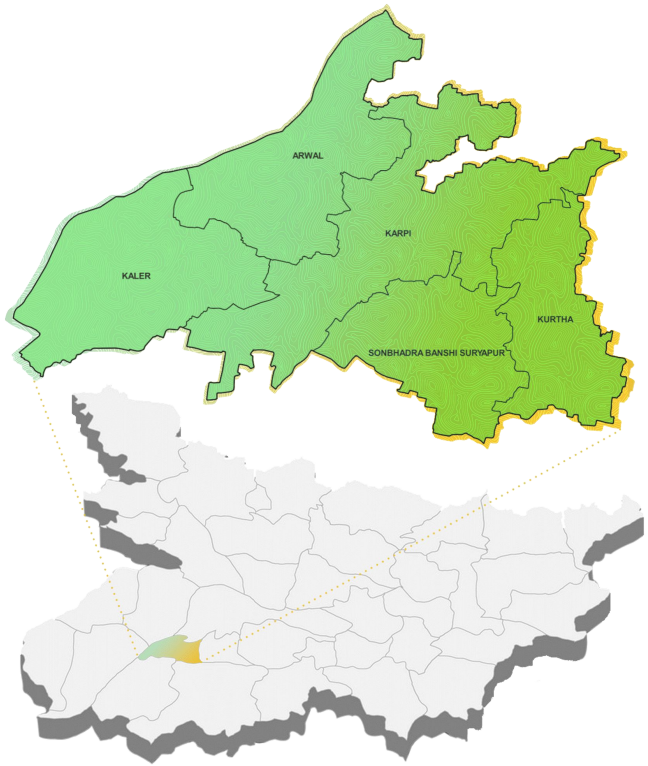
Arwal



TOTAL VACCINATED under RECOVER Bihar

DOSE 1

Total Targeted **5194** — Total Vaccinated **5783**

18+ years	15 to <18 years
4822	961

DOSE 2

Total Targeted **13081** — Total Vaccinated **13675**

18+ years	15 to <18 years
12107	1568

SPECIAL GROUPS VACCINATED

Lactating mothers 328	General 16569	Pregnant women 222	Migrant workers 50	Elderly 1529
Chronically ill 165		People with disability 48	Refusal 547	

NO. OF BLOCKS 5

NO. OF VILLAGES 58

POPULATION DEMOGRAPHICS

Caste & Religious Composition
Hindu Scheduled Castes, General, Other Backward Castes, Muslims

Common Occupations
Agricultural Farming, Day-Wage Labour, Brick Kiln Labour, Carpentry, Migrant Workers, Small Business Owners

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PCI A Global Communities Partner

विहारा VIHARA

OVERVIEW

Hard-to-reach

Arwal has a mixed terrain consisting of plain lands, coarse sandy patches in some regions, a canal flowing across the district, and rivers that seclude many villages. Arwal is infamous for its history of 14 genocides and naxal invasion, which makes villages, such as Baathe, an unfavourable place to visit. The district hosts three remote villages which are situated at large distances, with secluded and broken roads, no public transportation and limited phone connectivity. As a result, many villages and their inhabitants are consequently categorized as 'hard-to-reach' for the public health system and its representatives.

Systemic issues

Low trust on government authorities is prevalent due to regular police raids and coercion in the past. As a result, beneficiaries were opposed to speaking with any 'outsiders' or give any personal details during line listing. Furthermore, gendered response of district/block officials and beneficiaries towards the female leadership of PCI was common in the initial months of the program, and posed a hindrance to rapport building and liasioning, beneficiary mobilization, and internal team management.

Recruitment and attrition challenges

Limited access to resources, including education, has percolated into low literacy level among beneficiaries, especially women, which made mobilization and recruitment of Village Mobilization Coordinator (VMC) challenging across Arwal. Furthermore, the last-mile nature of work, salary concerns, and influence of opposing parties within the village resulted in dropouts.

