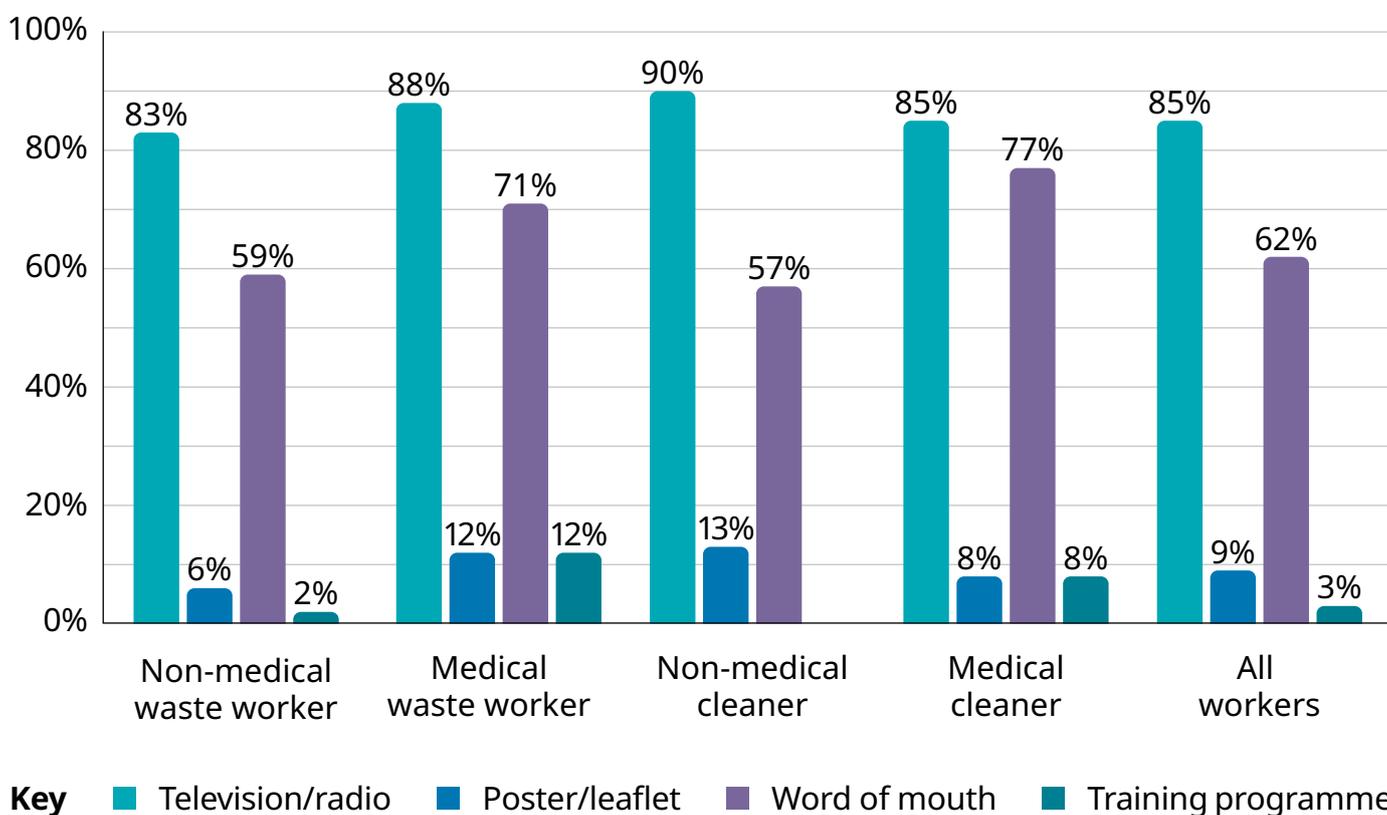
## Understanding the COVID-19 pandemic

### Perception of risks and knowledge on COVID-19

Overall, workers were aware of some of the common symptoms of COVID-19, such as having a cough, fever, flu-like symptoms and breathing difficulties. There is an understanding amongst the workers that COVID-19 is a contagious disease that spreads through close contact with an infected person – but knowledge of the various modes of transmission varied. News through the television was reported as the most common source of information, followed by word of mouth through friends, family, colleagues and social media. Information through posters, leaflets and newspapers was the least referred to source of information. Orientation and specific training on COVID-19 by employers was also mentioned in some cases in Nepal, India and Pakistan.

