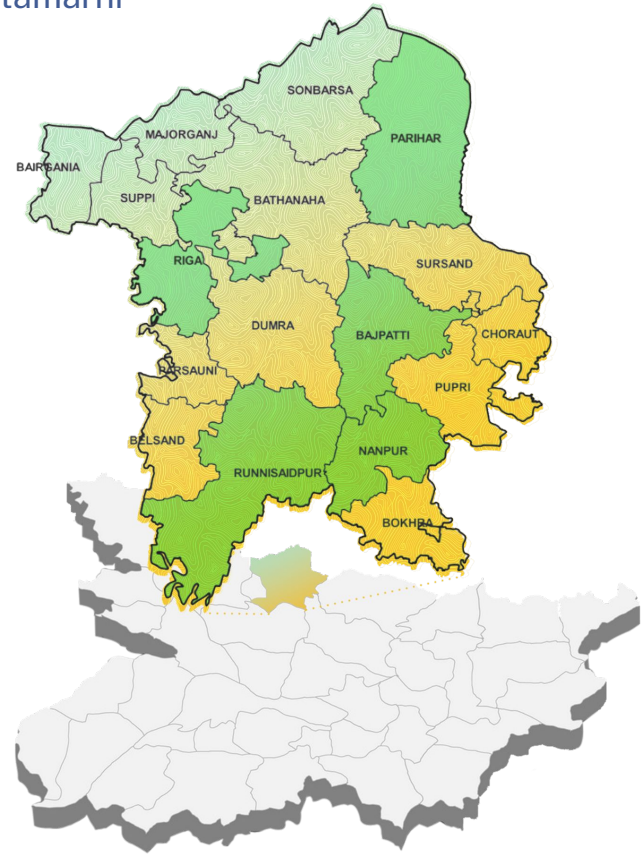
Sitamarhi



TOTAL VACCINATED under RECOVER Bihar

DOSE 1

Total Targeted **5878** — Total Vaccinated **4756**

18+ years	15 to <18 years
2130	2626

DOSE 2

Total Targeted **14256** — Total Vaccinated **11320**

18+ years	15 to <18 years
8998	2322

SPECIAL GROUPS VACCINATED

Lactating mothers 254	General 13723	Pregnant women 173	Migrant workers 119	Elderly 1478
Chronically ill 118		People with disability 33	Refusal 178	

NO. OF BLOCKS 5

NO. OF VILLAGES 55

POPULATION DEMOGRAPHICS

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

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

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OVERVIEW

Hard-to-reach

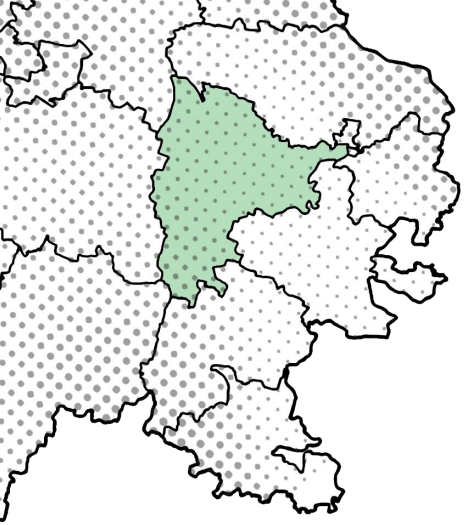
The district of Sitamarhi shares its borders with Nepal, and has a history of naxal invasion. It has a mixed terrain, consisting of plain land, with small lakes and rivers cutting through different blocks and villages. The district is prone to seasonal floods during monsoons, temporarily secluding communication with affected villages. Often, Sitamarhi's rivers tend to also flood when the dams in Nepal are opened or river water is diverted towards India to balance the water levels there. Due to its proximity to Nepal, few villages have limited access and internet connectivity. Thus, many villages and their inhabitants in Sitamarhi are consequently categorized as 'hard-to-reach' for the public health system and its representatives.

Recruitment challenges

Limited access to resources, including education, has percolated into low literacy level among beneficiaries, making mobilization and recruitment of Village Mobilization Coordinator (VMC) challenging in extremely remote villages. Furthermore, hesitation among Muslim beneficiaries to allow women of their community to step out and work as a VMC, exacerbated this recruitment challenge.

Perceptions and mindsets

Low literacy level among the majority of the population in Sitamarhi resulted in low awareness around COVID-19 and thus led to misinformation, such as vaccination being a political propaganda against a particular community. Fear of post-vaccination bodily side-effects and fatalities especially among specific population groups - pregnant women (PW), lactating mothers (LM), chronically ill, elderly, and people with disability was prevalent. Changing government protocols around vaccination exacerbated hesitancy especially among PWs and LMs.



