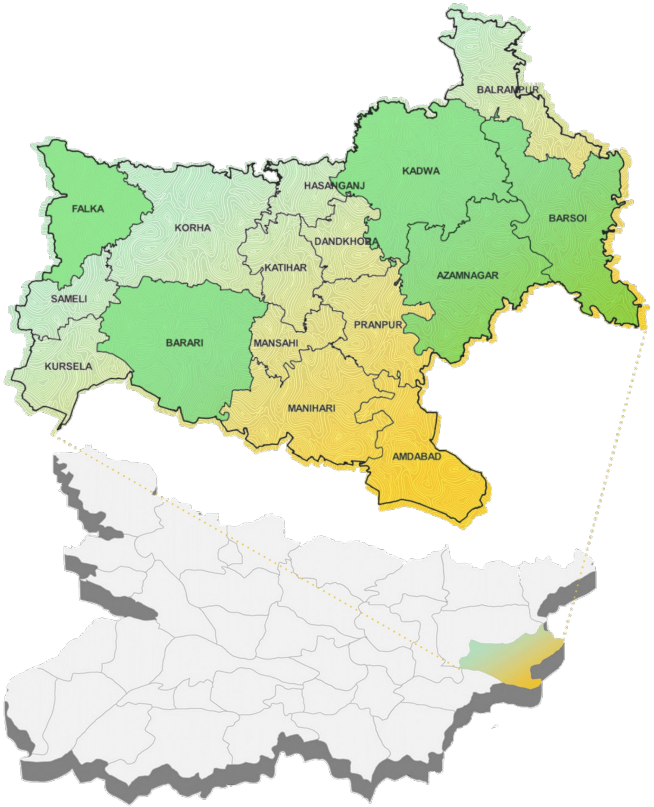
Katihar



TOTAL VACCINATED under RECOVER Bihar

DOSE 1

Total Targeted **11606** Total Vaccinated **13347**

18+ years	15 to <18 years
9424	3923

DOSE 2

Total Targeted **28101** Total Vaccinated **25065**

18+ years	15 to <18 years
22333	2732

SPECIAL GROUPS VACCINATED

Lactating mothers 1423	General 30333	Pregnant women 574	Migrant workers 1779	Elderly 2833
Chronically ill 308		People with disability 83	Refusal 1079	

NO. OF BLOCKS 5

NO. OF VILLAGES 78

POPULATION DEMOGRAPHICS

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

Common Occupations
Migrant Workers, Day Wage Labourers, Small Business Owners

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.

OVERVIEW

Geographical challenges

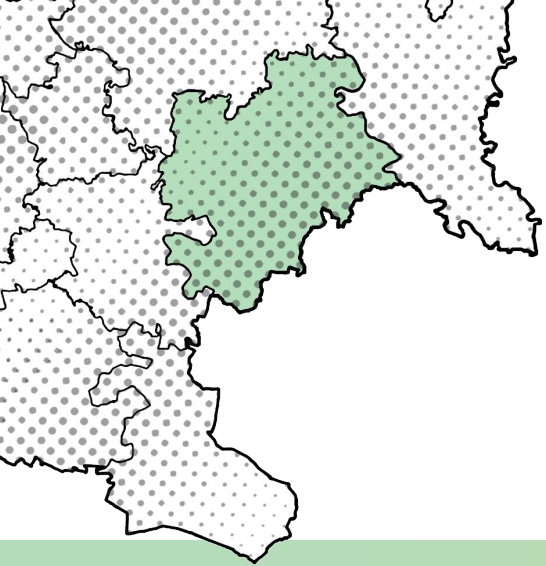
Katihar is a geography that has varied terrain, The climate of Katihar is nearly moderate with widespread rainfalls during the monsoons bringing in floods to the adjoining rural areas. Blocks like Azamnagar and Barari are at a distance of more than 30 kms from district headquarters. Factors of weather and large distance made this geography a challenging one, especially from the daily commute perspective. The inadequacy of public transport and lack of connectivity further added up to the tough working conditions for the PCI team here.

Lack of trust and belief in hearsay

The blocks selected for Katihar had some of the lowest vaccination rates, most of these were also areas which were Muslim minority dominant, lacking proper awareness and sources of information. A mix of other factors like hesitancy to share anything in counselling and distrust in cadres, belief in hearsay about the side effects post first dose vaccination led to beneficiaries delaying their second dose. Misconceptions due to lack of focussed counselling during the earlier phases of vaccination led to widespread belief within communities that vaccine is not for the benefit of the beneficiaries.