Fear of infection and concern for their family members were expressed by workers in all four of the study countries. Eight in ten workers interviewed in Bangladesh thought their job would put them at risk of infection. Around two-third of workers interviewed in Bangladesh also thought that their family members would be more vulnerable because of the high risks associated with the work they do. The perceived risk was particularly high among cleaning workers at hospitals in Bangladesh and Pakistan. The reasons cited for this included challenges in maintaining physical distancing; close proximity with COVID-19 patients; handling high-risk waste; lack of safety materials; not being able to clean themselves; and lack of facilities to wash hands regularly.

**Figure 3: Sources of information on COVID-19 for workers in Bangladesh.**





WaterAid/CS Sharada Prasad

**“I work in a hospital and I can’t avoid serving the patients when they need me. I cannot follow all the precautions and maintain a physical distance. I am performing my job with a certain level of risk that I cannot ignore due to the nature of my work.”**

**Hospital cleaner, Khulna, Bangladesh.**

## **Knowledge about preventive measures**

More than half of the respondents across the four countries were aware of at least one of the three key preventive measures – wearing masks, handwashing and physical distancing. However, there was more awareness of the need to wear masks than of the need to wash hands frequently. Workers in all countries reported concerns around their inability maintain physical distancing. There is gap in the knowledge on testing facilities, how to access treatment and the steps that need to be taken if they show symptoms or test positive for COVID-19. Only 60% of respondents in India, 50% in Nepal and 38% in Pakistan were aware that they should self-quarantine if infected.

## **Protective measures**

### **Access to and use of PPE**

Across all four countries, workers were aware of the need for protective equipment to reduce the risk of infection, but most reported challenges around the adequate supply, safe use and quality of these provisions.

In Bangladesh, 97% of respondents mentioned using masks and 76% confirmed the use of gloves. Other protective equipment such as gowns or aprons, shoes or foot covers and goggles were less widely used. Even among high-risk groups, like medical waste workers and hospital cleaners, less than 60% of medical waste workers mentioned use of any of these additional materials, while only 31% of cleaners in medical facilities mentioned gowns or aprons, and shoe covers.

In Nepal, a third of the respondents reported they did not receive any PPE from employers. Two thirds mentioned that employers had provided them with PPE, primarily with masks and gloves, while shoes/boots, aprons/gowns or jackets were also provided to certain categories of workers.

In India, 95% of respondents had some form of PPE, with masks and gloves again being the most common items. 80% workers received PPE from employers, and the rest either purchased or made cloth masks at home. However, more specialised PPE was not available for most workers, even when required. For example, hospital workers, who are the most vulnerable to COVID-19 among all of the categories, did not have access to all types of PPE that is required to carry out their work safely.

In Pakistan, most of the respondents had gloves and masks, usually provided by their employer.

Inadequate supply of equipment was identified across geographies as presenting a challenge to the consistent use of PPE. For instance, in Bangladesh, half of the respondents mentioned that they had to spend their own money to buy PPE and over a third said that they did not get supplies as frequently as required.

Fit and comfort is another critical challenge around ensuring the use of protective gear. Almost half of the respondents in Bangladesh mentioned that they do not feel comfortable using PPE, while workers in India and Pakistan reported feeling

**“At this moment, our major requirement is safety kits. Like doctors, we are also performing an important duty. Therefore, only doctors should not be the centre of attention, we are also human beings and deserve respect and support.”**

**Female waste collector in healthcare facility, Islamabad, Pakistan.**

**“Due to high temperature it is difficult to wear full apron which is made of plastic. Other than that, everything is OK.”**

**Sanitation worker in hospital, India.**

**“The municipality had provided us with gloves, mask, shoes and dress. However, the dress is made up of polythene and it tore apart when I was working. We are ladies, and we feel so embarrassed or shameful when dresses like it get torn apart. So, we didn’t take it the next time when the municipality distributed it.”**

**Female sweeper, public, Lahan, Nepal.**

suffocated when using PPE in the heat, and in some cases complained about the size and fitting, too. In some instances, workers were also not satisfied with the quality of PPE provided, with respondents in Nepal and Pakistan reporting PPE that tore easily or was damaged beyond repair after one use.