BLOCK BAJPATTI

10
NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Muslims; and very few Hindu Scheduled Castes and Upper Caste

> *My immunity is very strong, so nothing will happen to me. I won't take the vaccine.*
>
> **Beneficiary, Bajpatti**

KEY BARRIERS

Poor physical and phone connectivity

Bajpatti is prone to seasonal floods which secludes the block from the entire district when affected. It hosts a few villages which are extremely remote, with limited road access and phone connectivity. For instance, low phone signal or internet bandwidth in many villages posed a barrier in digital data entry and downloading certificates for the PCI team. Furthermore, villages like Bantara are as far as 8-10 kms from the nearest public health facility, with limited structural support within the village for any healthcare emergencies.

Recruitment challenges

Recruiting and retaining VMCs in this block was a major challenge in the initial months of the program, due to low literacy among women and the last-mile nature of work. There were also some hesitations around allowing women to step out of the house, especially in Muslim families, which made recruitment even more difficult. Furthermore, the target-based structure of monetary compensation instead of regular salary aggravated the challenge of retaining VMCs.

Perceptions of beneficiaries

Beneficiaries, especially special groups, across Bajpatti were hesitant due to the fear of bodily side-effects and/or fatalities post-vaccination. Other barriers included pressure or fear of the head of the family (often an elderly), restricting other family members from getting vaccinated; and refusals without any concrete reason. During mobilization by VMCs, even though beneficiaries would agree to getting vaccinated, their body language would say otherwise. Additionally, repetitive data collection of similar information by other partners as well, exacerbated these mobilization challenges among beneficiaries.

KEY STRATEGIES EMPLOYED

1

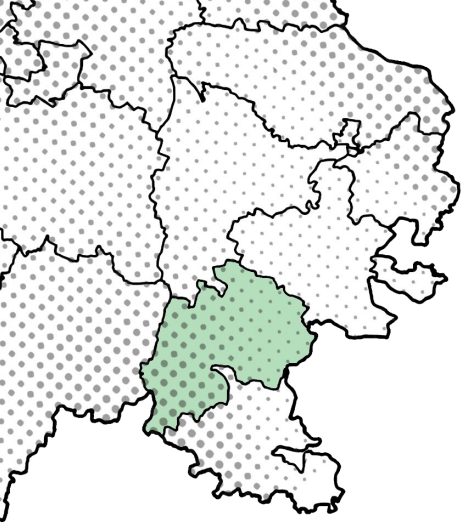
Leveraging trusted sources such as the Rural Medical Practitioner (RMP) for mobilization and vaccination (when ANM unavailable), and in case of any post-vaccination health emergency by providing contact details.

2

Door-to-door vaccination by mobile team for a handful of due beneficiaries spread across different villages.

3

Leveraging the support of religious leaders such as a maulana for mobilization of hesitant beneficiaries through announcements after azaans on the day of vaccination session.



BLOCK NANPUR

12
NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Muslims (Ansari, Hazzam, Kujra); Hindu Scheduled Castes (Dalit); and Hindu Other Backward Castes (Kurmi)

> *Why was it (vaccine) stopped earlier, and why is it being given now? Was there something in it that another medicine is being given now?*
>
> **Pregnant woman, Nanpur**

KEY BARRIERS

Low literacy and lack of awareness

Low literacy among the majority population of Muslims and Dalits posed challenges in their mobilization across Nanpur. Many beneficiaries wouldn't believe that the vaccine is for their protection. This lack of awareness percolated into misconceptions of bodily side-effects post-vaccination among pregnant women and children, among others.

Changing vaccination protocols

Another major barrier to vaccination among beneficiaries of Nanpur was changing government protocols over time, which exacerbated their hesitancy and created more confusion and suspicion. Furthermore, beneficiaries compared the effectiveness of vaccines with those given in the initial months, stating it to be "nicer" and the current one to be "wrong".

KEY STRATEGIES EMPLOYED

1

Addressing misconceptions and concerns of beneficiaries through targeted counselling by VMCs through collaterals designed by Vihara Innovation Network and testimonial videos.