Vaccination protocols and unavailability of beneficiaries

As per the official government mandate, a vaccine vial is to be opened only if a minimum of 8 adults or 15 children are present at a time. As a result, vaccination across many villages in Arwal was impacted. In addition to this, unavailability of beneficiaries during the day due to clashing work schedules, was another barrier to vaccine coverage.

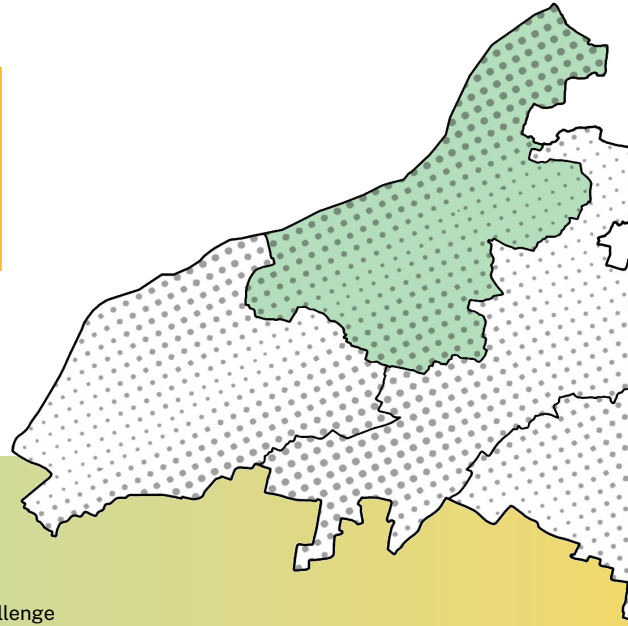
BLOCK ARWAL SADAR

13
NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Mainly Hindu Scheduled Castes (Musahar, Dusaad, Dalit); Other Backward Castes (Yadav, Badhahyi); General Castes (Bhumihaar); and a few Muslims

> *"If you don't hire me, I'll ensure no one in the village even talks to you."*
>
> **VMC Candidate, Arwal Sadar**



KEY BARRIERS

Low trust on authorities

Several villages in Arwal Sadar, such as Musahari tola in Konika are prone to police raids due to illegal production and sale of alcohol. As a result, low trust on 'outsiders' is prevalent, as residents perceive them to be authorities in disguise. This posed a major barrier to mobilization, as beneficiaries would either run away from their homes on seeing the PCI team or not open doors despite repeated knocks. Furthermore, line listing was a challenge as many beneficiaries' Aadhar Cards were torn in the past, or they would be reluctant to share personal details and instead, make excuses. Violence among beneficiaries was also prevalent, with instances of PCI team being threatened. For instance, during VMC recruitment in Musahari Tola, they were threatened to hire an ineligible candidate, otherwise working in this village would be impossible.

Recruitment challenges

Recruiting and retaining VMCs in this block was a challenge due to high illiteracy among women and hesitations of visiting certain villages. For instance, the PCI team was unable to find a suitable VMC candidate in Musahari Tola. Therefore, this village was allocated to the Konika village VMC. However, she would refuse to visit this tola unless another PCI team member accompanied her. Furthermore, attrition among VMCs was high due to the influence of opposing local health cadres who would instigate VMCs out of jealousy as they were not hired instead (missing out on an alternative source of income). Additionally, communication with VMCs and mobilization of beneficiaries was a challenge as phones would mostly remain with men.