Pre-existing verification gap and VMC recruitment

Factors like backend errors in documenting beneficiary details on CoWIN portal, seasonal migration, and reluctance towards government vaccination drives contributed to a recurring verification gap which required constant catching up. The delay in recruiting Village Mobilization Coordinators (VMCs) due to traditional mindset further exacerbated the vaccination of special categories in most of the minority dominant areas of Katihar.



BLOCK AZAMNAGAR

11
NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Muslims, a few Scheduled Castes, Other Backward Classes (Musahar, Manjhi) and Tribes (Santhal)

> *Just give us tokens but don't put these stickers on our doors. It will make our doors appear ugly.*
>
> **Beneficiary,**
> **Devgaon, Azamnagar**

KEY BARRIERS

Mobilization hurdles

Beneficiaries had a noticeable likeness for the mobilization token. While they kept it safe with them with great care, there was always a hesitancy to put home stickers in front of their doors. VMCs were given arguments like the stickers will soil the appearance of the house and the entrance would start to look untidy if children would pull them out.

VMC selection and retention

The criteria for selection of a female VMC who is at least high school qualified became a hurdle in itself, as the families of the qualified ones looked down upon the nature of work that involved conducting surveys. Some who agreed, refused the next day, citing lack of support from the community. This back and forth created delays in line listing. Additionally, candidates who were overqualified till Intermediate were selected, but their retention was a challenge as their expectations for incentives was also higher.

Mismatch between due list and actual turnouts

There is a sense of complacency amongst beneficiaries that since the Auxiliary Nurse Midwifery (ANMs) keep visiting often, vaccination will happen anyhow, so there is no need to hurry. In non-incentive vaccination, there was always a gap between the people who were invited and the ones who would turn up the next day. In areas of Harnagar (Dev ganv) this was always the case which required the PCI team to be in constant mobilization mode.

KEY STRATEGIES EMPLOYED

Prioritizing home visits to leverage the presence of elders in counselling and vaccinating family members from different focus groups all together.

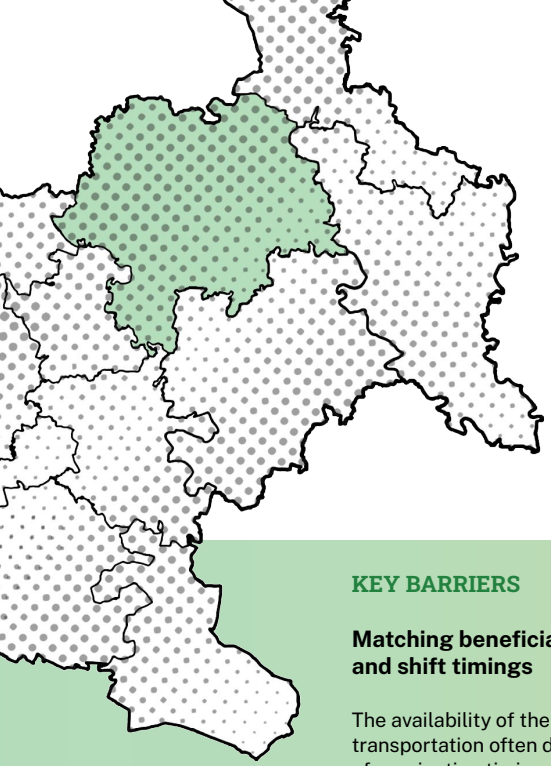
1

Addressing concerns of beneficiaries through targeted counselling by VMCs as part of pre-mobilizing efforts.

2

3

District Coordinator, VMCs and Verifier counselling refusal cases among children in the presence of School principal, and addressing their concerns at Harnagar village.



BLOCK KADWA

10
NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Primarily Muslims, Hindu Scheduled Castes (Mahadalit), Other Backward Castes (Yadav, Kurmi)

> *If anything happens to the child, we would be thrown out of the house.*
>
> **Beneficiary, Kadwa**

KEY BARRIERS

Matching beneficiary availability and shift timings

The availability of the public transportation often dictates the stretch of vaccination timings for cadres. The unavailability of transport across the day puts a constraint over session timings. The PCI team was hard-pressed from both the ends. In case they leave early, beneficiaries won't be available or if they choose to stay late, then they were challenged to ensure ANMs' conveyance and safety.

