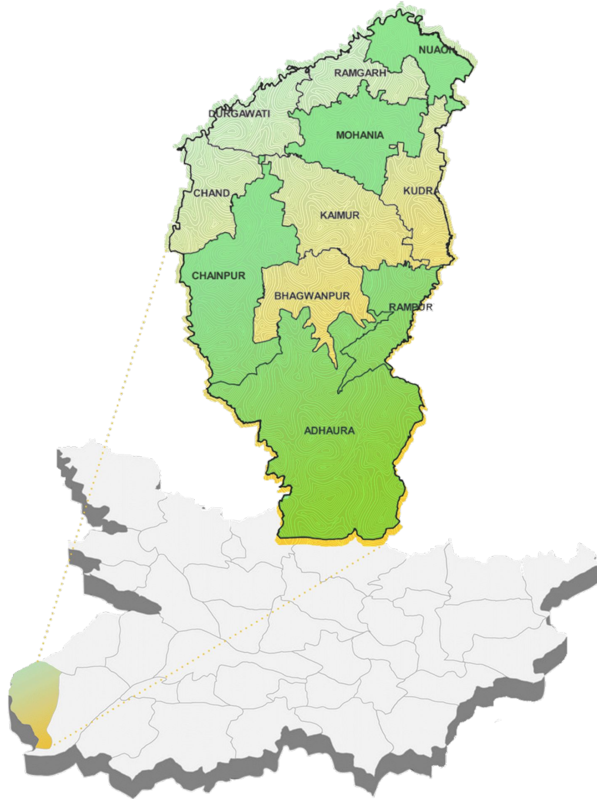
Kaimur



TOTAL VACCINATED under RECOVER Bihar

DOSE 1

Total Targeted **9718** Total Vaccinated **10990**

18+ years	15 to <18 years
7206	3784

DOSE 2

Total Targeted **19240** Total Vaccinated **17174**

18+ years	15 to <18 years
13871	3303

SPECIAL GROUPS VACCINATED

Group	Number
Lactating mothers	615
Chronically ill	227
General	23244
Pregnant women	342
People with disability	99
Migrant workers	462
Refusal	741
Elderly	2434

NO. OF BLOCKS	NO. OF VILLAGES
5	63

POPULATION DEMOGRAPHICS

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

Common Occupations
Farmers, Day-wage Labourers, Brick Kiln Labourers, Migrant Workers, Small Business Owners

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PCI A Global Communities Partner

विहारा VIHARA INNOVATION NETWORK

OVERVIEW

Accessibility barriers and hard to reach populations

Kaimur has a mixed terrain with plains and hills inhabited by animals. Thick forests surround villages situated on hilltops. Many villages in this district are located at large distances from district headquarters and Primary Health Centres (PHC), with secluded broken roads, no access to public transportation, and limited phone connectivity. Due to these geographical constraints and naxal presence, commuting after sunset becomes dangerous. Hence, many villages and their inhabitants are categorized as 'hard-to-reach' by the public health system and its representatives.

Low trust on authorities and corresponding misinformation

Low literacy among many beneficiaries across Kaimur has resulted in low awareness around COVID-19, leading to misinformation, such as vaccination being a political propaganda against a particular community. Fear of post-vaccination bodily side-effects and fatalities were prevalent, along with demands for guarantee of wellbeing post-vaccination. Furthermore, opposition in the form of violent threats and verbal abuse towards the PCI team was also exhibited in some cases.

Difficulty in tracking beneficiaries

Getting some face-time with beneficiaries across many blocks in Kaimur was a challenge due to competing occupational priorities. Many beneficiaries would leave their house for work during early hours of the day, especially during harvest season, and return late. This mismatch in vaccination session timings and their work schedules severely impacted vaccination uptake.

Recruitment and attrition challenges

Limited access to resources, including education, has percolated into low literacy level among beneficiaries, which made recruitment of Village Mobilization Coordinators (VMC) and Verifiers challenging. Furthermore, the last-mile nature of work, salary structure, ill behavior by beneficiaries, and instigation by opposing health cadres and community leaders resulted in dropouts.