KEY STRATEGIES EMPLOYED

1

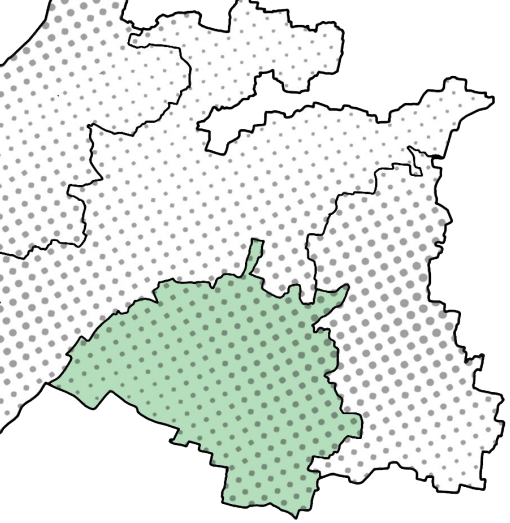
Verifiers stepping in to mobilize beneficiaries by showing videos, in the absence of a mobile phone.

2

Block Coordinator undertaking line-listing in villages such as Konika Musahari Tola, where no VMC or Verifier agreed to work.

3

Leveraging mobilization support of frontline workers such as ASHA and Anganwaadi by providing them with collaterals developed by Vihara Innovation Network.



BLOCK BANSHI

10
NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Muslims (Sheikh, Malik, Ansari); Hindu Scheduled Castes (Sharma, Singh); and Other Backward Castes (Yadav, Paswaan, Mala, Chamaar, Koeri)

> *I won't get my child vaccinated. I got a fever after the vaccine, so no, won't get him vaccinated.*
>
> **Parent of a 12-year-old, Banshi**

KEY BARRIERS

Poor physical connectivity

Punpun river cuts through Bansi, with equal number of villages on either side, connected by a narrow bridge. Access to a few villages such as Kurmawa and Parpura is limited due to damaged roads, with commute possible only on bike. Improper, secluded roads and alcoholism prevalent among beneficiaries across the block also makes it unsafe to move around. Furthermore, delays due to Auxiliary Nurse Midwives (ANMs) not reaching on time as a result of geographical constraints, impacted vaccination coverage, especially among beneficiaries who leave the house early mornings for work.

Fear of side-effects and competing priorities

Beneficiaries were hesitant to take the vaccine due to lack of risk perception and fear of side-effects as well as fatalities post-vaccination, especially guardians of 12-14 year-old children and residents of Harijan tola in Kumrawa. Additionally, the clashing work schedules of beneficiaries across the block made mobilization and vaccination difficult. For instance, beneficiaries in Daudpur Bhun Tola leave their house for work early in the morning at 4:00-5:00 a.m. which made it difficult for the PCI team to even meet them.

Challenges around vaccine vials and adequate due beneficiaries

As per the official mandate, enough number of eligible beneficiaries need to be present before opening a vaccine vial to avoid wastage. This posed a major bottleneck across villages, especially when vaccinating children, who had to be at least 15 in number per vaccine vial.

Lack of mobilization support

Health cadres such as ASHAs provided limited mobilization support to the PCI team due to concerns around inadequate monetary compensation. Furthermore, availability of ANMs on preferable dates for vaccination sessions was a challenge during the initial months of the program. In addition to this, school administrators were reluctant to hold session sites within the school campus, as they were opposed to risking their students' lives.

KEY STRATEGIES EMPLOYED

Use of Alternate Vaccine Delivery (AVD) vehicle arranged by PCI to transport the vaccine carrier, ANM, and Verifier to hard-to-reach areas for organizing vaccination sessions.

1

2

Leveraging the support of community influencers such as Mukhiya (PRI Head) and Ward Members for door-to-door mobilization and vaccination of reluctant beneficiaries as well as out-of-school children.