2

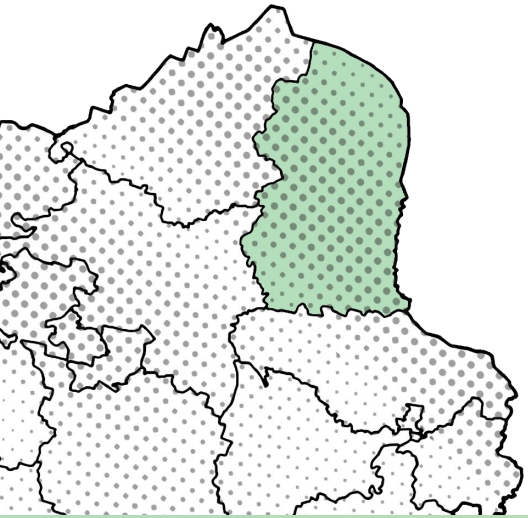
Token distribution by VMCs, a day prior to vaccination session as an invitation and reminder, along with a repeated door-to-door reminder on the day of session.

3

Home-to-home distribution of vaccination certificate by PCI within a day or two after vaccination.

4

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



BLOCK PARIHAR

12
NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Primarily Muslims; few Hindu Scheduled Castes; Other Backward Castes (Yadav); and General Castes (Jaiswal, Bhumihar)

> *Don't want our lineage to grow. That's why this vaccine is being given to us.*
>
> **Beneficiary, Parihar**

KEY BARRIERS

Poor physical and phone connectivity

Parihar is the biggest block of Sitamarhi, sharing its borders with Nepal. It is prone to seasonal floods, with the majority of the roads getting blocked during the monsoons, resulting in limited access to several villages. Due to its proximity to Nepal, the block also experiences low phone signal and internet bandwidth, which not only makes communication difficult, but also remote monitoring and digital data entry a challenge.

Low literacy and lack of awareness

One of the most challenging blocks, the majority of the beneficiaries here have low literacy, which posed a major roadblock for the PCI team in mobilization of beneficiaries as well as recruitment of VMCs. Myths around vaccination leading to infertility and it being a political propaganda against a particular community was prevalent across the block. Furthermore, female beneficiaries had a higher sense of dissatisfaction due to all the rumours and misconceptions.

Impact of festivals

Another barrier to vaccination was difficulty in recruiting a VMC during the month of Ramzaan in few villages. Beneficiaries were hesitant to get vaccinated due to differing religious beliefs and full day fasts during hot summers.

Lack of mobilization support

Challenges around lack of support from community leaders such as Ward Members and religious leaders were other barriers to vaccination as a result of low motivation and similar perceptions as the rest of the beneficiaries. Despite liasioning with religious leaders, they would either not provide the necessary support requested by PCI team or not convey the message to the community with the same intent as committed.

KEY STRATEGIES EMPLOYED

Mobilization of extremely hesitant beneficiaries by religious leaders such as a maulana, through mic announcements.

1

Liasoning with school principal to mobilize school students and hold a vaccination session within the school for all due beneficiaries.

2

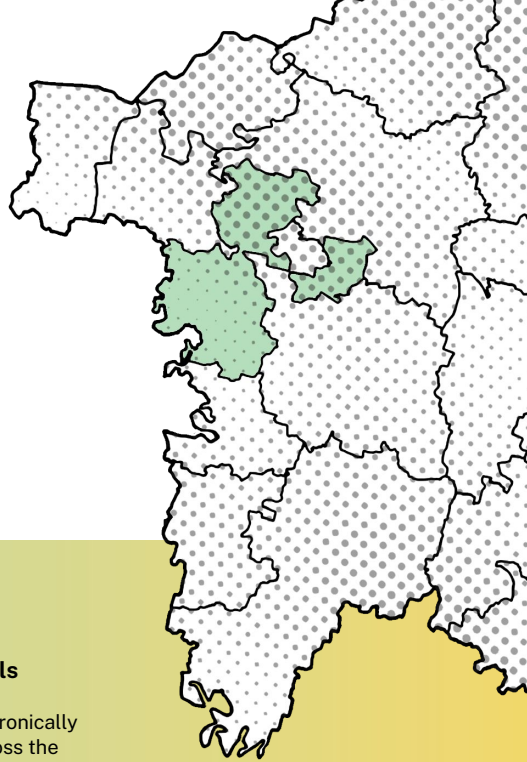
BLOCK RIGA

10
NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Hindu Scheduled Castes (Dom, Maanjhi, Paswaan, Dhobi); Other Backward Castes (Yadav, Hazaam, Sudi, Kumar, Koeri, Kurmi); General Castes (Bhumihar, Brahmin, Rajput, Lala); and Muslims

> *All this is rubbish. You go ahead and kill me, but I will not take the vaccine.*
>
> **Beneficiary, Bulakipur, Riga**



KEY BARRIERS

Low trust on authorities and lack of structural support

Low literacy and awareness around COVID-19 among beneficiaries of Riga is prevalent which made mobilization difficult for the PCI team. Low trust on authorities exacerbated this challenge, as residents would question the PCI team's genuineness and would demand evidence of their association. Lack of structural support within many villages, in case of an emergency post-vaccination was another barrier.

