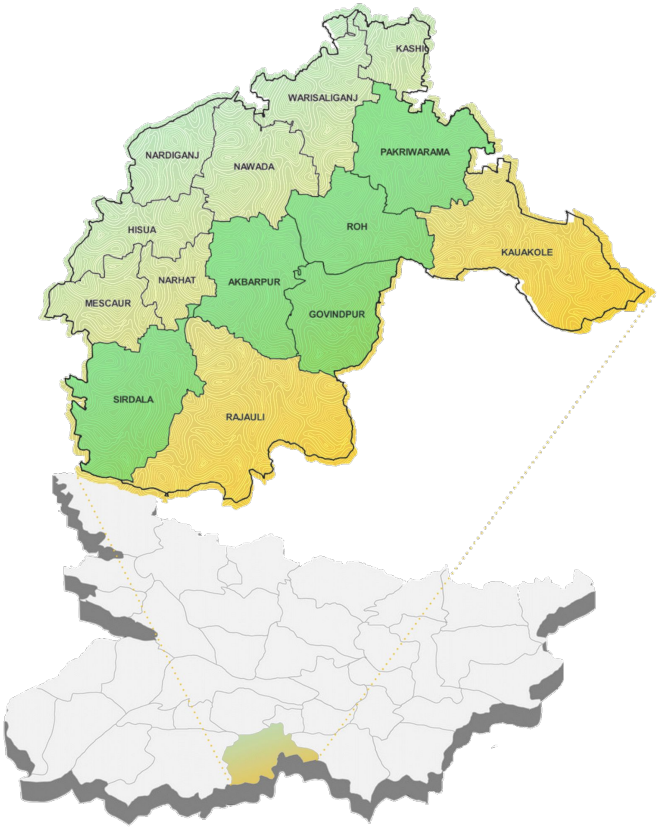
Nawada



TOTAL VACCINATED under RECOVER Bihar

DOSE 1

Total Targeted **7065** — Total Vaccinated **9457**

18+ years	15 to <18 years
5326	4131

DOSE 2

Total Targeted **13577** — Total Vaccinated **14923**

18+ years	15 to <18 years
11071	3852

SPECIAL GROUPS VACCINATED

Lactating mothers 792	General 17350	Pregnant women 323	Migrant workers 2944	Elderly 2123
Chronically ill 241		People with disability 136	Refusal 471	

NO. OF BLOCKS 5

NO. OF VILLAGES 71

POPULATION DEMOGRAPHICS

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

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

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OVERVIEW

Seasonal migration and refusals impacting vaccination

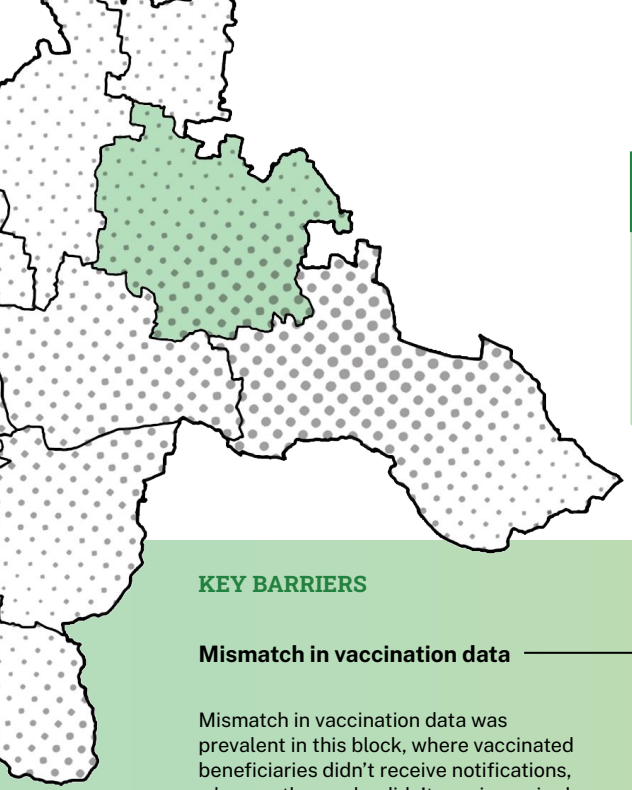
Nawada has high migration rates due to lack of opportunities in the region. There was seasonal migration to nearby cities with families absent in villages which delayed mobilization and line listing across many villages. Gaps in backend CoWIN data collection because of refusals to share Aadhar Cards among Muslim Minorities were prevalent. Parents, who had doubts about the severity of the problem if they chose to remain unvaccinated, presented another challenge for the PCI team, which impacted vaccination coverage in Nawada.