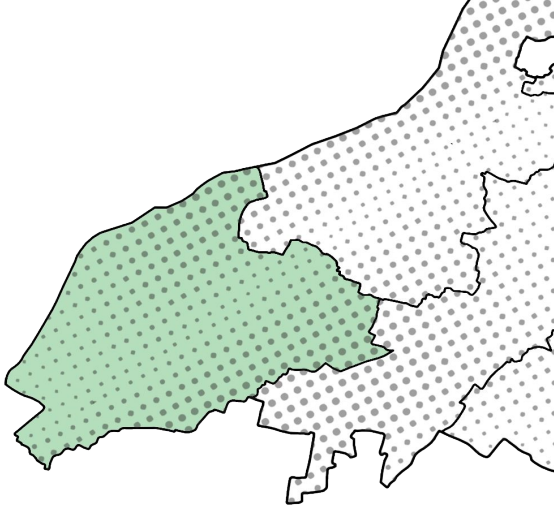
BLOCK KALER

10
NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Hindu Scheduled Castes (Musahar, Dalit); Other Backward Castes (Yadav); General Castes (Rajput, Bhumihaar); and Muslims

> *People don't want to take the vaccine at all now, since COVID-19 is not at its peak any more.*
>
> **Block Coordinator, Kaler**



KEY BARRIERS

Poor physical and phone connectivity

One of the main barriers to vaccination uptake in Kaler was accessibility (physical and digital) due to geographical constraints. Villages are situated at large distances in the interiors; broken roads and coarse sandy patches in a few regions are common, with villages secluded by Son river. This block is infamous for its history of 14 genocides in Baathe, and continues to be an unfavourable place to visit because of the fear and stigma associated with it. Kaler has three hard-to-reach villages that are difficult to access and have limited phone connectivity.

Recruitment challenges and repetitive data collection

Most of the beneficiaries in Kaler have low literacy levels and low awareness around COVID-19 vaccination, which negatively impacted mobilization and was also a barrier to VMC recruitment. Lack of awareness resulted in reluctance around producing Aadhar Card or vaccination certificate, and in turn led to instigation of others to also not cooperate with the PCI team. Furthermore, repetitive data collection of similar information for surveys conducted by multiple partners aggravated beneficiaries' hesitancy and posed a major roadblock during line listing.

Challenges around vaccine vials and adequate due beneficiaries

Since several beneficiaries across villages have been vaccinated, only a few remain now. As per the official mandate, a vaccine vial can be opened for usage only if a minimum of 8 beneficiaries are present. Matching the number of due beneficiaries in a single village with vaccine vials to avoid wastage became a challenge for the team and delayed vaccination.

Perceptions and mindsets

Prevalence of misinformation around post-vaccination side effects and fatalities, especially among pregnant women and elderly, limited vaccination uptake in Kaler. Due to the dip in COVID-19 cases, beneficiaries also didn't feel the need to get vaccinated, unlike earlier.

KEY STRATEGIES EMPLOYED

1

Signage installed by PCI in villages such as Rupibigha to mark the achievement of 100% saturation of COVID-19 vaccination (first dose).

2

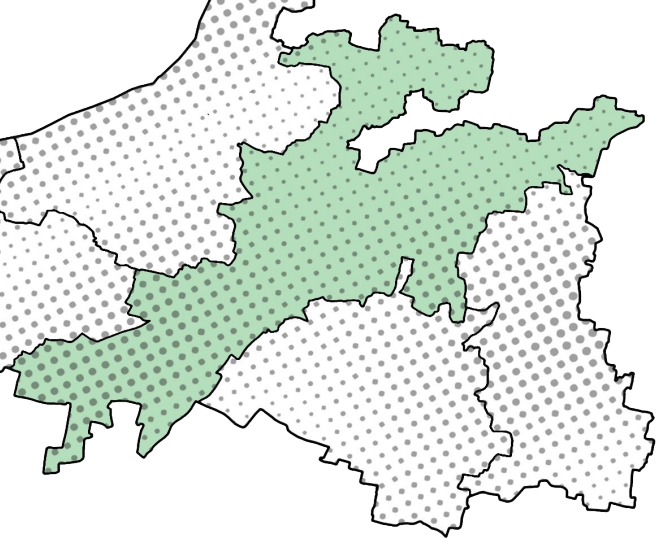
Leveraging support of school principals and other authorities to mobilize parents/guardians of students, and address their concerns.

3

Liasioning with Block Health Manager (BHM) to build strategy for villages with less vaccination coverage.