Recruitment and retention challenges

Last-mile nature of work, low motivation, and target-based monetary compensation posed barriers to recruitment and retention of VMCs in Riga.

Fear of side-effects and changing vaccination protocols

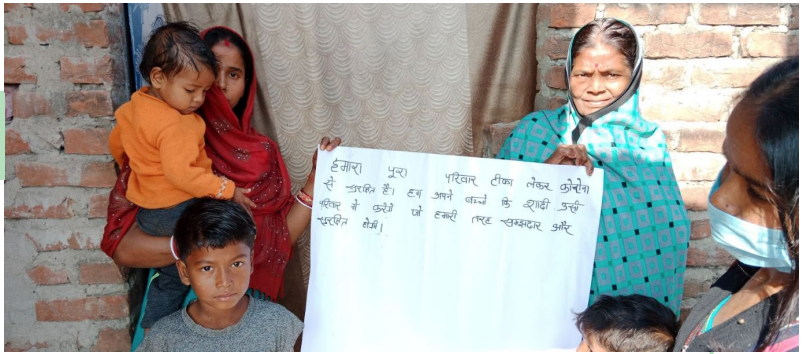
Refusals among PWs, LMs, and chronically ill beneficiaries was prevalent across the block due to the fear of side-effects and fatalities post-vaccination. Misinformation around Auxiliary Nurse Midwives (ANMs) initially telling PW not to take the vaccine was a major bottleneck to mobilization. This was due to changing government protocols over time, which exacerbated their hesitancy.

KEY STRATEGIES EMPLOYED

1

Leveraging local community influencers like ration dealers to mobilize beneficiaries during ration distribution and at session site.

2



Pledge taken by families across Righa to voice their commitment towards maintaining relations with fellow vaccinated residents only - an activity organized by PCI to mobilize hesitant beneficiaries.

3

Usability testing of collaterals' prototypes with Community Mobilizers (JEEViKA) conducted by Vihara Innovation Network to develop contextually relevant products that address barriers identified during the situational analysis.

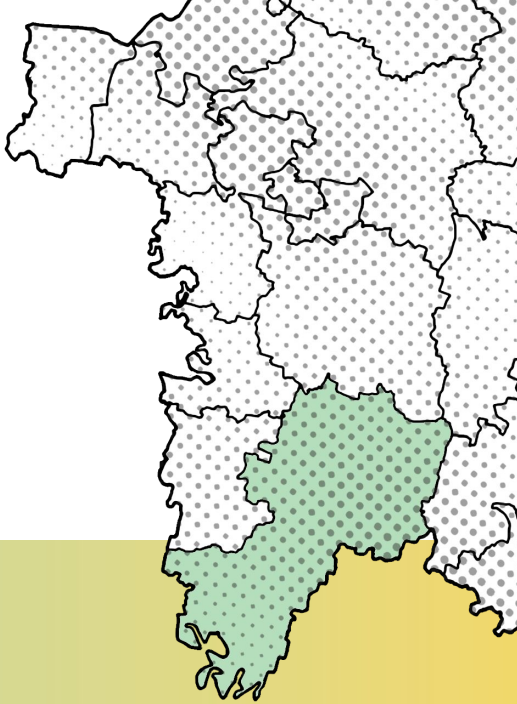
BLOCK RUNNISAIDPUR

11
NO. OF VILLAGES

POPULATION DEMOGRAPHICS

Primarily Muslim (Sheikh, Kujra, Ansari, Hazam); and Other Backward Caste (Kurmi)

> *Everyone else is getting both, the vaccine and coupon. Why am I just getting the vaccine?*
>
> **Beneficiary, Runnisaidpur**



KEY BARRIERS

Poor physical connectivity and harsh weather conditions

Runnisaidpur has a few villages that have limited physical access due to broken roads and no commute. For instance, in Tilak Tajpur, PCI team and Auxiliary Nurse Midwife (ANM) faced difficulty in reaching the village for physical monitoring and session site. Additionally, high temperature during summers made it challenging for VMCs to undertake door-to-door mobilization, unlike in winters. Furthermore, beneficiaries were also hesitant to step out during the day, which limited vaccination uptake.

