COLLECT RISK COMMUNICATION & COMMUNITY ENGAGEMENT

Facilitating Community-led COVID Appropriate Behaviour and Vaccination Linkages for Marginalised Communities Across India

PRAXIS

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Introduction

The Collect Risk Communication & Community Engagement [C-RCCE] is a community led initiative spread across **11 states**, supported by UNICEF India. The initiative covers **70 districts**, rooted in **560 hamlets**, predominantly inhabited by **Dalit, Adivasi, De-notified and Nomadic Tribes** and **minority communities**. The programme particularly focuses on building a resource base at community level for easy access to information and instituting a system of data flow, which can be used to create an evidence-based system of communication with local administration. This holds importance particularly in the context that in these targeted hamlets of marginalised groups, access to digital tools is minimal and even when available, not everyone is able to access these tools owing to varied reasons ranging from ownership to access control.

Overall Programme

With the second wave spreading to rural areas mid-2021 and the impending third wave of the pandemic, the immediate problem in most of the selected hamlets was the fear of rural spread of the virus in a rapid way, the lack of awareness about Covid Appropriate Behaviours and the myths clouding the vaccination drive. It was in this background that in November 2021, RCCE Collect initiative began a six-month programme focused on building community level awareness on Covid Appropriate Behaviour (CAB) and ensuring higher vaccination through mobilisation among vulnerable groups. The programme selected hamlet level and district level fellows in each location that were from the community itself. The key objectives of the six-month programme were as follows:

Fellows understand and practice Covid appropriate behaviours (CAB), are facilitated to make informed decisions about vaccinations and are provided access to the same.

Link the community with the local health services and administration for early COVID testing, treatment and vaccination with the view to the improvement of vaccination systems overall for the left-out dropped-out community

Enhance capacity/understanding of Covid Appropriate Behaviour of volunteers to help them take the message of CAB to communities

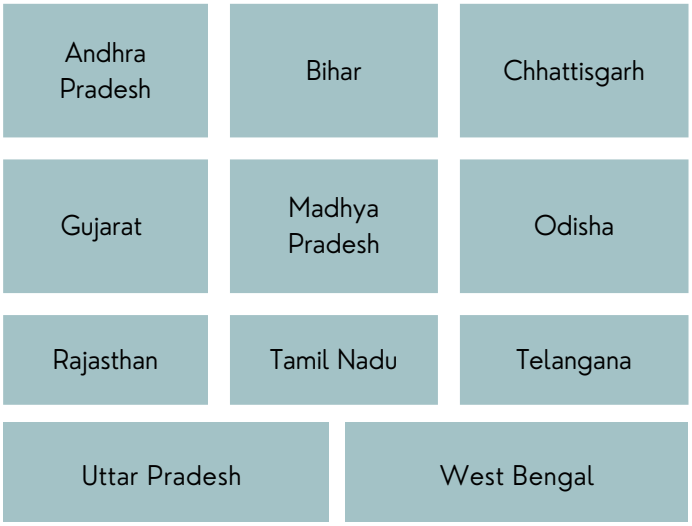
Programme timeline

In a phased manner, the programme began with a strong and consistent focus on CAB as well vaccination efforts, following this, from the third month onwards work on social accountability aspects with particular focus on government supported schemes and entitlements also began parallely.

Month	Activity / Project
November	560 hamlet fellows and 71 district fellows trained on CAB and vaccination, following which community meetings held to spread this knowledge
December	A survey was conducted to better understand the status of vaccination in all states. Sessions with doctors and experts held for fellows to understand vaccine myths. Links made with local administration for supporting vaccine camps
January	Based on the findings of the vaccination survey - target vulnerable groups were engaged with (e.g pregnant women, persons with disability, elderly, etc.). Door to door campaigns, engagement with Panchayat and local administration strengthened.
February	Along with the ongoing efforts for vaccination, 10 districts were selected to focus on social accountability work. The fellows identified the schemes difficult to access for the community. The capacity of the fellows was built on these schemes and liasoning with local administration for scheme was initiated. Focus on youth vaccination and its challenges added.
March & April	Endline vaccination survey conducted. Focus on 12-17yr vaccination in community meetings. In the social accountability focus districts, fellows continued to engage and identify the challenges faced by the community. Fellows were also trained on online applications for relevant schemes.