BLOCK ADHAURA

10

NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Mainly Hindu Scheduled Castes (Musahar, Chamaar), Hindu Scheduled Tribe (Kharwaar, Rajghar), Other Backward Castes (Yadav, Baniya), General Castes (Brahmin, Rajput), and Christians

> *Are you [PCI team] leaving, or should I beat you up?*
>
> **Young beneficiary, Kolhua, Adhaura**

KEY BARRIERS

Poor physical and digital access

Villages in Adhaura are situated on hilltops; with narrow, zigzag, and muddy roads, and a deep valley on one side, which made commute to villages very challenging. Large distances from the district headquarters and PHC, farthest being 90 Kms, made it difficult for VMCs to come to the PHC for trainings. Thick forests with wild animals, secluded roads, and naxal presence made it dangerous for the PCI team to travel, especially after sunset. Limited phone connectivity made communication with and monitoring of VMCs difficult. Additionally, lack of internet access posed challenges in downloading vaccination certificates for distribution, which beneficiaries perceived as false promises, breaking their trust.

Unavailability of beneficiaries

Most beneficiaries in this block left their houses early in the morning for work, especially during Mahua season. As a result, it became very difficult for the PCI team to meet with them for mobilization and vaccination efforts. This required the team to execute tasks as planned and reach on designated time, otherwise beneficiaries would leave. However, the long distance from PHC and difficult terrain, made it very challenging for the team to reach during early hours of the day which impacted vaccination coverage.

Misinformation and violent threats impacting vaccination

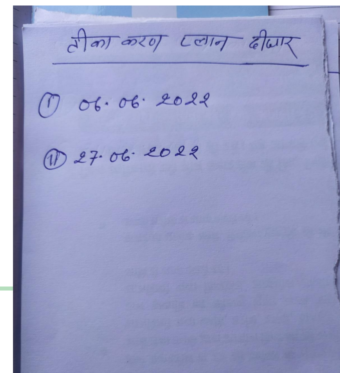
Most beneficiaries in Adhaura have low literacy level and limited awareness around COVID-19 vaccination. This percolated into misinformation and fear of side-effects post-vaccination, with many demanding guarantees of wellbeing, and women citing concerns regarding lack of support to care for their children, in case of side effects. Resistance in the form of violence and verbal abuse was also prevalent in a few villages, where the PCI team was threatened to leave at gunpoint and other weapons during mobilization. Thus, these barriers severely impacted vaccination coverage in Adhaura.

KEY STRATEGIES EMPLOYED

Alternate Vaccine Delivery (AVD) vehicle leaving early morning from PHC Adhaura after picking up the vaccine carrier, the verifier and Auxiliary Nurse Midwife (ANM).

1

(*Left*) Monthly plans developed in advance by the PCI team with the Medical Officer In-Charge (MOIC) and Block Health Manager (BHM)). (*Right*) Because of limited network, the team exchanging information with VMCs using chits.



2

3

PCI team converting hard refusal amidst marriage celebrations by leveraging community influencer and Block Coordinator (BC) building trust with beneficiaries by sharing his experience.

BLOCK CHAINPUR

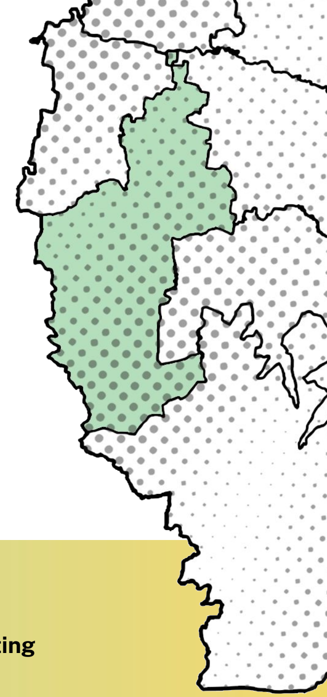
14

NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Hindu Scheduled Castes (Musahar, Chamaar), Hindu Scheduled Tribe (Kharwaar, Chero, Rajbhar), very few Muslims and Christians

> *We put our life at stake, every time we go to these hard-to-reach villages. It's very dangerous.*
>
> **Block Coordinator, Chainpur**



KEY BARRIERS

Poor physical and digital access

Villages are situated on hilltops, amidst thick forests and are quite far (ranging 20-50 kms) from the district headquarters and PHC, prolonging the commute duration. Travelling unaccompanied by a local resident is dangerous due to risks of robbery, wild animal attacks, or getting lost amidst unfamiliar, secluded roads. Thus, session durations were impacted as ANM would worry about getting home before sunset and ask the PCI team for assurances to drop home. Phone connectivity and internet access was limited, which made communicating with VMCs difficult,thus impacting mobilization and planning of session sites. Furthermore, limited internet access hindered data entry on CoWIN portal, along with download and distribution of vaccination certificates.

