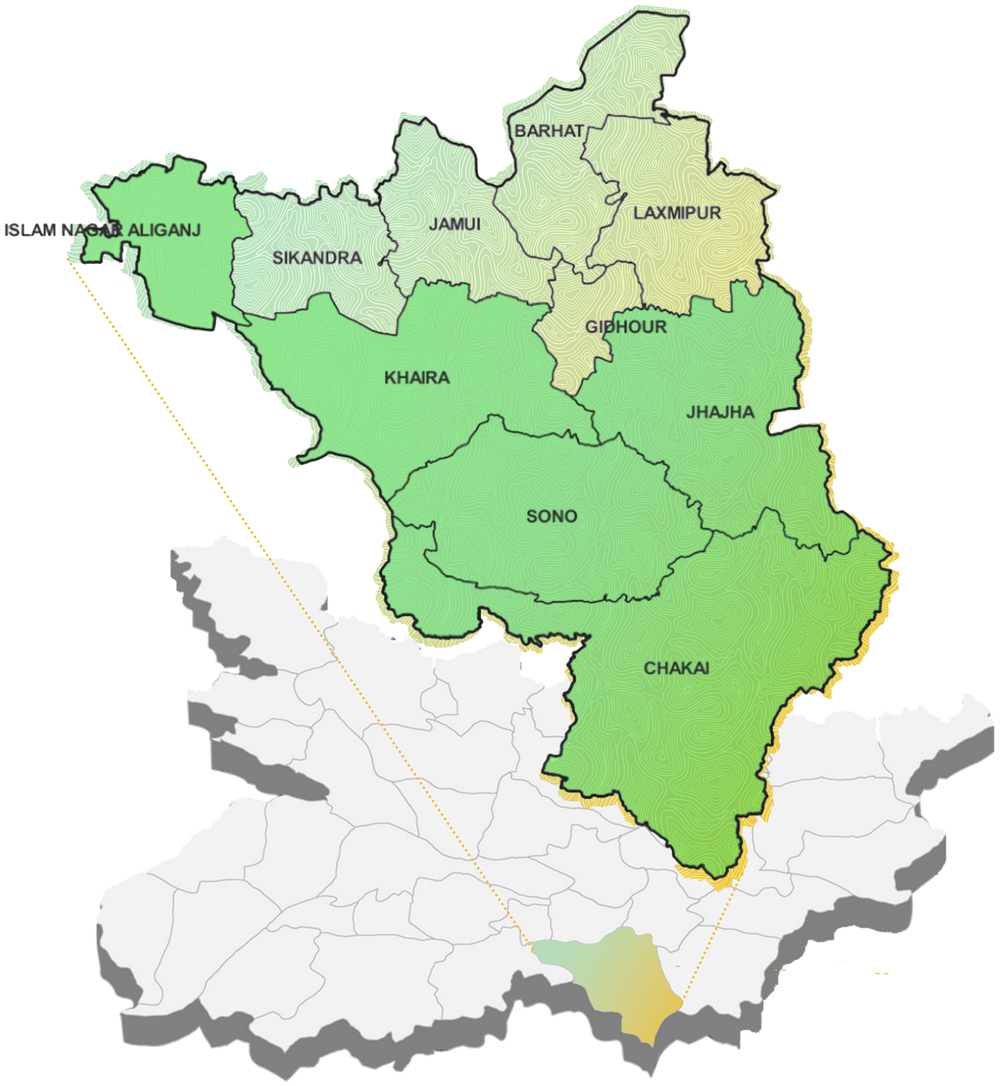
# RECOVER Bihar
# DISTRICT PROFILE

## JAMUI




### TOTAL VACCINATED under RECOVER Bihar

**DOSE 1**

Total Targeted **4671** Total Vaccinated **8773**

| 18+ years | 15 to <18 years |
|---|---|
| 3591 | 5182 |

**DOSE 2**

Total Targeted **16030** Total Vaccinated **14390**

| 18+ years | 15 to <18 years |
|---|---|
| 9847 | 4543 |

**NO. OF BLOCKS** 5

**NO. OF VILLAGES** 64

### POPULATION DEMOGRAPHICS

**Caste & Religious Composition**

Hindu Scheduled Castes, Schedules Tribes, Christians and Muslims

**Common Occupations**

Migrant Workers, Farming, Wood Cutting / Collection, Leaves Collection, Brick Kiln Workers, Bidi Rolling, Day Wage Labourer, Business Owners