Misaligned expectations and confusions impacting vaccination uptake

The expectation to get the vaccination certificate and some incentives, coupled with a denial and hesitation to take the vaccine, created a push and pull in the mindset of beneficiaries at Nawada. A similar confusion was also widespread among migrant workers, who feared losing out on their livelihood if they did not produce a vaccination certificate, but also feared health risks post-vaccination. These led to significant delays in uptake of vaccination among beneficiaries across Nawada.

Operational issues and accessibility factors

Lack of public transport to hilly areas, and underdeveloped road infrastructure, made it challenging for Auxiliary Nurse Midwives (ANMs) to stay late. This was exacerbated by difficult temperature conditions, and unpredictable availability of migrants and below 18 beneficiaries, which needed longer waiting time and coordination. Other barriers to vaccination at Nawada were low response of beneficiaries despite several mobilization efforts, and delayed Verifier recruitment in a few villages, which further delayed vaccination commencement.



BLOCK PAKRIBARAWAN

11
NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Primarily Muslims, General Caste (Bhumihar), Hindu Scheduled Castes (Manjhi, Paswaan), Other Backward Castes (Yadav)

> *Nobody has taken a second dose in our family, but we have notifications.*
>
> **Beneficiary, Dumrawan, Pakribarawan**

KEY BARRIERS

Mismatch in vaccination data

Mismatch in vaccination data was prevalent in this block, where vaccinated beneficiaries didn't receive notifications, whereas those who didn't receive a single dose were marked as fully vaccinated. This resulted in re-verification in many areas. In villages like Chamanbagh, beneficiaries who were migrants to other countries were ready to even pay up to Rs. 5000 at the Primary Health Centre (PHC) to get a false certificate made without taking the vaccine.

Gaps in verification data affecting vaccine delivery

At Dumrawan, due to high migration, there was always unpredictability on how many cases would be available. This led to verification challenges initially due to which even PHCs would not get valid data. For instance, often the PCI team reached villages only to find they brought fewer vials as compared to eligible due beneficiaries, as many had returned from their place of work.

Clashes and denials from beneficiaries

At Pakribarawan block, the PCI team had to make extra efforts to cover up a gap of just 80 due beneficiaries. More than 10 sessions were organized wherein only an average of 8 to 10 beneficiaries got vaccinated. This was because there was widespread opposition and lack of trust in authorities, especially those who would talk about vaccination and COVID-19. Furthermore, an argument was triggered when during a visit, District Coordinator (DC) tried to visually document a vaccination site.