Fear of side-effects and demands for incentivization

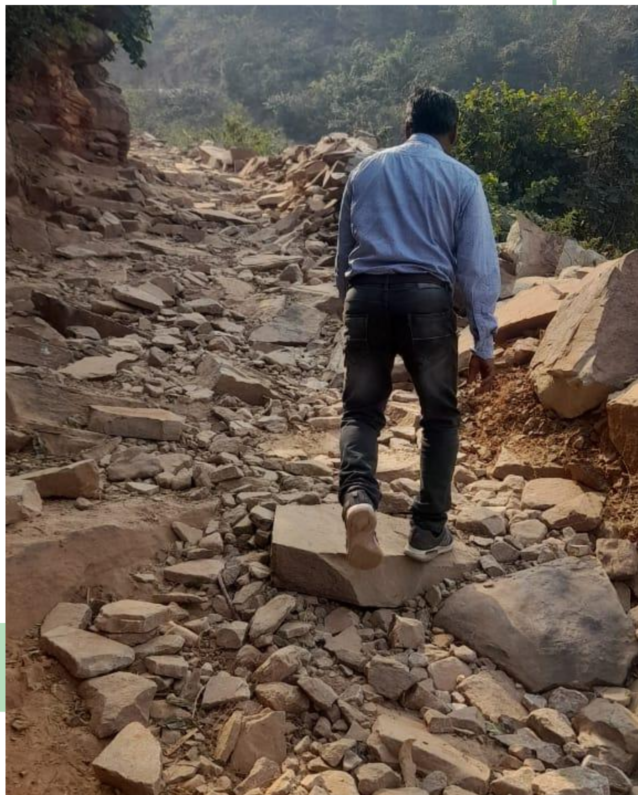
Fear of side-effects post-vaccination was prevalent among beneficiaries, which acted as a barrier to vaccination. Beneficiaries would demand guarantees of wellbeing post-vaccination, would run away at the sight of PCI team, or would believe COVID-19 doesn’t exist due to limited visibility to such cases. In villages like Jigni, mosquito nets were also distributed to the vaccinated beneficiaries by the PHC as an incentive to motivate people. However, this also made a few beneficiaries adamant about getting vaccinated only after receiving such incentives.

Challenges with vaccinating younger populations

Vaccinating younger populations was a huge challenge, especially among out-of-school children. Absence of Aadhaar Card or any other identity proof posed a barrier in feeding personal details, supported by a valid document, into the CoWIN portal. As a result, vaccination uptake among many willing children was low. In addition to this, finding enough number of eligible children (i.e. minimum 10 in number as per the official mandate) to open a vaccine vial for avoiding any wastage, was another challenge that the team grappled with.

KEY STRATEGIES EMPLOYED

The PCI team used all means to travel to extremely difficult geographies to vaccinate beneficiaries in hard-to-reach villages-on foot, bikes, boats or tractors.



1

Designated ANM hired by the health department to support PCI team in vaccinating due beneficiaries in hard-to-reach areas.

2

3

Verification and data entry by the PCI team after reaching network spots on completion of vaccination session in villages situated on hilltops.

BLOCK MOHANIA

14

NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Muslims, Scheduled Tribes (Gond, Kharwaar, Lohaar), Scheduled Castes (Ram, Chamaar, Musahar, Bind, Dhobi), Other Backward Castes (Yadav, Paswaan), and General (Brahmin, Rajput, Lala)

> *My body is aching. My arm still pains. I'm not going to get the second dose.*
>
> **Young beneficiary, Kulwa, Mohania**

KEY BARRIERS

Hurdles in mobilization

Mobilization in Mohania was very challenging for the PCI team. It is an urban area where beneficiaries are literate and aware of COVID-19 disease and vaccination related information. However, despite several mobilization efforts, very few beneficiaries would get vaccinated due to misconceptions around vaccination. In villages like Barej, lack of structural support to compensate for loss of income on the day of vaccination or post-vaccination illness was another concern among beneficiaries that limited vaccination uptake.

Clashes and denials impacting vaccination

Certain communities that were politically inclined engaged in abusive encounters with the PCI team during mobilization. Also, young beneficiaries between the ages of 18-30 years, were reluctant towards vaccination due to concerns around post-vaccination illness and infertility among other side-effects. Mobilizing the people for second dose posed a further challenge as many complained about body ache, pain in their arm, and fever from the first dose. In some cases, even leveraging influencers proved ineffective as people only trusted their family members.