### SPECIAL GROUPS VACCINATED

| | | | | |
|---|---|---|---|---|
| Lactating mothers 509 | General 19280 | Pregnant women 328 | Migrant workers 506 | Elderly 1477 |
| Chronically ill 183 | | People with disability 38 | Refusal 842 | |

The Packard Foundation supported RECOVER project, an embedded partnership between Project Concern International (PCI) and the Vihara Innovation Network (VIN), is actively supporting the Government of Bihar's endeavour to achieve 100% vaccination coverage.

PCI A Global Communities Partner

विहारा VIHARA INNOVATION NETWORK


## OVERVIEW

### Hard-to-reach

The district of Jamui is situated on the Bihar-Jharkhand border and has a history of naxal invasion. It has a mixed terrain of hills and thick forests, with rivers and small streams cutting through different blocks and villages, which makes it particularly difficult to access by transport. This region and its inhabitants are consequently categorized as 'hard-to-reach' for the public health system and its representatives. In some villages, the penetration of health services and schemes, including COVID-19 vaccination, is also limited due to its difficult topography. Limited access to education has also percolated into low literacy level, making mobilization of beneficiaries challenging.

### Systemic issues

Low trust on government authorities due to past experiences is prevalent across the district. Lack of structural support to compensate for one's loss of day-wage earning, no support for women undertaking various domestic duties, and limited external support by system stakeholders to PCI team in some villages acted as other barriers to vaccination. Mobilization and tracking of migrant workers was another challenge that PCI faced.

### Perceptions and mindsets

Misinformation as a result of rumours around COVID-19 vaccination being a political propaganda was widely prevalent across Jamui. Other reasons for hesitancy include fear of post-vaccination bodily side-effects and fatalities, especially among specific population groups - Pregnant Women (PW), Lactating Mothers (LM), Chronically Ill (CL), Elderly (EL), People With Disability, and Muslim Minorities.