4

Training of ASHAs and ANMs conducted by PCI team to educate them on the collaterals, its usage in targeted counselling, and for addressing queries.



BLOCK KARPI

10
NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Muslims; and Hindu Scheduled Castes (Malaa, Paswaan, Chamaar, Naayi, Musahar, Harijan)

> *On revisiting houses after 2 hours, we would see that the home stickers have been removed. People don't want others to know that they're unvaccinated.*
>
> **Block Coordinator Karpi**

KEY BARRIERS

Low trust on 'outsiders'

Low literacy and awareness around COVID-19 is prevalent among beneficiaries of Karpi. Use of coercion to increase vaccination uptake in the past, led to mistrust on 'outsiders'. Association of vaccination with political leaders or it being a political propaganda against a particular religious community aggravated this mistrust. Beneficiaries would run away from their homes on seeing the PCI team, be extremely reluctant to even converse with the team, and/or not share their Aadhaar Card details during line listing because of fear of robbery from their bank accounts. Lack of team's identification proof with regard to their association with PCI and repetitive data collection of similar information by multiple partners exacerbated beneficiaries' hesitancy.

Perceptions and competing occupational priorities

Karpi has a large population of migrant workers, working in neighbouring districts and/or metropolitan cities. The remaining beneficiaries in the block leave their house early in the morning for work. This made it challenging for the PCI team to identify due beneficiaries, mobilize, and track them for post-vaccination care as well as certificate distribution. Furthermore, in a few villages, despite pasting home stickers across all houses of due beneficiaries, the stickers would be torn apart by beneficiaries, to hide their vaccination status amidst other village residents and avoid potential social exclusion.

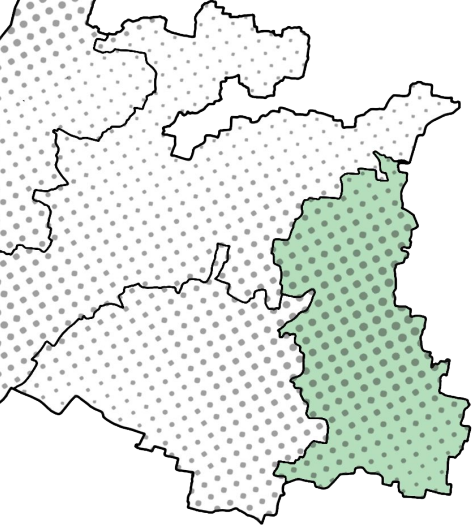
KEY STRATEGIES EMPLOYED

Pasting of home stickers by VMC to help identify the number of unvaccinated beneficiaries in a household and help track due date of subsequent dose.

1

Vaccination of beneficiaries at session site after validation of personal details and updating of Aadhar Card details on line list by Verifier.

2



BLOCK KURTHA

15
NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Muslims; and Hindu Scheduled Castes (Malaa, Paswaan, Chamaar, Naayi, Musahar, Harijan)

> *I wouldn't be able to go to more houses now. It's too hot. I'm tired."*
>
> **Auxiliary Nurse Midwife, Kurtha**

KEY BARRIERS

Poor physical connectivity and harsh weather conditions

Kurtha is home to a few hard-to-reach villages situated at large distances, with broken roads and no public transport in some part of the block. In addition to the geographical constraints, scorching heat during summers made it difficult for the ANM and PCI team to walk door-to-door, especially in villages with houses scattered around at large distances.

Competing priorities

The majority of the population in this block is involved in outdoor jobs, for which they leave their house early in the morning. This posed a barrier in identification of due beneficiaries, mobilization, vaccination as well as tracking for post-vaccination care, impacting the overall coverage in Kurtha. Unavailability of beneficiaries during the day, since many would rest and not open the door, was another challenge that PCI faced.