Demands for vaccination at home

Many beneficiaries were habituated to receiving vaccination at home, due to vaccination campaigns such as Ghar Ghar Dastak. As a result, beneficiaries (mainly Muslim Minorities, Rajput, Brahmins, and women across communities) would refuse to visit the session site but were open to being vaccinated at home. Furthermore, women also believed that the vaccine would lead to infertility or harm the foetus, which required additional mobilization efforts by the PCI team.

KEY STRATEGIES EMPLOYED

1

The PCI team visiting beneficiaries' workplaces such as brick kiln or field to vaccinate them, ensuring minimal effort for beneficiaries, thus reducing the burden of missing work and losing income.

2

Door-to-door vaccination of beneficiaries who refused or were unable to visit session sites, but were willing to get vaccinated.

3

Beneficiaries arriving at session sites with mobilization tokens distributed a day prior. Collaterals developed by Vihara Innovation Network, emerged to be very effective in mobilizing reluctant beneficiaries and improving their vaccination experience.

BLOCK NUAON

14

NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Muslims (Ansari, Sayed), Hindu Scheduled Tribes (Gond, Kharwaar), Hindu Scheduled Castes (Musahar, Harijan, Kumhaar, Paswaan, Bind, Dhobi); and Other Backward Castes (Yadav, Naayi, Kunhaar), General Caste (Brahmin, Rajput, Srivastava)

> *Everyday someone or the other keeps coming to do survey. Go away!*
>
> **Beneficiary, Nuaon**

KEY BARRIERS

VMC recruitment and retention challenges

Recruiting and retaining VMCs across Nuaon was a big challenge for the PCI team. VMCs would join and leave in a few days due to the challenging nature of work. Additionally, beneficiaries were reluctant to share personal details and would ask the VMCs to leave. Often, some young boys would instigate them creating doubts around payments, exacerbating the issue of attrition among VMCs. Hiring new candidates also became difficult in a few villages due to their lack of trust on the PCI team around ample amount of work to be undertaken by them and corresponding payments.

Village landscape and mistrust among beneficiaries

Most villages in Nuaon are densely populated with closely constructed houses. Several narrow, interconnected lanes made it challenging for the team to create a numeric system to sequence, mark and identify houses of due beneficiaries. This led to confusion delaying the line listing process. Moreover, the repetitive data collection and surveys by different stakeholders aggravated beneficiaries, making them more reluctant to cooperate. There was also mistrust in the PCI team due to the belief that they would siphon off money from their bank accounts using Aadhar Card details, which stemmed from a past experience.

Political influence, misinformation and violence

Political inclination among beneficiaries, especially within the Yadav community was prevalent, which impacted the vaccination coverage. Beneficiaries wouldn't agree to get vaccinated unless their political leader approved of it. Hard refusals among Musahar and Bind communities were also prevalent as a result of misinformation around vaccine efficacy. Reluctance for second dose uptake was prevalent as many had fallen sick after the first dose. Aggressive verbal abuse was prevalent in such communities when the field team engaged in mobilization.

KEY STRATEGIES EMPLOYED

1

The BC organizing regular meetings with Verifier and VMCs to monitor field activities and challenges faced by them as a way to provide handholding support and ensure team wellbeing.

2

The PCI team meeting community influencers from varied religious groups to discuss their concerns around vaccination and reassuring that this isn't a propaganda against any religious community.

3

The PCI team leveraging support of MOIC and BHM to recruit Verifier and VMCs, build strategy to mobilize politically inclined reluctant beneficiaries and address concerns around second dose uptake.

BLOCK RAMPUR

13

NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Mostly Hindu Scheduled Castes (Paswaan, Chamaar), Other Backward Castes (Yadav), General Caste (Brahmin, Rajput), and Muslims

> *They got all the work done from us, and didn't even pay us. You (VMC) will also not get paid, just like us.*
>
> **ASHA, Rampur**

KEY BARRIERS

Misinformation and fear leading to refusals

High refusals in Rampur were prevalent due to fear of post vaccination due to rumours in many villages across the block. Primarily chronically ill and women with concerns around infertility were most hesitant to get vaccinated. Many beneficiaries would run away from their homes at the sight of the PCI team to avoid vaccine administration. Others would keep the door shut despite persistent knocks. In villages like Sabaar, few members from the Muslim Minority community were reluctant as they perceived vaccination to be nothing but a political propaganda against their community.

Delays in line listing

In Rampur, several factors impacted line listing. Many beneficiaries, especially Muslim Minorities, would refuse to share their personal details with the VMCs during line listing activities due to their fear and concerns around vaccination. Issues around retrieving data of beneficiaries who got vaccinated in the initial months persisted due to mismatched personal details and not remembering dose-1 date or phone number, as many were unaware of the importance of giving a valid and accessible phone number. This posed a huge barrier in line listing as well as tracking for second dose and post-vaccination care.