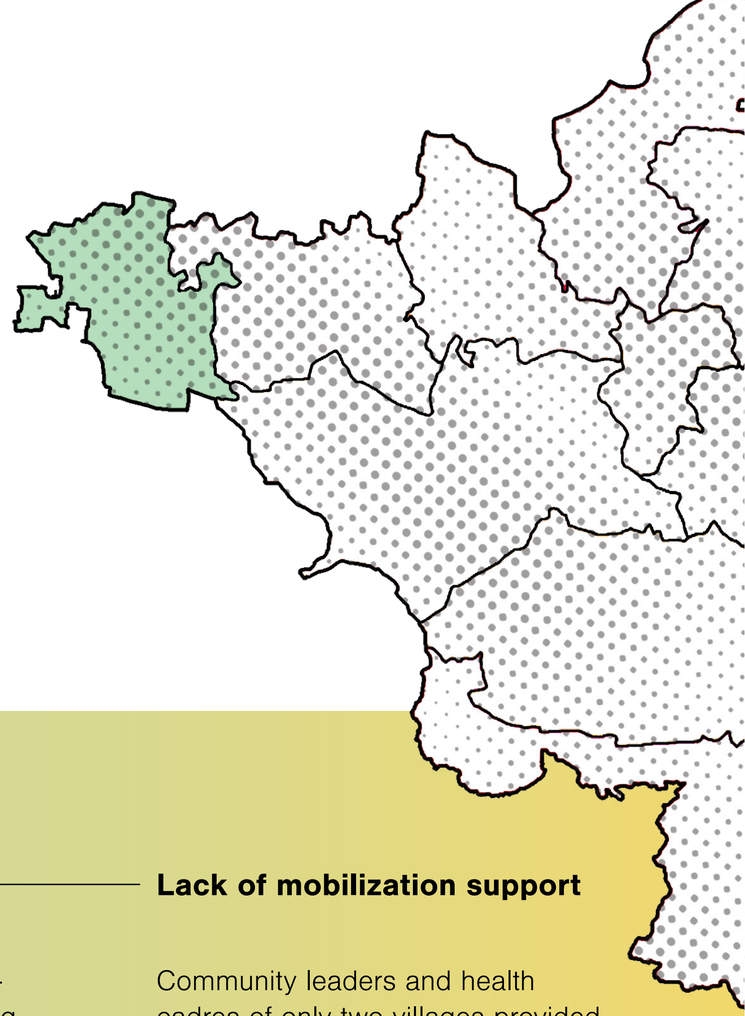
# BLOCK ALIGANJ

13
NO. OF VILLAGES

**POPULATION DEMOGRAPHICS**

Hindu Scheduled Castes and Other Backward Castes (Maanjhi, and Yadav); and Muslims

> *If you give in writing that nothing will happen to me (post-vaccination), then I'll get vaccinated.*
>
> **Beneficiary, Deen Nagar, Aliganj**



## KEY BARRIERS

### Low trust on 'outsiders'

Strong in-group social dynamic pronounces the 'us vs. them' dynamic, leading to a lack of trust in 'outsiders'. This lack of trust was a result of past fraudulent activities (someone posed as a JEEViKA representative and collected money), which became one of the biggest barriers to vaccination uptake. As a result, beneficiaries were reluctant to share their personal details, including Aadhaar Card, as they feared being robbed.

### Low literacy and awareness impacting mobilization

Low literacy level and awareness around COVID-19 among some populations also made it challenging to gain their trust, as it is a new concept to them.

### Fear of side-effects and expectations around incentives

Apart from fear of post-vaccination side-effects among special groups, requesting incentives or written guarantee of wellbeing after vaccination was a common practice which hindered vaccine uptake.

### Lack of mobilization support

Community leaders and health cadres of only two villages provided necessary mobilization support, despite several requests made by the PCI team. They would come forward only during visits by health officials and other governance stakeholders, as a result of competing priorities and limited motivation.

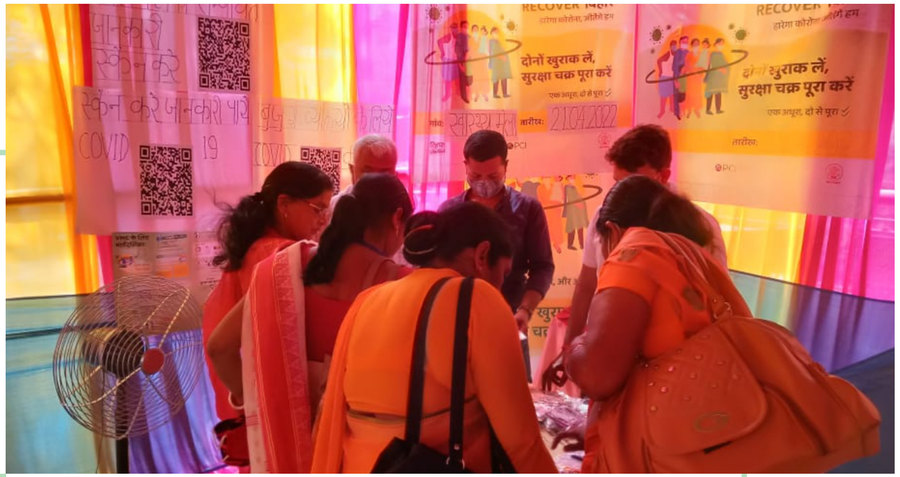
## KEY STRATEGIES EMPLOYED

1

Supportive supervision of line listing undertaken by PCI to ensure no one is left unvaccinated.

3

Distribution of certificates post-vaccination at camp site by PCI.




2

PCI proactively participates in Health Fair inaugurated by MLA Mr. Prafull Manjhi, by setting up a mask distribution cum mobilization counter.


4

PCI leverages Madarsa Islamia's teacher in mobilization and distribution of dry fruits to vaccinated beneficiaries under the Randomized Control Trial (RCT) to encourage vaccination uptake.