Another challenge in terms of risk of contamination is unsafe use and re-use of protective equipment. For example, in Bangladesh, only 19% of workers changed or cleaned gloves after using them, and over 10% did so very infrequently (either weekly or monthly). 22% of workers did not wash their hands after removing safety gear. In Pakistan, workers reported washing reusable PPE before the next use, but did so at home as cleaning agents were not available to use at their workplace.



WaterAid/CS Sharada Prasad/Safai Karmachari Kavalu Samiti

**“All the sanitation staff received a training on following SOPs [standard operating procedures] which include wearing mask and gloves, keeping social distance and reporting to the employer in case of having fever. There is a fine imposed if SOPs are not followed.”**

**Sanitation worker (private office), Khyber Pakhtunkhwa, Pakistan.**

## Hand hygiene

Awareness around frequent handwashing as a key safety measure to prevent the spread of the virus is also generally high amongst workers. However, practice lagged behind awareness due to challenges around access to handwashing facilities and supplies, particularly at work sites or while on the move.

In Pakistan and Nepal, all of the respondents mentioned handwashing as a key preventive measure during the pandemic and reported increased frequency of handwashing, especially during work hours. In India, most workers reported washing or sanitising hands at least twice during a workday. However, 40% of workers reported lack of any handwashing stations at work, and handwashing was not consistently carried out at times most relevant for COVID-19 prevention. Handwashing prevalence was comparatively lower in Bangladesh, where over two thirds of workers reported washing hands at the end of the day, and only a quarter of cleaners in medical facilities reported washing their hands with soap after helping a patient.

In the four countries, handwashing practice was strongest where facilities, soap and sanitiser were readily available. For example, in Nepal, where reported practice is high, all the respondents confirmed that they had handwashing facilities at the office, and most of them also reported adequate arrangements while working outside.

## Other preventive measures

In Bangladesh, only 3% of workers reported receiving any kind of training on health and safety issues – these were mainly workers engaged in medical waste management or cleaners working in hospitals. In Nepal, all of the respondents shared that their employers had provided them with separate guidance and instructions on how to do their job safely during the COVID-19 outbreak.

In Pakistan, workers across most locations reported some form of training, briefing or guidance about safety measures during

COVID-19 – such as disinfecting PPE, social distancing, hand hygiene and disinfecting toilets. Sanitation workers employed at public offices said that their employers had placed disinfecting sprays and sanitisers at the entry and exit points of their offices.

In India, interviewees from local urban bodies reported that they had trained workers on PPE use and handwashing using WhatsApp videos and training sessions in small groups to ensure physical distancing. They also reported that workers in their cities were tested with thermal screening, however less than 20% of the workers in the survey reported any thermal screening.

In most countries, workers and key informants were unaware of any guidelines and protocols on how to operate during the pandemic and lockdown. The exception was India, where there were guidelines available at both national and state levels, although the level of awareness and implementation of this guidance varied across the study locations.

Exclusion of informal workers from trainings and other initiatives on preventive measures taken by the state or employers was reported in all the countries.

**In a study location in Telangana, the urban local body was facilitating weekly health check-ups for municipal sanitation workers, which included tests of blood pressure, blood sugar and temperature. The prescriptions were being recorded in the health diaries provided to sanitation workers, which also had key messages on COVID-19 prevention.**

**In a study location in Chhattisgarh, the urban local body facilitated COVID tests for municipal sanitation workers who had COVID symptoms, as was reported by the sanitation workers interviewed.**

## Safety net

### Insurance

Only a small percentage of sanitation workers are covered by some sort of insurance and informal workers are excluded from the insurance cover.

In India, where several states decided to provide health insurance as a response to the pandemic, 35% of the respondents reported being covered. The breakdown by contract type is 70% among permanent workers, 36% among contractual workers and 0% among informal workers.

In Nepal, 42% of the respondents reported having health insurance – with half of them getting coverage after the pandemic hit.

No cases of workers with health insurance were found in Pakistan and Bangladesh.

**“We are poor people, how can we cover our insurance?”**

**Public/community toilet cleaner,  
Lahan, Nepal.**

**“Provision of insurance is there for the employees, but only to the permanent ones – not to the temporary or to those on probation period.”**

**Member, Solid Waste Management  
Association of Nepal.**

## Emergency support

Despite their vulnerability, many workers missed out on support measures that have been introduced due to the pandemic. For instance, only half of the respondents in Nepal and Pakistan were able to access the social security aid for vulnerable populations. Over a quarter of respondents were left out from the regular Public Distribution System for the provision of food grains in India, and only 5% of respondents benefitted from a direct cash transfer that was distributed as part of the COVID-specific emergency support led by the national government.