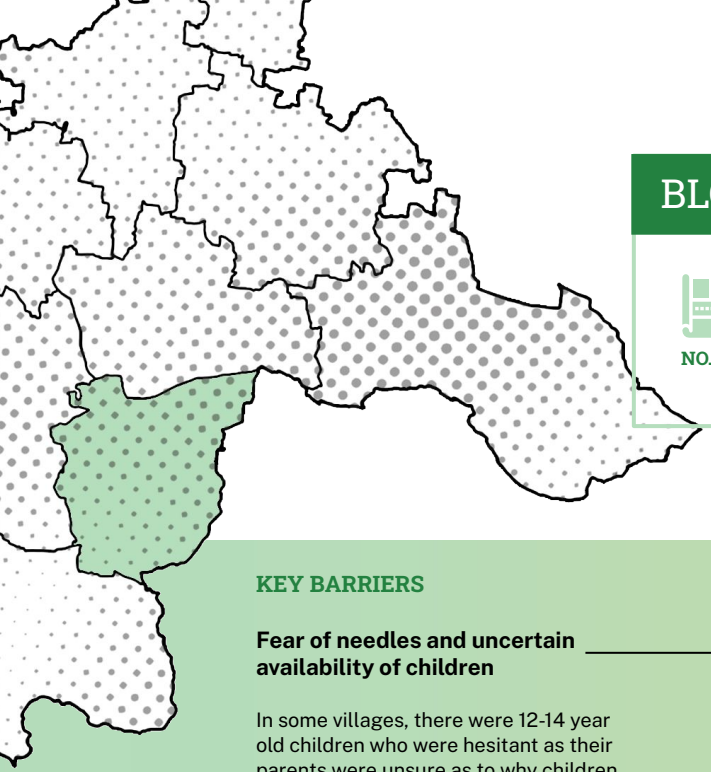
KEY STRATEGIES EMPLOYED

District Immunization Officer (DIO) inspecting a session site by PCI team at a primary school. PCI team also leveraging his presence to assert the importance of vaccination amongst the community leaders.

1

2

Addressing unpredictable availability of migrant beneficiaries in the family's presence to coordinate vaccination schedule, and also target other special categories within family for verification.



BLOCK GOVINDPUR

19
NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Muslims, a few Hindu Scheduled Castes (Dalit, Musahar, Paswaan), Other Backward Castes (Yadav)

> *My husband has gone to the construction site. If he stays here at home to take vaccine, who will work?*
>
> **Beneficiary, Budinaki, Govindpur**

KEY BARRIERS

Fear of needles and uncertain availability of children

In some villages, there were 12-14 year old children who were hesitant as their parents were unsure as to why children were being vaccinated separately. Furthermore, it was challenging to identify, coordinate, and track children who were not enrolled in schools, along with their unpredictable availability. In some villages, the fear of needles was also apparent in children, which added to their hesitancy.

Expectations of material incentives in exchange for vaccination

Many beneficiaries invariably perceived vaccination as a welfare scheme where some material aid would be provided to them. As a result, there were several silent refusals as they expected free ration, just like Public Distribution System (PDS) as an incentive or aid. For instance, many at Bartoli village even thought that the aid exists, but cadres like ANM and Verifiers were keeping it to themselves, and have marked them as vaccinated without actually administering the vaccine so that they don't have to share the aid.

Hurdles in reaching deeper pocket

In few remote areas like Budinaki village, accessibility issues were prevalent as commute through narrow lanes was possible only on bikes. To save on time, meetings were held in a common area, which would be attended by only a few beneficiaries and most of them would also leave eventually with a promise that they would take the vaccine in their next visit. Similarly, when the team reached deeper pockets for home visits, while leaving vehicles aside, they were told that nobody was at home.

KEY STRATEGIES EMPLOYED

1

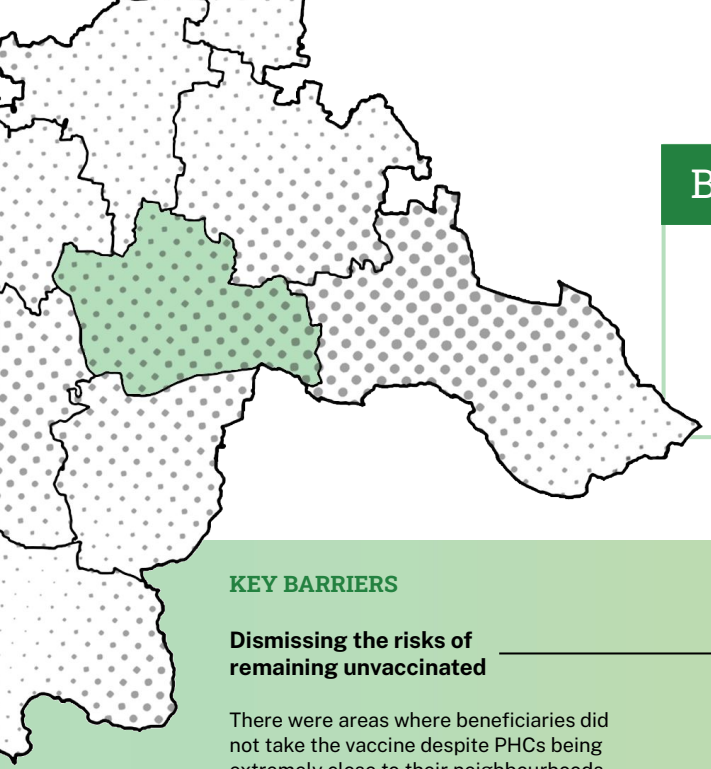
PCI team reaching deeper pockets as a part of hyperlocal campaign to reach beneficiaries as per their availability.