# BLOCK CHAKAI

**13**
**NO. OF VILLAGES**

**POPULATION DEMOGRAPHICS**

Mainly Hindu Scheduled Tribes (Kisku, Murmur, Marandi, Tuddu); few Other Backward Castes; Muslims; and Christians

> *I don't have enough money to get my treatment done in a good hospital (in case of a health emergency post-vaccination).*
>
> **Beneficiary,**
> **Ansari Tola, Chakai**

## KEY BARRIERS

### Poor physical and communication connectivity

The main barrier to vaccination uptake in Chakai was accessibility (physical and digital) due to geographical constraints. There are villages on hilltops, or villages surrounded by the river, or streams that cut off access to a connecting road, secluding villages from access to healthcare. This posed a difficulty in communication and monitoring due to geographical barriers and limited phone connectivity.

### Low literacy and awareness impacting mobilization

Low literacy among the majority population, which consists of tribal communities, exacerbated the challenges of recruiting Village Mobilization Coordinators (VMCs) and mobilizing beneficiaries.

### Low penetration of healthcare

One of the supply-side barriers prevalent here was low penetration of health schemes and services due to difficulty for an Front-Line Worker (FLW) to reach these villages or lack of a designated FLW, Anganwaadi Centre or school in some villages. This resulted in high refusal among many beneficiaries, particularly in regions with limited penetration of Routine Immunization (RI), where people were alien to the concept of vaccination.

## KEY STRATEGIES EMPLOYED

1

Offsite vaccination through door-to-door delivery for remaining unvaccinated beneficiaries in difficult terrains.

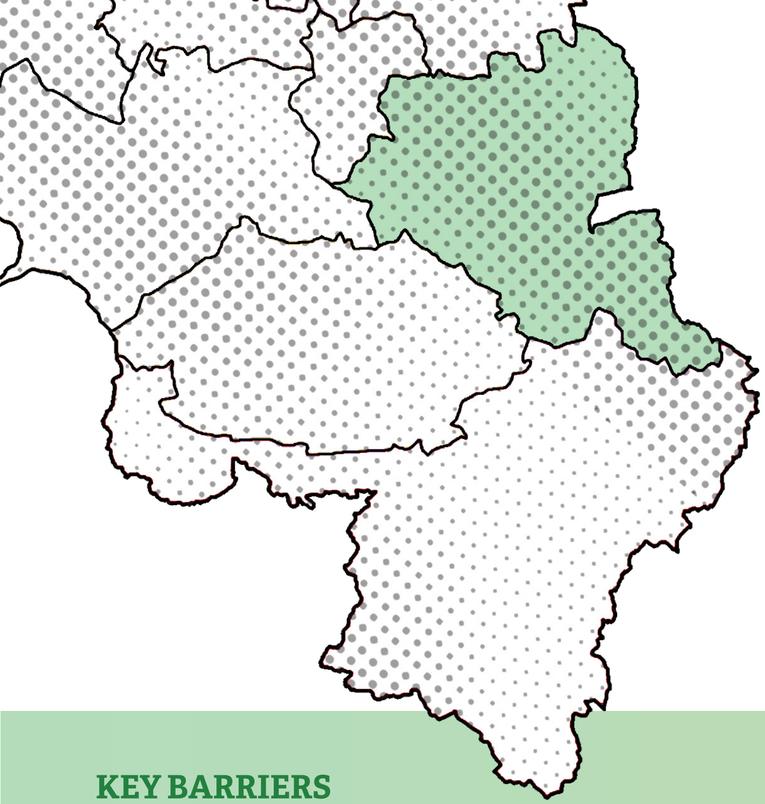
Arrangement of Alternate Vaccine Delivery (AVD) by PCI to transport ANM and the vaccine for vaccinating beneficiaries in hard-to-reach areas.

2



Under the RCT study conducted in collaboration with Yale University, beneficiaries receive Rs.150-200 worth of coupons post-vaccination, which is redeemed at the local kirana store.

3



# BLOCK JHAJHA

9
NO. OF VILLAGES

**POPULATION DEMOGRAPHICS**

Primarily Muslim; few Hindu (Ravidas, Yadav, Varnawaal, Pandit Brahmin, Dhobi, Mandal / Kurmi)

> *When the doctor (RMP) comes, only then will I take the vaccine.*
>
> **Beneficiary, Tahwa, Jhajha**

## KEY BARRIERS

### Difficulty in tracking vaccination of migrant workers

A large proportion of the population in Jhajha are migrant workers, which made mobilization and registration of beneficiaries challenging, along with follow-up and tracking for post-vaccination care and subsequent dose.