Sample

The study was conducted in 11 states enlisted in table below. The data was collected from 48,086 respondents in the baseline and from 44,900 respondents in the end-line. The state-wise numbers of the districts, blocks, panchayats and villages are given below. The table shows that the maximum districts were chosen from Bihar and Uttar Pradesh, whereas the least number of districts were from Telangana state. The baseline was carried out between 20 December 2021 to 10 Jan 2022. The endline survey was conducted in April 2022.



States covered

	Baseline				*Endline*			
	Districts	*Blocks*	*Panchayats*	*Hamlets*	*Districts*	*Blocks*	*Panchayats*	*Hamlets*
Andhra Pradesh	3	11	18	23	3	11	18	20
Bihar	10	28	59	79	11	26	55	70
Chhattisgarh	7	12	49	62	6	11	39	55
Gujarat	6	14	38	47	6	13	35	40
Madhya Pradesh	5	9	30	41	5	9	24	35
Odisha	9	10	30	70	9	10	28	65
Rajasthan	5	8	24	36	5	7	17	27
Tamil Nadu	9	22	62	70	9	20	61	69
Telangana	2	5	11	36	2	6	16	16
Uttar Pradesh	10	27	74	80	10	27	74	65
West Bengal	4	7	20	13	4	7	15	28
	70	**153**	**415**	**557**	**70**	**147**	**382**	**490**

Locations covered

The state wise distribution of sample in the baseline and end-line survey is given below:

State	Baseline (Dec 21 - Jan 22)	Endline (April 22)
Andhra Pradesh	1929	2358
Bihar	7940	7465
Chhattisgarh	5449	4165
Gujarat	4260	3559
Madhya Pradesh	2706	2329
Odisha	5081	5027
Rajasthan	3846	2226
Tamil Nadu	5030	5506
Telangana	814	1537
Uttar Pradesh	7779	7696
West Bengal	3252	3032
Total	**48086**	**44900**

Sample distribution

The social group distribution of the sample households is given below. The sample consisted of Scheduled Caste (SC), Schedule Tribe (ST), Other Backward Classes (OBC) and also covers households from the Denotified and Nomadic Tribes (DNT) and those from the minority communities. In terms of proportion of the sample, the highest proportion was of SC households, followed by ST and OBC households.

	Scheduled caste	Scheduled Tribe	Other Backward Classes	Minority	DNT
Baseline (n=48086)	49%	26%	20%	10%	11%
Endline (n=44900)	51%	26%	19%	11%	12%

Social disaggregation of sample

Overview of Key Findings

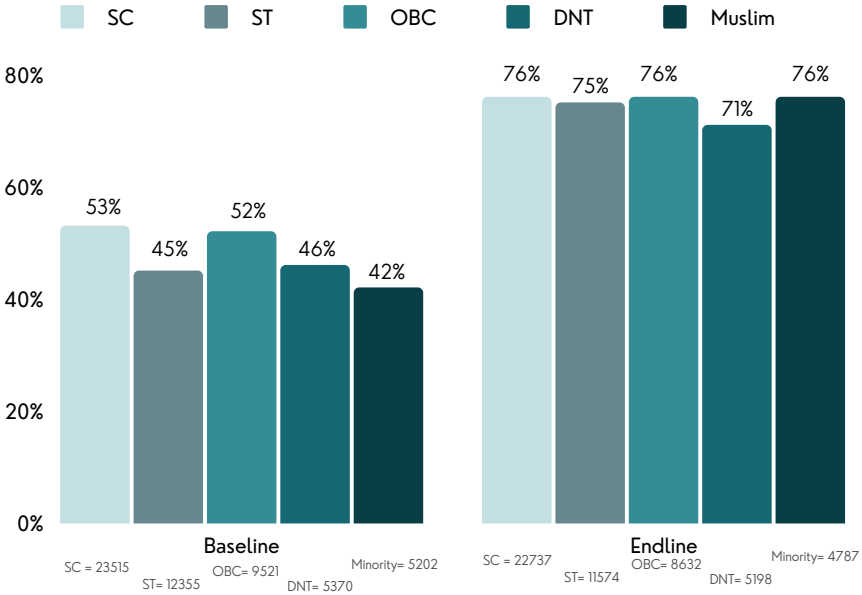
Over the six-month project, there has been a significant increase in the number of vaccinations within the marginalised communities across 70 districts - there has been a 25% increase in vaccinated adults since the start of the project.