Fear of getting singled out within family

Fear of getting singled out within their family in case opted for vaccination was prevalent in this block. Pregnant mothers were hesitant of taking a call on themselves without familial consent, sited familial pressure and a lack of support in case of any side effects to self or their child. Mothers feared that it might also lead to affecting their fertility.

Lack of trust and need for relentless efforts

Lack of trust on the health cadres led to some instances where even the basic survey would be refused by beneficiaries. Once somehow the survey was done, vaccination would need further efforts to mobilize refusals. This eventually moved the vaccination at a snail pace and made the vaccination process extremely complex.

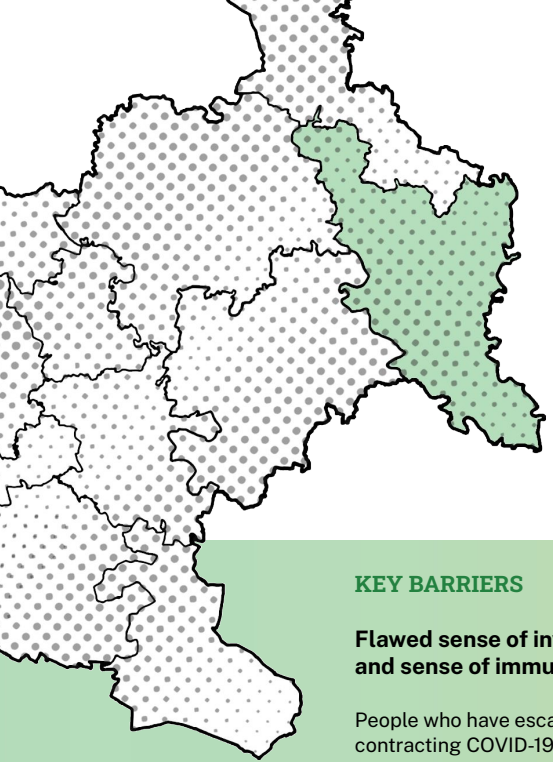
KEY STRATEGIES EMPLOYED

1

Teams crossing hard to reach flood affected areas along the Ganga Kosi belt of Kadwa as per local transportation availability to reach beneficiaries.

2

Addressing refusal cases amongst male members in presence of elders of the family to allay fear of getting singled out within family amongst special categories like lactating, pregnancy mothers and also women in general.



BLOCK BARSOI

12
NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Primarily Muslims, a few Scheduled Castes (Dalit, Mahadalit), Other Backward Castes (Yadav)

> *We have understood (what you've explained). We will take the vaccine when you visit us next time. You anyway keep visiting us.*
>
> **Beneficiary, Barsoi**

KEY BARRIERS

Flawed sense of invincibility and sense of immunity

People who have escaped without contracting COVID-19 during the second wave and didn't receive any counselling, despite best efforts, are the ones who wanted to continue without vaccine. These beneficiaries were still on due list but wanted to wait and watch. The argument is the belief that the worst has been over, and they were able to sail through safely, have not yet needed vaccination, so there is no need to hurry.

Data errors from past vaccination drives

Beneficiaries in some cases received notification for vaccine without getting actually vaccinated. This led to spread of misinformation amongst people that cadres have taken money without giving vaccination. For instance, in some areas at Kalidangi, Verifier received harsh criticism and was not allowed to survey after receiving notifications.

Repeated attempts at counselling special category cases

Despite mobilization, there was little effect on pregnant and lactating mothers. In many cases, they would reserve their decision to take up the vaccine and push it for ANMs' next visit. Convincing them required a lot of patience and repeated attempts at counselling by the PCI team.

KEY STRATEGIES EMPLOYED

1

Leveraging influence of religious leaders, health officials, and development partners to create awareness around COVID-19 vaccination among due beneficiaries.

2

ANM briefing with Medical Officer In-Charge (MOIC), Block Health Manager (BHM), and Block Community Manager (BCM) to discuss field challenges and required support.

3

House-to-house mobilization of due beneficiaries, and line list updation at Pomra block in Barsoi district.