2

Verifiers visiting backward areas in an attempt to convince beneficiaries to share their updated vaccination status and also cross-verify already vaccinated cases.

3

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



BLOCK ROH

14
NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Muslims, Scheduled Castes (Dalit, Musahar, Paswaan, Manjhi), Other Backward Castes (Yadav, Sahu), General Castes (Brahmins, Rajputs, Baniya)

> *I won't spare you if anything happens to my old grandmother after vaccination.*
>
> **Beneficiary, Koshi, Roh**

KEY BARRIERS

Dismissing the risks of remaining unvaccinated

There were areas where beneficiaries did not take the vaccine despite PHCs being extremely close to their neighbourhoods, for example beneficiaries in Ward no. 8, 9, 10. These areas were Muslim Minority dominant, wherein beneficiaries ignored the vaccination drive and dismissed the risks of remaining unvaccinated. In order to motivate them, a dry fruit incentivized campaign was planned, however this area presented a unique challenge as even an incentivized campaign failed to motivate beneficiaries and conversions were slow.

Hiccups in mobilization efforts

Despite several mobilization efforts, vaccination coverage was less. Beneficiaries would pull off stickers pasted on the doors as they felt it made their home entrance look dirty. Beneficiaries would keep the mobilization tokens very carefully. Those who would be left out would even come and ask for it, but later only a few would show up at the session site. This was partly due to hesitancy or incomplete understanding of why tokens were handed out in the first place.

Refusals citing illness and chronic cases

In some areas of this block, prevalence of chronic illnesses such as cancer existed, where even doctors were unable to clearly give surety for no side-effects. Such cases required multiple speciality consultations, which was challenging for the PCI team to undertake. Other barriers included, fear of weakness among chronically ill and elders.

KEY STRATEGIES EMPLOYED

Vaccinating chronic illness cases post targeted counseling in presence of beneficiaries from the same age group to build familiarity and comfort for the beneficiary.

1

2

Dry fruit distribution in areas with low coverage to motivate beneficiaries and strengthen communication between PCI teams and community.

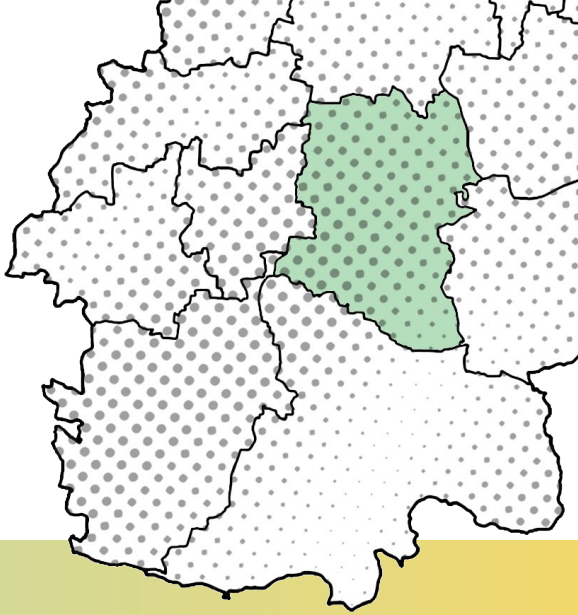
BLOCK AKBARPUR

13
NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Muslim, Hindu Scheduled Castes (Kumhar, Musahar), Other Backward Castes (Yadav, Mandal)

> *They will charge money from us for vaccines. Many have already paid for even certificates.*
>
> **Beneficiary, Bhawanipur, Akbarpur**



KEY BARRIERS

Hesitancy in sharing verification details

The biggest barrier to mobilizing minority communities and economically weaker beneficiaries was their lack of trust in cadres. In villages like Dulha Bigha, many households expressed denial in sharing Aadhar Card details, which delayed line listing. Village Mobilization Coordinators (VMCs) faced extreme challenges as they would visit houses multiple times, but beneficiaries perceived them as crooks who would use their Aadhar Card details to siphon off money from their bank accounts.