### Limited agency of women

Dependency of women on their migrant husbands to get the vaccine is a causal barrier to vaccine coverage, and in few cases led to hidden refusal of using their absence as an excuse to avoid getting vaccinated.

### RMPs as a trusted source, but lack involvement in vaccination

Another challenge this block grapples with is its proximity to a health facility. Rural Medical Practitioners (RMPs) are a trusted source for all their healthcare needs, especially during emergencies, as they're readily accessible. However, lack of formalized involvement of RMPs around vaccination made it challenging to mobilize beneficiaries in Jhajha. For instance, in Tahwa, beneficiaries demanded the RMP's presence in order to take the vaccine.

## KEY STRATEGIES EMPLOYED

1

Usage of mobile sticker for migrant workers to enable tracking of due date for subsequent vaccination dose.

2

Vaccination camp organized by PCI at schools for 15-17 year olds.

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

3

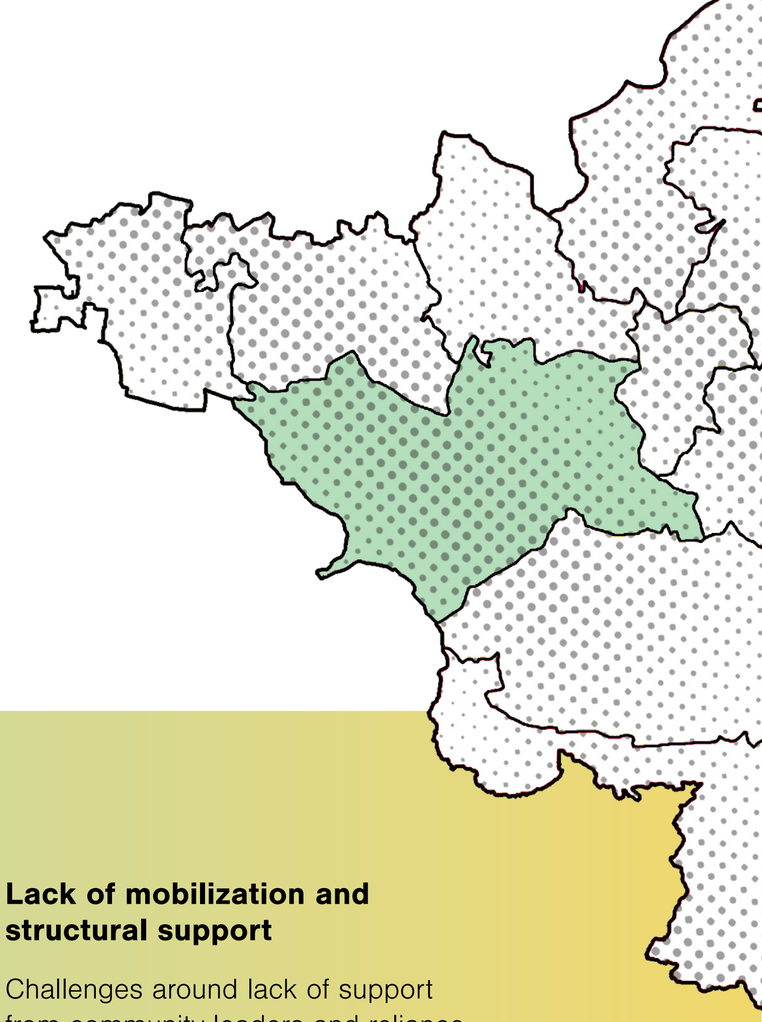
# BLOCK KHAIRA

12
NO. OF VILLAGES

**POPULATION DEMOGRAPHICS**

Hindu (Manjhi, Yadav, Pandit, Kumar, Baniya); and Muslims

> *You'll vaccinate me and leave, but who will look after me (for post-vaccination care)?*
>
> **Beneficiary, Khaira**



## KEY BARRIERS

### Difficulty in tracking vaccination of migrant workers

Khaira has a large population of migrant workers working in nearby villages or other States such as Bengal, Orissa, Uttar Pradesh or Jharkhand. Mobilization, registration, and tracking of these populations posed as a major challenge.