Perceptions and mindsets

High refusals were prevalent in Kurtha as a result of low risk perception, especially among young people (20 to 25-year-olds) who felt they're strong enough to escape the virus. Other barriers included fear of post-vaccination side-effects and fatalities among pregnant women (PWs) and lactating mothers (LMs). Additionally, elderly beneficiaries didn't see any benefit of getting vaccinated, as they believed to only live a few more years.

KEY STRATEGIES EMPLOYED

1

Coordination with Coldchain authorities to develop a microplan, further vetted by Medical Officer In-Charge (MOIC) and Block Health Manager (BHM).

2

Against all odds, PCI team conducts door-to-door vaccination of due beneficiaries, unable to visit the session site.

3

Training conducted by PCI for VMCs to introduce collaterals and its usage in targeted counselling, address challenges faced on field, and answer queries.

CASE STORY

Line listing conducted by Block Coordinator in the absence of recruiting a Village Mobilization Coordinator (VMC).

Konika Musahari community belongs to the Arwal Sadar Block of Arwal District. Musahar, named after their traditional occupation as 'rat catchers and eaters' are a Mahadalit community. Low level of literacy and lack of employment opportunities continue to hold the community back, and in most areas, the members of the community are forced to rely on rat catching as a means of survival owing to destitution and poverty.

Lack of literacy and, thereby, negligible exposure around current happenings, has made it extremely difficult to convince and inform the hesitant and ambivalent populations of the community. Building trust among the community members, who are rightfully concerned about being exploited, is quite a challenge for any organization. Any outsider is looked with suspicious eyes, and there is an immense fear of the police. And therefore, the Project Concern International (PCI) team was also not given a warm welcome.

Multiple efforts of finding and recruiting an eligible person as Village Mobilization Coordinator (VMC) went in vain due to high illiteracy rates and reluctance among people. The RECOVER team, finally, decided to extend their responsibilities and work in place of VMC here. However, the challenges did not end here. The next biggest challenge was to persuade the people for vaccination uptake.

Mobilization in groups to further motivate other village residents, followed by door-to-door vaccination of due beneficiaries by PCI.

The team faced immense hesitancy in the enrolment process itself. People were not ready to give their names or any information to the personnel. To tackle this barrier, the team first identified and persuaded beneficiaries outside the Musahari community, who were situated in close proximity. Later on, the team leveraged their help to build trust with the Musahari community.

After the Musahari witnessed the communities near them participating in the vaccination process, they came forward for line listing and eventually started getting vaccinated. It took the Block Coordinator (BC) about 10 days to complete the line listing and set up a site vaccine session.

On the day of the vaccination session, an unforeseen barrier emerged. Despite having completed the line listing and having informed the beneficiaries about the session date and time, people did not turn up. Upon inquiring further, the RECOVER staff learned that it is the *katni season* i.e. harvesting season and everyone was busy with their work. This news required the team to evolve their strategy. The team decided to switch to vaccine-on-the-go mode and started visiting each house to get people vaccinated. Initially, only 20 residents were vaccinated.

Although this number might seem small, this was certainly a huge victory for the team, given the extreme opposition they faced. PCI continued using this strategy, and has been able to vaccine a significant proportion of the population, with an overall coverage of 90% (both first and second dose) - a noteworthy win, indeed.

We appreciate the commendable efforts of Monika Panwar (District Coordinator), Amit Kumar (Block Coordinator), Madhulika Kumari (Block Coordinator), and the entire team of Village Mobilization Coordinators and Verifiers in bringing this district one step closer to 100% vaccination.

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Abbreviations & Acronyms

ANM
Auxiliary Nurse Midwife

ASHA
Accredited Social Health Activist

AVD
Alternate Vaccine Delivery

AWW
Anganwadi Worker

BC
Block Coordinator

BHM
Block Health Manager

DC
District Coordinator

LM
Lactating Mother

MOIC
Medical Officer In-Charge

PRI
Panchayati Raj Institution

PW
Pregnant Woman

VMC
Village Mobilization Coordinator