The reasons behind the workers' exclusion from these various support measures included: being a government employee, not living in rented accommodation, or not having the right paperwork, as reported by workers in Nepal.

**"We haven't received any funds or extra ration from the government because government employees don't get relief packages."**

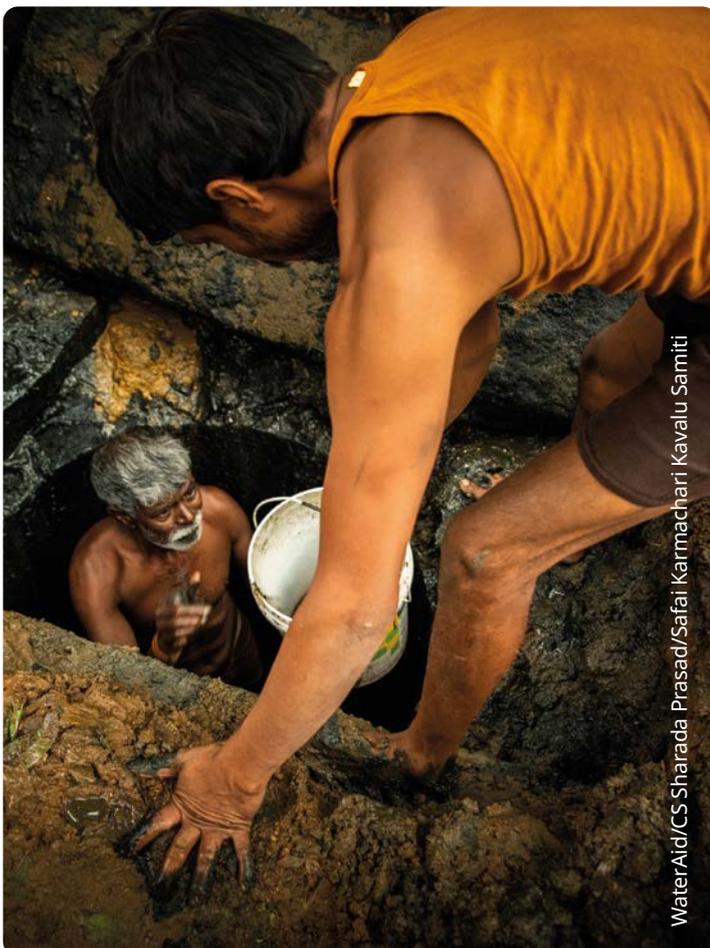
**Septic tank desludging worker,  
Lalitpur Municipality, Nepal.**

**"I have not received any donations/funds because relief packages are provided only to those who lives in rented homes."**

**Waste collector,  
Lalitpur Municipality, Nepal.**

**"I didn't get the relief because I was not able to produce a copy of the citizenship of my landlord."**

**Septic tank cleaner,  
Lalitpur Metropolitan City, Nepal.**



Apart from the emergency support for the vulnerable population, in India there were also targeted financial aid, incentives and insurance cover designed specifically for sanitation workers at national and sub-national levels during COVID-19. However, informal workers were not covered under these provisions that were specifically for sanitation workers – although some of them did receive assistance from non-governmental organisations (NGOs).

The workers interviewed in all the four countries demanded (more) targeted welfare measures, bonuses or financial aid, food rations/coupons and insurance – along with the regularisation of informal workers or at least their inclusion in the available safety nets and welfare measures that have been put in place.

# Conclusions

## Highlights

Sanitation workers are already some of the most marginalised groups in society – often working in conditions that are hazardous and stigmatising, with little to no equipment and low income. These essential public workers have been affected by the coronavirus pandemic in many different ways, with some nuances depending on the type of job they do and level of formality they work at. The outbreak of COVID-19 has had a direct impact on the livelihoods of these workers – in the worst-case scenarios, workers have reported losing all of their income (especially informal female workers, such as cleaners of homes, offices and dry latrines). In the best-case scenarios, most of the sanitation workers have been able to retain work opportunities, but there are also cases of having to work longer shifts without compensation, especially in the health facilities. This has been compounded by an increase in daily expenses. Within the broader context, where workers from many

sectors have lost all their livelihoods during the lockdown, the impact on the financial security of most sanitation workers has been comparatively limited.