### Low trust on authorities

Prevalence of low trust on government authorities in Khaira made mobilization of beneficiaries even more challenging. For instance, in Kurwadih, even though the Sub-Divisional Magistrate visited the village to personally address the residents, the vaccine coverage was fairly lower than anticipated.

### Lack of mobilization and structural support

Challenges around lack of support from community leaders and reliance of beneficiaries on RMPs for all health-related needs were other barriers to vaccination. Another major barrier in Khaira was the lack of proper structural support in some villages, compelling beneficiaries to worry about a potential health emergency post-vaccination.

## KEY STRATEGIES EMPLOYED

1

Sub-Divisional Magistrate (SDM) visits Kurwadih village, along with PCI to mobilize beneficiaries and personally address their concerns.

Medical Officer In-Charge (MOIC), Dr. Amit Ranjan addresses and motivates unvaccinated beneficiaries during the RCT village inauguration.

2


Drawing competition held across different schools in Bela to engage with students and build more awareness around protection against COVID-19, including through vaccination.

3

# BLOCK SONO

**16**
**NO. OF VILLAGES**

**POPULATION DEMOGRAPHICS**
Muslims; and Hindus (Mandal, Kumhaar, Yadav, Varnawaal, Ravidas)

> *Nothing has happened over the past 6 months, then what will happen over the remaining 3 months? Will get vaccinated later.*
>
> **Pregnant woman, Sono**

## KEY BARRIERS

### Poor physical connectivity and low healthcare penetration

Sono block is divided by Ulayi river, with almost equal number of villages on either sides of the river. Accessing many villages is a challenge due to mobility issues - crossing the river, especially during monsoons was impossible. About 2 years ago, a bridge was constructed which made travelling to different villages fairly better. As a result, penetration of health services and schemes, including Routine Immunization, is historically low in few villages.

### Differing religious beliefs limiting vaccination uptake

Refusal among special groups, including Muslim minorities was also high across the block. For instance, in Babudi village, the maulwi was reluctant to get the COVID-19 vaccine as it was against their religious beliefs. This further influenced other village residents, especially special groups, and posed as a challenge for the PCI team.

### Difficulty in tracking vaccination of migrant workers

Furthermore, this block also consists of many migrant workers whose mobilization, registration, and tracking for post-vaccination care and subsequent dose was a challenge.

## KEY STRATEGIES EMPLOYED

1

Coordinated effort between the VMCs, Verifiers and Block Coordinator to ensure the linelist is updated and ready for use.


2

Innovative ways (such as lottery prize) employed by PCI in collaboration with local influencers to mobilize beneficiaries and engage with the community at large.

PCI works closely with Dr. Parwez, a trusted and influential figure in the community, to mobilize unvaccinated beneficiaries by also holding a free health check-up camp with free medicine distribution to reassure people.

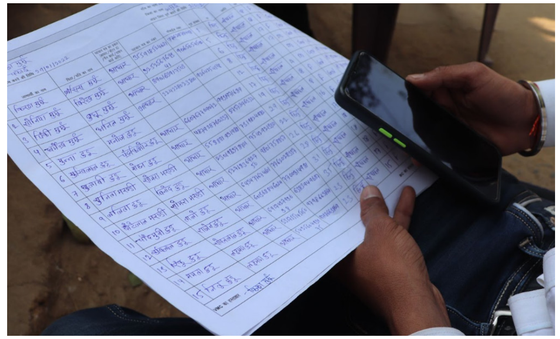
3

## CASE STORY

The Garudbad village is located on Bihar-Jharkhand border, making it a hard-to-reach settlement. This village consists of Muslims, who primarily work as day wage labourers and/or are migrant workers, mainly in Kerala, Bengaluru and Kolkata. Residents are devoid of basic facilities like school, Anganwadi Center, and even Routine Immunization - only polio drops have been reported as an accessible intervention. The nearest PHC is 17-20 kilometres away. They are not exposed to any kind of vaccines, as a result, building intent was difficult. There was also a heightened fear of the unknown. As most males are day wage labourers, they fear losing wages if they fall sick after vaccination.