25%

increase in fully vaccinated **Female** (18+)

25%

increase in fully vaccinated **Male** (18+)



Change in percentage of vaccinated adults disaggregated by social group

Vulnerable groups

Transgender/Non-binary

30%

increase in fully vaccinated transgender/non-binary persons

Persons with Disability

30%

increase in fully vaccinated Persons with Disability

Pregnant Women

43%

increase in fully vaccinated pregnant women

Key drivers for change

The hamlet and district level fellows have used a number of innovative ways to address the myths and challenges surrounding vaccination. Some of the key drivers for change were:

- **Trainings**
- **Linkage with Panchayat**
- **IEC material**
- **Community meetings**

- COVID appropriate behviour trainings, including sessions with doctors over video held with all fellows. This information taken forward to the community.
- Several meetings held with Panchayat members and local leaders to build their support for the vaccination process.
- Widespread use of IEC material to generate awareness and tackle myths.
- Busting myths and building trust through conversations with community members to understand their challenges and address these.

25% **overall increase in fully vaccinated individuals (18+) from baseline to endline**

Baseline: 48086 Households
Endline: 44900 Households

Baseline: 86076 Male (18+)
Endline: 83984 Male (18+)

Baseline: 86408Female (18+)
Endline: 81750 Female (18+)

Vaccination Survey

The importance of the COLLECT architecture is its ability to bridge last mile gaps. It focuses on hamlets that are generally excluded even from the village level decision making processes and basic infrastructure. In that sense, in the first place, capacitating a cadre of community volunteers on CAB and health provisioning has been perceived as a sustainable advocacy and implementation model. The community volunteers and district coordinators worked closely with medically trained personnel and also sought support from ASHA workers on the ground. In terms of providing support or complementing the efforts of the ASHA workers, the volunteers shared information about vaccination camps, conveyed factual information to households on vaccination, helped ASHAs in discussions with community to encourage and helped dispel doubts regarding vaccination and identified most vulnerable households including PwDs, single women, those requiring mental health support. The Praxis team worked closely with the district coordinators and supported them in continuing to liaise with local authorities to organise vaccination camps/drives, to ensure that the eligible people in these hamlets receive the first and second dose of the vaccine. The team also generated reports and infographics as needed on vaccine ready community members to help build a case with authorities. The team held 1046 hamlet level meetings, 1166 meetings with frontline workers, 392 meetings with block level officials including Block Medical Officer, 1115 meetings with local influencers and 943 meetings with panchayats. In all, 1117 vaccination camps were provided with mobilisation support.

- Community meetings
- Trainings on Covid Appropriate Behaviour
- Liasoning with local administration to support vaccination camps
- Support to ANM and ASHA workers for vaccination drives
- Door to door interactions with community members to tackle the myths and rumours
- Engaging with local influencers and Panchayat to support vaccination
- Supporting marginalised communities with access to social welfare schemes

- Samvet from Bhagalpur, Bihar spread awareness through street play [nukkad natak] called 'Afwahon ki Hattya'
- Community leader of Gond tribe from Balaghat, Madhya Pradesh composed Covid awareness songs
- Partners from Rajasthan spread awareness through puppet show [Kathputli] and composed songs on vaccination
- Paschim Banga Kheria Sabar Kalyan Samiti from Purulia, West Bengal supported communities to compose vaccination awareness songs

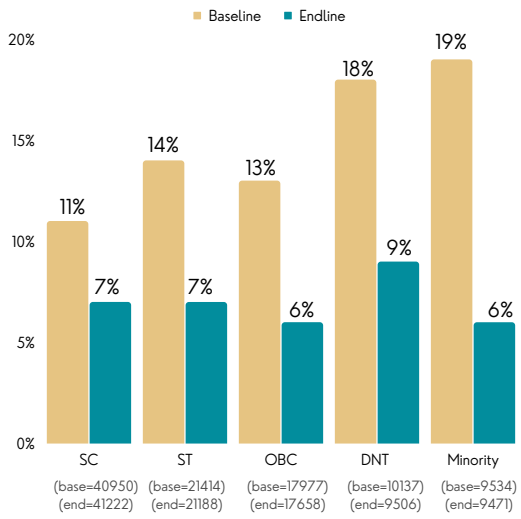
"There are many elderly people in the communities we are working with. Since they are heads of the households and perceived as the key members of the families, if they do not get vaccinated the whole family would not. In many places we strategically engaged elderly as volunteers. This brought a big change in the vaccination scenario - when a person of similar age group told others to get vaccinated, it worked quite effectively and motivated them a lot. People in Dalit and Muslim communities were initially unwilling to get vaccinated, we brought in a team of elders together to spread information and share their success stories. When people spoke about asthma or any other health issues, we directed them to the doctor for immediate consultation and vaccination related advice.