Concerns around timely monetary compensation

Accredited Social Health Activists (ASHAs) in villages like Belaon had complaints around delayed payments. As a result, they would instigate the VMCs, citing that similar actions would be exhibited by the PCI team as well, and they also wouldn't get paid. Influenced by them, VMCs started refusing to hand over the line list to the Block Coordinator (BC) and Verifier until they were compensated for the work done.

KEY STRATEGIES EMPLOYED

1

Liaising with MOIC to discuss refusal cases and the issue of retrieving data of beneficiaries with no records to track vaccination status.

2

Training of ASHAs and ANMs by PCI team around collaterals developed and their usage for targeted counselling with empathy forward techniques.

3

Vaccination of eloping beneficiaries by PCI team through empathy driven counselling and reassurance around safety.

4

Leveraging religious events to organize vaccination sessions and making announcements to inform the camp details and mobilize attendees to get vaccinated.

CASE STORY

PCI team commuting through difficult terrain of Chainpur block on a tractor to reach hard-to-reach village, Bhaluburan, which is situated on a hilltop. [Here's a short video of how the teams travelled.]

Situated in the Chainpur block, Bhaluburan is one of the most hard to reach villages of the Kaimur district. One has to cover a distance of about 40 kilometers from the Bhabua city headquarters, cross three hills with secluded routes to first reach Jigni village. From there, it is an arduous journey of 7-8 kilometers of extremely rocky hill road to Bhaluburan which is impossible to cross using a four-wheeler or a two-wheeler.

First time when the Project Concern International (PCI) appointed Verifier made his way to Bhaluburan on his bike, he had to bear the brunt of the rocky roads that damaged his bike. Upon speaking to the local villagers, finally the PCI team realized that the best and the only way to reach Bhaluburan from Jigni village was through a tractor, which took almost 2 hours to get across the 7 kilometers rough patch.

The next step was recruiting a Village Mobilization Coordinator (VMC) to establish trust with the village residents, especially as the area has Naxal presence. Whenever the team would go to the village, the residents would mostly be out in the city or the forest for work, which made the process quite tedious. The team finally managed to successfully select a determined VMC. However, several other challenges were to follow.

Limited connectivity and digital access posed a major problem, hampering the team's internal communication. It was extremely difficult to connect with the VMC for information exchange. The Verifier had to travel for almost 3 to 4 hours one way to communicate with the VMC and plan vaccination session sites.

Vaccination session site and door-to-door vaccination organized by PCI to vaccinate due beneficiaries in hard-to-reach village itself.

The VMC and Verifier began the line listing process, through which around 600 due beneficiaries were identified. Post line listing, they went door-to-door mobilizing the community members. The team created a micro-plan in sync with the Health Department for each site. Accordingly, vaccine vials were calculated and ANM was assigned to administer vaccines. A day prior to the camp, the team distributed mobilization tokens to remind people of the site date, time and location, along with tips on vaccine preparedness to avoid any side-effects.

On the day of the vaccination, using an Alternate Vehicle Delivery (AVD) provided under the project, vaccine vials, ANM and Verifier were picked up from the Chainpur PHC. The four-wheeler was parked at the Jigni village and with the help of a community influencer, a tractor was arranged.

Organizing two session sites in Bhaluburan was an achievement for the team, as no vaccination camp had been hosted in the village before. How to reach there had remained an unanswered question. But, the team managed to vaccinate around 190 beneficiaries in the first session and 141 in the second session across 18+ and 15-18 age groups.

The residents, who had to otherwise cross a hill and walk 3 kilometers to get a vaccine dose, now had easy access to it. And most importantly, this encouraged special groups such as Pregnant & Lactating women, Chronically Ill, Elderly and persons with disability also to avail both the vaccination doses.

We appreciate the commendable efforts of Saleem Ahmad Siddiqui (District Coordinator), Manoj Kumar Dubey (Block Coordinator), Mayank Kumar Dwivedi (Block Coordinator), Anup Kumar Pathak (former 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

ASHA
Accredited Social Health Activist

ANM
Auxiliary Nurse Midwife

AVD
Alternate Vaccine Delivery

BC
Block Coordinator

BHM
Block Health Manager

DIO
District Immunization Officer

DC
District Coordinator

MOIC
Medical Officer In-Charge

PHC
Primary Health Centre

VMC
Village Mobilization Coordinator