Additionally, the village doesn't have a designated ASHA or Anganwadi.

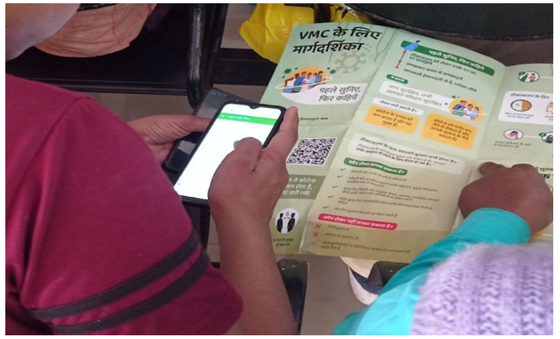
In response to this, the PCI team appointed a VMC and Verifier to line list and mobilize all eligible beneficiaries by visiting each house. Further, the Block Coordinator facilitated microplanning at the block, organized a session site to include this village, and also arranged for an AVD to transport ANM and the vaccines. In addition to this, the VMC visited each eligible individual and educated them about the benefits of vaccination with the help of a leaflet to address any stakeholder specific concerns.



*Appointing of VMC and Verifier to line list and mobilize.*

*Microplanning for session site and provision of Alternate Vaccine Delivery (AVD) by PCI.*

*VIN's team interacting with beneficiaries to understand community's perceptions around vaccination.*




*Building awareness among beneficiaries about vaccines through collaterals developed by VIN in collaboration with PCI.*

## CASE STORY

*Inauguration of RCT by Medical Officer In-Charge, PHC Chakai on 7th March 2022, who also talked to beneficiaries around preparedness & vaccine safety.*

*Beneficiaries getting vaccinated within their village itself.*

Karijhal village lies in the lap of Chakai hill range and is situated in the interiors of Chakai Block, Jamui. It has an extremely rocky terrain with scanty vegetation, and is prone to Naxal invasion, making it unsafe to move around after sunset. It consists of three tolas - Karijhal, Chandosol and Jamnitar, which are home to several Hindu Scheduled Tribes such as Murmur and Marandi, and a small proportion of Christians. Accessibility is a major challenge here as the main hamlet is divided by a stream of river, and crossing the rocky terrain is only possible on a bike or by foot. Access to healthcare among other things is a challenge as the nearest PHC is located about 10 kms. Initially, residents had to walk to a nearby village (located ~4kms away) to get the first vaccination dose. But since this site also hosted neighboring villages, crowd management was difficult and limited vaccine supply resulted in multiple visits by the residents. Additionally, targeted counselling and mobilization has been another challenge, due to the lack of a designated ASHA in this village. As a result, majority of the mobilization efforts are undertaken by the ANM and the AWW.

In response to this, PCI appointed a VMC who conducted line listing and mobilization along with the Block Coordinator. They also distributed mobilization tokens a day prior to the vaccination camp, organized a session site, and arranged for an AVD. Additionally, Karijhal was shortlisted as an intervention site under a Randomized Control Trial (RCT) conducted by Yale University in collaboration with PCI. Here, vaccinated beneficiaries received a coupon of Rs.150 which was to be redeemed at the local kirana store, and ASHAs received a coupon of Rs. 50 per vaccinated beneficiary.

*Village residents arriving at the site with their mobilization tokens and receiving Rs. 200 coupon post-vaccination which were distributed to encourage vaccination uptake.*

We appreciate the commendable efforts of Makeshwar Rawat (District Coordinator), Alok Kumar (Block Coordinator), Prince Kumar (Block Coordinator), Manoj Kumar (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

**AVD**
Alternate Vaccine Delivery

**AWW**
Anganwadi Worker

**ANM**
Auxiliary Nurse Midwife

**BC**
Block Coordinator

**DC**
District Coordinator

**FLW**
Front Line Worker

**RCT**
Randomized Control Trial

**RMP**
Rural Medical Practitioner

**VMC**
Village Mobilization Coordinator

**MOIC**
Medical Officer In-Charge

**PHC**
Primary Health Centre