While the situation is changing regarding vaccination, untouchability issues still exist. Many communities were finding it difficult to reach the centres. We took initiative to start vaccine camps in Dom and muslim communities to make it easier for them. We had seen that some other 'higher' caste communities were infact coming to the vaccination camps put up for the Dom community, which has been a big positive change"
- Sanjeev Dom, Khagaria district, Bihar

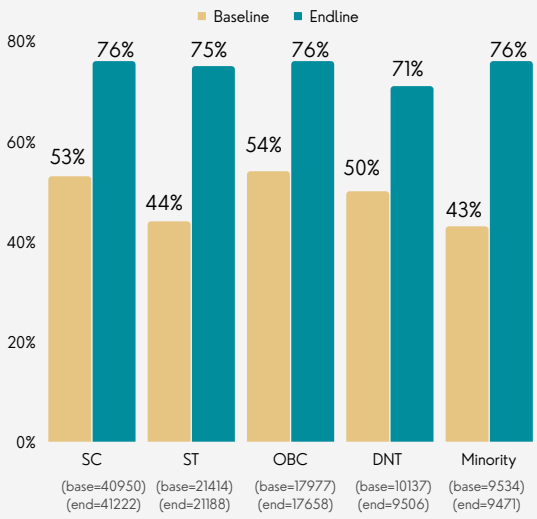
Measuring Progress: Vaccination status among adults

The programme survey covered 1.72 lakh adults in the baseline and 1.65 lakh in the endline. Data from the 11 sample states reveal that there has been a significant shift in the overall vaccination of adults from baseline (51%) to endline (76%). When disaggregated by caste as well, it is seen that the highest increase has been among the minority community (33%), followed by the ST community (31%) and then the SC, OBC and DNT community. In terms of those who had not been vaccinated as yet, the number has come down by half - changing from 12.5% overall in the baseline to 6.5% in the endline.

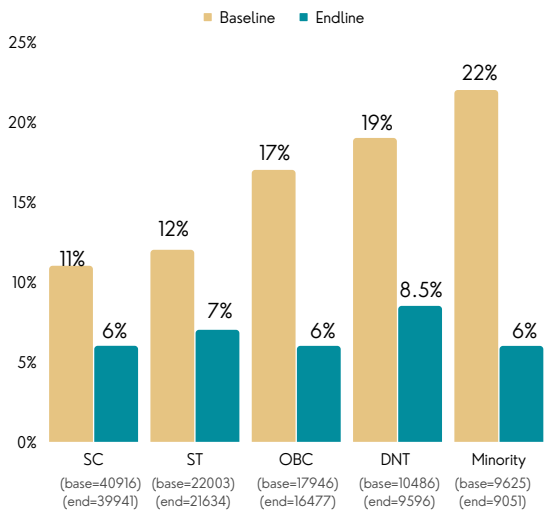
The tables below show a gender and caste disaggregation of the adult vaccination. The most stark increase in vaccination was among the minority community, with a jump from 43% to 76% in men and 40% to 75% among minority women. The percentage of not vaccinated still remains relatively high among the DNT community (9% in men and 8.5% in women). Efforts still remain to convince the last few community members for vaccination. Over the course of the programme, our fellows have engaged closely with the community to work on the myths and fears, some challenges and learning from engaging on the issues of adults are listed in the section below.