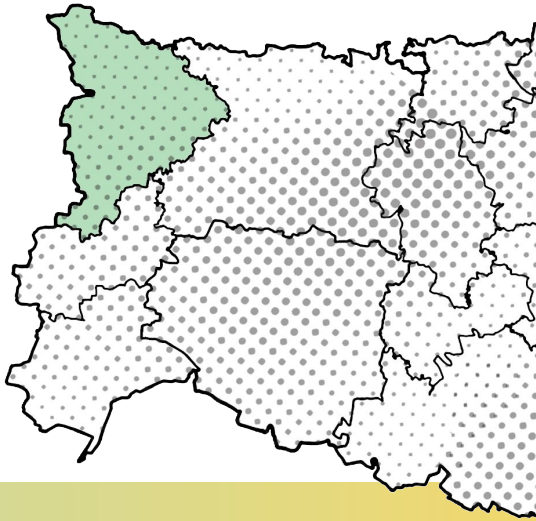
BLOCK FALKA

13
NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Primarily Muslims, Other Backward Castes (Yadav, Musahar), General Castes (Baniyas)

> *Why should we take vaccine, you and government both care about yourselves only. Nobody hears what we need.*
>
> **Beneficiary, Pirmokam, Falka**



KEY BARRIERS

Lack of motivation amongst administrators

The commute to the far off vaccination sites after reporting at PHCs/CHCs amidst summers made ANMs physically tired, and often after reaching sessions sites beneficiaries would not turn up without focussed counselling. PCI had an uphill task to both kickstart vaccination sites, motivate ANMs and also make sure beneficiaries keep showing up steadily.

Hesitancy and indirect refusal

Vaccinating beneficiaries for the first dose was relatively easier compared to the second dose, as they used to share their doubts and discomforts about vaccination directly. But in the second dose, beneficiaries stopped sharing - they would neither refuse nor agree for anything directly. Hence, the numbers kept declining slowly, especially at Dayalpur and Makku Tola at Banka.

Perception and mindsets of beneficiaries

The trust in health cadres kept declining overtime, and the belief in vulnerable communities that vaccine is a measure to create a pressure on them kept getting stronger. The perception that cadres are either working for their own benefit or that the government is using them to create pressure was prevalent that cadres received criticism for even basic mobilization activities. This led to halt and delays in line listing and preparation of due lists.

KEY STRATEGIES EMPLOYED

House-to-house certificate distribution and parallel line listing updation to build trust, mobilize and motivate beneficiaries from all categories.

1

Training VMCs, ANMs on how to effectively use VMC counselling guide for targeted counseling using Human Centred ways of communication to build trust within a community.

2

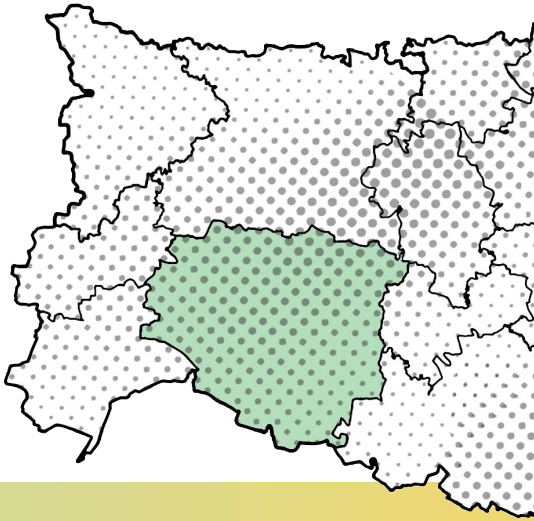
BLOCK BARARI

13
NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Primarily Muslim (Sheikh, Ansari), Other Backward Caste (Yadav, Mandal, Kumhar, Musahar)

> *We can't share Aadhar cards & phone numbers. Please leave, we have taken vaccine already.*
>
> **Beneficiary, Bhawanipur**



KEY BARRIERS

Varying terrain and unpredictable connectivity

The village is situated at the dam itself on the banks of Ganges. The village is flood effected, some areas get cut off every year due to broken roads and excess water flow. There are low lying areas where data connectivity is also a challenge. The Verifiers always carry a notebook to write verification data, then climb a rooftop to get access to running internet. This back and forth created bottlenecks in verification.

Accounting for sudden delays and changes

Many times the ANMs would get changed based on their availability at the PHC only one day prior to the session day, on a short notice, requiring BCs to orient ANMs well in advance. Given the fact that many villages at Barari have accessibility issues, this last minute change was a coordination challenge for the PCI teams.