Repercussions of incentivization

Beneficiaries from villages that were not part of the Randomized Controlled Trial (RCT) study would also come to the session site in an RCT village and demand incentives post-vaccination (such as monetary coupons, dry fruits, etc). On learning that they aren't eligible to receive the same, they would argue with the PCI team or return without taking the vaccine. This was prevalent across the block and required additional mobilization efforts by PCI.

Repetitive data collection impacting mobilization

Repetitive data collection of similar personal details (such as name, Aadhar Card details, etc) for surveys conducted by multiple partners aggravated beneficiaries' hesitancy and posed a major roadblock during line listing and mobilization.

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 Ward Members to mobilize beneficiaries reluctant to share personal details and take the vaccination.

CASE STORY

Bagmati river that cuts through the Khadka panchayat, requiring residents to use makeshift pedestrian bridges for faster access to villages on the other side.

District Coordinator and Block Coordinator from PCI meeting with Mukhiya and Ward Members to share District Magistrate's concerns, and plan a mitigation strategy.

The District Magistrate (DM) of Sitamarhi, Sunil Kumar Yadav, learnt about the grave situation of Khadka panchayat in Runnisaidpur block, which had a very low COVID-19 vaccination coverage as a result of high hesitancy among beneficiaries. In response to this, during the District Task Force (DTF) meeting on 30th January 2022, the DM requested Project Concern International (PCI) team to intervene. District Coordinator (DC), Abhishek Kumar, who was present at the meeting, immediately spoke with Block Coordinator (BC), Kaushal Kumar, who further arranged for a meeting with Khadka's Mukhiya (Panchayati Raj Institution Head).

Khadka panchayat hosts 3 villages consisting of 13 wards, and is home to a mixed population of Muslims, Hindu Scheduled Castes (Dhobi, Paswaan, and Khatri), and Hindu General Castes (Brahmin and Bhumihar). Bagmati river divides the panchayat, with 3 wards on one side and 10 on the other, connected by broken roads and small pedestrian bridges. The only public commute here is an auto. It is also prone to seasonal floods, which destroys many neighbouring settlements, compelling residents to commute by boat and/or temporarily live on the roofs of their houses till the water settles down.

On meeting with the Mukhiya, PCI team enquired about the current status of COVID-19 vaccination in the area and challenges faced in improving the coverage. The team then proposed a strategy to make this panchayat 100% vaccinated for dose-1. It was suggested that all 13 wards could be collectively covered in a day if 13 separate teams consisting of an ANM, Verifier and Ward Member each are made available. The Mukhiya was impressed

Vaccination sessions organized collectively within a day by 13 dedicated teams across all 13 wards in Khadka.

Mukhiya felicitating PCI's Runnisaidpur block team for their commendable efforts.

and joined hands with the PCI team to work towards executing this plan. He arranged for a meeting with all the Ward Members, who were told about the DM's concerns and the strategy that will be employed to increase vaccination coverage in Khadka. A few potential dates were decided for the vaccination, and 8th February 2022 was finalized on meeting with the Medical Offer In-Charge (MOIC) and Nodal Officer at Primary Health Centre, Runnisaidpur. Thereafter, a microplan was created by the PCI team, and 13 ANMs and Verifiers were arranged. The PCI team even coordinated with the Mukhiya to plan which team of ANM and Verifier would accompany which Ward Member to hold a vaccination session within the ward itself.

The sessions started by 9:00 a.m. and lasted till about 5:00 pm. The Mukhiya visited all the 13 wards to ensure all arrangements were made and were progressing as planned. The support of the local ASHA, Anganwaadi, and/or Sevika was also taken for identification of due beneficiaries and mobilization, especially pregnant women and lactating mothers. Against all odds and through the collective efforts of everyone, approximately 300 beneficiaries were vaccinated in one day, with 92 beneficiaries having received their first dose and ~200 beneficiaries their second dose. The incredible efforts of the team made it possible to reach the 100% first dose vaccination goal in Khadka.

To applaud this commendable effort, the Mukhiya even felicitated the PCI team with a certificate. This was, indeed, a momentous achievement for the PCI team, one that will always be remembered by everyone who witnessed it.

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We appreciate the commendable efforts of Abhishek Kumar (District Coordinator), Kaushal Kumar (Block Coordinator), Kriti (Block Coordinator), Sumit 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

ANM
Auxiliary Nurse Midwife

AVD
Alternate Vaccine Delivery

AWW
Anganwadi Worker

BC
Block Coordinator

DC
District Coordinator

PHC
Primary Health Centre

PRI
Panchayati Raj Institution

RMP
Rural Medical Practitioner

VMC
Village Mobilization Coordinator