Resistance due to fear of side-effects

In Muslim Minority dominant villages like Paijuna South, there was resistance to vaccines due to spread of misinformation about side-effects. The rumors gripped women and their husbands equally. Parents feared for their unmarried daughters losing fertility, while married men felt this would adversely affect virility.

Riddled with assumptions and trust deficit

There were assumptions that Verifiers could extract money from beneficiaries for vaccination. Even for post-vaccination activities like certificates, beneficiaries felt that they would have to pay for them. A rumor spread across the block that one could escape vaccination and still get a certificate by bribing the health administration. All of this contributed to lack of trust in front line workers (FLWs).

KEY STRATEGIES EMPLOYED

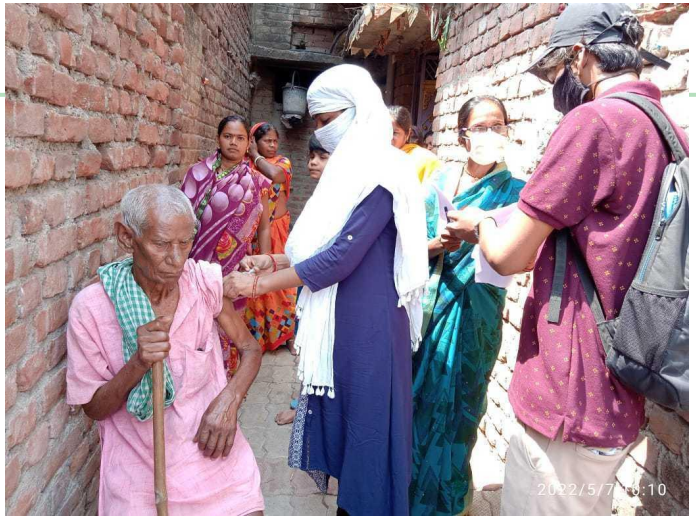
1

PCI team conducting house visits to counsel beneficiaries in-person as per availability and comfort at Muslim dominant areas with resistance to build empathy and trust.

2

Meeting district health staff to give a detailed brief of the hurdles faced, and stating the required support to assert positive influence within beneficiaries.

3



Targeted counselling with special categories using videos in an attempt to foster empathy and allay their doubts related to verification process, fear of side-effects and vaccination.

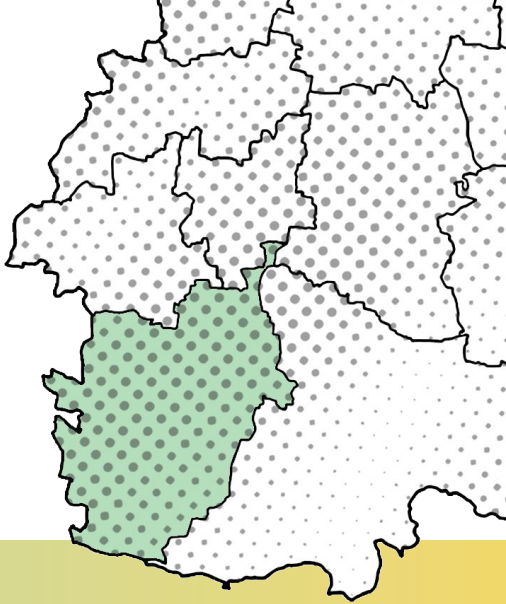
BLOCK SIRDALA

14
NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Muslims, Hindu Scheduled Castes (Musahar, Mochi), Other Backward Classes (Yadav) and General Caste (Rajvanshi)

> *In other villages people got something else. Give us the same incentive or simply give us money.*
>
> **Beneficiary,**
> **Murli, Sirdala**



KEY BARRIERS

Operational challenges for cadres in tough situations

Habituated to structured work hours and office set up, ANMs would often stay at one place and would request to leave latest by 5 pm to tend to domestic duties. This effectively strained the session site duration, as beneficiaries would return late post work days at farms and construction sites. Excessive heat waves in summer exacerbated already constrained movement on the field during day hours. All these issues became an operational challenge, delaying overall vaccination coverage.