Verification hurdles

Far off distance, difficult access of roads and patchy data connectivity have made the task of verification extremely slow. For instance at Bhawanipur, along with access and connectivity issues beneficiaries are also reluctant to share current vaccine status, Aadhar and contact numbers. Verifiers after reaching such far off areas have also been asked to leave. Teams have instead focussed on empathy building making verification a still ongoing process.

KEY STRATEGIES EMPLOYED

1

Verification at low lying areas with low connectivity directly at the place of occupation as per beneficiaries' availability and comfort.

2

Targeted counselling with special categories using videos and collaterals to build empathy and trust.

3

Session site at Kazara village in primary school, teams leveraging the presence of teachers as influencers to counsel students below 18 years in an attempt to foster empathy and allay their fears related to verification process and vaccination.

The Medical Officer In-charge of Falka PHC inaugurating RCT session by distributing dry-fruits amongst pregnant women

A total of 53 villages in five Blocks with lowest coverage were selected by Project Concern International (PCI) in coordination with the District Health Department to achieve complete saturation. All 53 villages of Katihar were reviewed and a total of two villages of Falka Block (Pirmokam, Bhangaha and Sahasram Saldev Rishi Tola) were selected for the targeted campaign. The beneficiaries vaccinated under this RCT were to be distributed dry fruits as incentive. The planning was initiated with the coordination of MOIC and the BHM of Falka. A total of 11 sessions were planned, with 5 and 6 sessions for Pir Mokam and Bhangaha respectively.

Before starting the vaccination drive, a due list had to be prepared, making sure all the doubts of the community were taken care under thorough mobilization. A total of four Village Mobilization Coordinators and one Verifier were designated to conduct the line list survey, mobilize and orient beneficiaries at the Falka PHC.

The VMC conducted house-to-house visits to prepare the line list of beneficiaries and as per the analysis, most of the unvaccinated beneficiaries were found to be from Pregnant, Lactating Mothers and Refusal categories who were not getting vaccinated as many of them were hesitant and believed in myths such as vaccine's potential to affect fertility or their child in future. A sizeable number also belonged to Migrant category, as Katihar experiences seasonal migration, with people going to nearby States for employment. While the VMCs prepared the line list, the Verifier parallelly verified data for migrants who were unvaccinated and handed out certificates to those who got vaccinated somewhere else but did not have the certificate.

House to House mobilization of Refusal cases by VMCs at Pirmokam, and 351 out of 624 at Bhangaha and Sahasram Saldev Rishi Tola.

After the survey, house-to-house mobilization activities were conducted, such as pasting stickers on unvaccinated beneficiaries and showing videos via QR codes on collaterals to special categories.

For inaugurating the session, PCI team had invited MOIC at Falka PHC. The session was inaugurated in the presence of local Panchayati Raj Institution (PRI) members and Influencers. However, during vaccination, the team started facing refusals. To counsel such cases, assistance from the local PRI members was sought. Post vaccination, every beneficiary was given dry-fruits and at the end of the 11 sessions, the team achieved the following figures across both the sites:

GN	PW	LM	EL	CD	DA	R	MIG
306	4	21	25	2	1	42	5
281	7	14	20	2	4	15	8

Moreover, the remarkable achievement was that the team was able to mobilize and vaccinate 11 Pregnant women and 35 Lactating Mothers, who were turning out to be the toughest hard-to-break cases. In addition to this, yet another feat was vaccinating a total of 406 out of 816 at Pirmokam, and 351 out of 624 at Bhangaha and Sahasram Saldev Rishi Tola (mostly refusals in General category) under this initiative.

The PCI team covered the entire vaccination process implemented under the project, right from line listing for due list identification, using mobilization tools for preparedness, to certificate distribution for completion of the vaccination journey.

विहारा VIHARA INNOVATION NETWORK

PCI A Global Communities Partner

We appreciate the commendable efforts of Md. Rashid (District Coordinator), Sunil Kumar Shah (Block Coordinator), Ravi Shankar Kumar (Block Coordinator), Amrendra Pandey (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

BC
Block Coordinator

BCM
Block Community Manager

BHM
Block Health Manager

DC
District Coordinator

FAQs
Frequently Asked Questions

MOIC
Medical Officer In-Charge

PHC
Primary Health Centre

PRI
Panchayati Raj Institution

VMC
Village Mobilization Coordinator