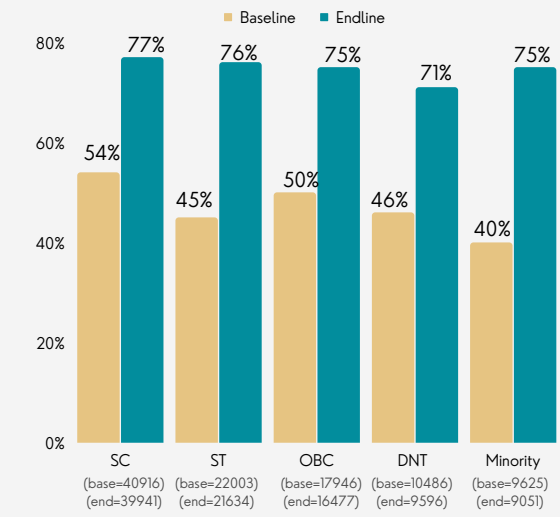
Not vaccinated Adult Male (18+)



Fully vaccinated Adult Male (18+)



Not vaccinated Adult Female (18+)

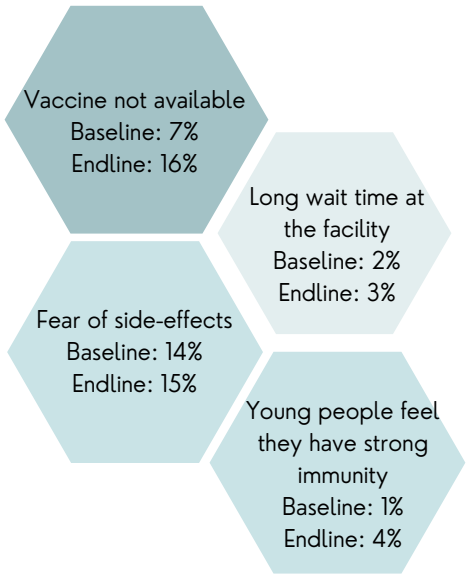


Fully vaccinated Adult Female (18+)

Challenges and Learnings from the ground

As emerged from the community survey and substantiated from the discussions with implementing partners, vaccine hesitancy was driven by people's lack of confidence, prevailing myths, misleading information, risk calculation and moreover, inconvenience to reach the vaccination centers. Vaccine denial and reluctance has been in existence since beginning of the vaccination drive by the central government.

Rumors, myths and misinformation about vaccines especially amongst the DNT communities such as immunity would reduce, or their likelihood of getting more side effects, neem would cure Covid infection were rampant as elucidated by the partners from Tamilnadu, Rajasthan, Gujarat and other states as well. Lots of confusing fake information circulating across social media platforms and few death incidents that might have happened due to existing illness aggravated people's doubts about vaccination and it led them to believe people might die if they get vaccinated. The fear of death was so prominent among elderly that if they heard about any deaths in their area their fear increased - many also sent away ANMs/ASHAs.



Those suffering from asthma too feared vaccination. In spite of meetings with gram panchayat and ward members, not many people from tribal communities agreed to get vaccinated. Also, the family members of aged people were hesitant to take them to hospital. Availability of transport emerged as one of the major issues in tribal locations. As ANM & ASHA workers especially in tribal areas have to travel to remote locations to administer vaccination service, they even said that people of 80 years and above do not require vaccinations. Due to lack of access to public transport, lack of money and absence of government support, many of them avoided vaccination as they were losing out on their daily wage if travelling to faraway places for vaccination. Sheer hesitancy towards vaccination has also been observed among the people with addictions. No matter what the team tried to explain and make them understand the need for vaccination - it had been extremely challenging to help them overcome their misconceptions related to alcoholism and vaccination.

For communities living in very remote areas, like the Sabar Tribe, reaching the vaccine centre is very expensive. It costs them between Rs 100-150 to reach the vaccine centre. A cost not feasible for most families who have just enough earnings for their day-to day existence. - Puruliya, West Bengal

"We didn't get infected in last two years, so why shall we take the vaccine?" - Keonjhar, Odisha

"What is the need to get vaccinated at this age?" - Elderly persons, Jaunpur, UP; Jalpaiguri, West Bengal

"Due to prevailing caste discrimination in Krishna district, lots of people are deprived of vaccination support. Influential people and people with political background are being able to get booster shots whereas others in remote locations are unable to access vaccines" - Chittoor, Andhra Pradesh

"We drink, Corona will die from the alcohol. Drinkers do not need vaccine. Those who do not drink need vaccine". - Purulia and Bankura, West Bengal

Actions on ground

As part of the intervention strategy, intensive awareness meetings and campaigns were conducted with different sets of caste, community, gender, religious groups viz. SC, ST, NT-DNT [Sapera, Kalbeliya, Nat, Banjara, Sabar], Muslims, with people from different occupational backgrounds viz. brick kiln workers, bidi workers, daily wage labourers, farmers, agricultural labourers, MGNREGA workers, and college going youth. Partners facilitated one to one engagements and in-depth conversations with substance addicts, elders, people with various kinds of accessibilities, pregnant and lactating women to demystify the widespread rumours, myths and misinformation related to vaccination and convince them to take vaccines.