This occupation comes at the price of heightened health risks, among workers who were already working in dangerous surroundings with high risks of mortality. Those working in hospitals or quarantine centres are also at high risk. This is compounded by the fact that they tend to live in communities with poor access to WASH services. Due to the fear of COVID-19 spreading, some workers have faced pressure from neighbours and communities to stay away. On the other hand, workers have reported increased self-respect for the critical role they are playing in these difficult times – which is sometimes also being recognised by employers and citizens, despite the long-standing caste-based and religious-based discrimination these workers often face.



While most workers have a basic understanding of the symptoms and measures to protect themselves from coronavirus, it comes mostly from information they see on television and can be generic in nature, rather than occupational-focused and in the shape of formal training.

Workers also reported access to PPE, but it is rarely sufficient in terms of fit, quality, and regularity of supply. The casual workers operating in informal settings, have also had to buy their own PPE – which can often be costly and difficult to source.

Hand hygiene was similarly hindered by insufficient access to handwashing facilities and supply while at work, which also affects their ability to wash their hands and their PPE before going home.

Health insurance, was provided to some permanent and contractual workers, but it is still very far from being the norm – and it is not widely available across the four countries.

With a few exceptions, there were no targeted support measures designed for sanitation workers. A considerable amount of workers have been able to access support packages available to the broader vulnerable population.

## Recommendations

Regional actors need to recognise and highlight the critical role sanitation workers play in current times and the need to protect their rights. Specifically, we propose:

- Regional and global donors and financial institutions review their existing and planned urban investment projects to integrate considerations of sanitation workers, and ensure their health, safety and dignity during the COVID-19 pandemic and beyond.
- Regional and national offices of the International Labour Organisation to support workers' representation and engagement with authorities, and provide guidelines and support to member countries to identify and support informal workers.
- The South Asian Association for Regional Cooperation (SAARC) to create an emergency fund which will provide emergency support to the safety and welfare of sanitation workers during the COVID-19 pandemic.





National governments (or sub-national governments where relevant) need to set up the frameworks and make the required finances available to protect sanitation workers. Specifically, we suggest national governments:

- Develop COVID-19-specific guidelines and protocols for solid waste, sanitation and cleaning work, outlining the necessary health and safety measures and the roles and responsibilities of employers, municipalities, and so on. It should include recommended PPE for different categories of workers, and considerations on waste management settings with COVID-19 patients (hospitals, quarantine centres and households etc.).
- Design a comprehensive safety net and welfare programme in recognition of the services workers are providing during the COVID-19 pandemic, ensuring informal workers are included and mainstreaming gender considerations.
- Put in place strategies to urgently enhance access to WASH in sanitation workers' 'colonies' and settlements.
- Provide earmarked funds to support these measures and ensure they are made rapidly available to sub-national and municipal levels.

Municipal authorities (and town and local authorities), along with private employers, need to effectively implement the actions that will make a difference to the conditions in which sanitation workers operate.

We recommend they:

- Provide handwashing stations with soap and water in workplaces, along with adequate supply of hand sanitisers.
- Ensure adequate supply of PPE for all workers, particularly those at risk of encountering COVID-19 patients, such as cleaners in healthcare facilities.
- Provide COVID-19-specific training on health and safety measures, using physically distanced means (small batches, videos, phone-based etc.).
- Provide oversight of the implementation of health and safety measures through regular checks, and worker and client feedback mechanisms.
- Organise testing, medical check-ups and thermal screening of workers, with clear referral, quarantine periods or isolation protocols for suspected cases. Provide health insurance for all workers – including contractual and daily wage workers – as well as risk bonuses and financial compensation for infected workers.

Civil society, private sector, research institutions and development partners also need to play their part. Primarily, we suggest they:

- Support research and innovation on sanitation work, such as the development of PPE adapted to better suit hot climates.
- Raise awareness about the public service of sanitation workers and challenge perceptions and drivers of stigma and discrimination.
- Support the long-term formalisation of sanitation work, including the support of worker unions, worker-owned enterprises and professional associations.

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