Expectation for incentives against vaccine

In villages where dry fruits were distributed as incentives to motivate refusal cases, beneficiaries had expectations for cash in exchange for vaccination. Beneficiaries heard about the Randomized Controlled Trial (RCT) in nearby villages and demanded similar incentives. Any difference in incentives led to beneficiaries feeling cheated or inferior. In other cases where non-incentivised sessions were carried out, beneficiaries even opposed, as their demands for cash and dry fruits were not met.

Recruitment challenges around Verifier

In a few villages, recruiting Verifiers was a major challenge amidst harsh opposition to anything remotely related to vaccination. There was anger amongst political leaders with influence in the villages. As a result, nobody volunteered for the Verifier role for a long time, which delayed line listing and verification. For instance, a meeting was convened in the Nunfar village to oppose Verifier recruitment, where it was explicitly declared not to cooperate with anybody who joined as a Verifier.

KEY STRATEGIES EMPLOYED

1

PCI team briefing ASHAs and ASHA Facilitators on challenges faced on field including spreading the word about Verifier recruitment.

2

BC and ANM reaching out to beneficiaries at remote areas in early hours using an Alternate Vaccine Delivery (AVD) to stretch session timings and enhance coverage.

CASE STORY

PCI field team at the session site ready to start vaccination, taking care of all the COVID-19 protocols.

Akbarpur is one of the least vaccinated blocks of Nawada district in Bihar. The working population here is majorly involved in farm activities as marginal laborers and are usually engaged during harvest seasons. The winter harvest season 'katni' is spread over the last months of a year and most people are involved in the farms throughout the day. They usually leave early in the morning and return after sunset. Time paucity is one of the major challenges here, making it difficult to mobilize people to get vaccinated.

Field protocols in this block began with a small village, Navadi. As per the existing plan laid down by PHC, a session site was supposed to be organized on 22nd December 2021. The PCI block team aimed to leverage this event and maximize vaccination uptake.

To achieve maximum vaccination, the BC along with VMC, visited the village a few days before the session site day. They listed all individuals eligible for COVID-19 vaccination to assist the execution of session site. During line listing, the PCI team emphasized refusal cases and counselled them during the process. The VMC visited each house again a day before the planned vaccination session to remind everyone about it. The PCI team along with the PHC team had set a target of 100 vaccinations for the day. On the session day, the vaccination team reached by 8:00 AM to vaccinate all the beneficiaries before they left for work.

The team vaccinating an Elderly at her house as part of door-to-door campaign post closure of session site.

Towards the closure of the vaccination session, the team decided to switch to door-to-door mode, as beneficiaries had stopped coming to the site. Their prior efforts of marking refusal cases during line listing came in handy. They visited the beneficiaries who were hesitant earlier and addressed their doubts again. The presence of ANM during counselling helped convert a lot of refusal cases.

Joint efforts of the PHC and PCI team made this vaccination event a success. They were able to vaccinate 99 beneficiaries from the 100 target, of which 14 beneficiaries received their first dose and 85 received the second dose. The team educated the beneficiaries about possible Adverse Events Following Immunization (AEFIs) and whom to reach out to in case of an emergency. A few who received the first dose were also told about their next due date.

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We appreciate the commendable efforts of Prince Kumar (District Coordinator), Nagendra Kumar (Block Coordinator), Pankaj 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

ASHA
Accredited Social Health Activist

ANM
Auxiliary Nurse Midwife

AVD
Alternate Vaccine Delivery

AEFI
Adverse Event Following Immunization

BC
Block Coordinator

DIO
District Immunization Officer

DC
District Coordinator

FLW
Front Line Worker

PHC
Primary Health Centre

VMC
Village Mobilization Coordinator