Several strategies showed positive impacts such as - dissemination of messages created by those who got vaccinated talking about after effects, creation of role models who have received vaccines encouraging others and supporting the vaccination drive, rewarding with token of appreciation to those who got vaccinated, circulation of IEC materials in local dialects [audio and video clips, posters, artworks etc.] and likewise. Besides the communities, several engagements took place with panchayat level service providers in a structured manner to seek their support for community mobilisation and ensure 100% vaccination including the marginalised and deprived communities.

"The team directly met the elders, interacted with their family members and assured them all possible support from doctors and Village Health Nurse (VHN). The elders were supported with scheduling appointments, accompanying them to vaccination centers and necessary follow-ups. This way the team has been able to build trust among the community members. Our effort towards linkage with doctors had been another strategy that helped communities gain confidence about vaccination. The doctors directly spoke with those suffering from hypertension and diabetes. Workers registered under MGNREGA were also persuaded to get vaccinated".

- Tirupattur, Tamilnadu

Access

Many centers lack basic infrastructure like seating and drinking water, making it difficult to access for elderly, PwD and other vulnerable groups.

Fears

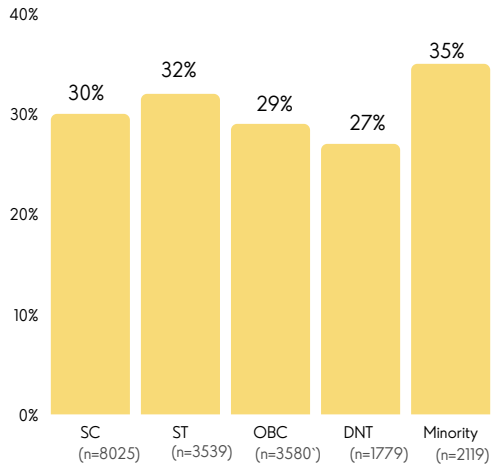
All locations reported the myth of the link between vaccines and infertility (particularly of women). Families were particularly fearful of vaccinating pregnant women

"The strategy of creating role models or champions worked. We organised awareness meetings with bidi workers and explained the need to take extra precaution as bidi workers undergo occupational hazards. This type of work affects their lungs and impacts overall health. We disseminated the information we gathered from our sessions with doctors and helped them understand their need for vaccines more than others. There were a few in the group who were very determined not to get vaccinated. We did fail in a few cases, but we are continuing to give our best efforts (primarily working with Muslim community). We always notify them to take the second dose on time. We have also approached the local administration and doctors to visit our area and encourage people for vaccination".

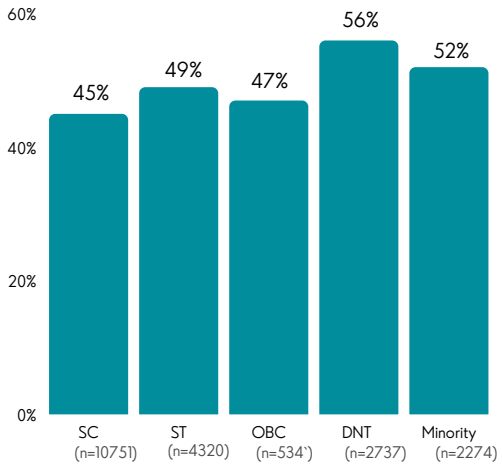
- Jaunpur, Uttar Pradesh

Vaccination status among 12-17 age group

As the vaccination of persons younger than 18 years began only in January 2022, the data for the vaccination of this age group was not collected in the baseline. The analysis of the 12-17 age grouup vaccination is based on the data collected only in the end-line survey (April 2022). Overall, it was found that 30% out of 15,854 children between 12-14 years were vaccinated, while 46% out of the 21,137 youth between 15-17 years were vaccinated. The data reveals that the vaccination of youth between 12 to 17 years has been symmetric across the two genders. Even in terms of the caste-based analysis, the social group wise coverage of vaccination has been similar, with lowest among SC community (45%) in 15-17 age group and lowest among DNT community (27%) in 12-14 age group.



12-14 age group vaccination coverage (April 2022)



15-17 age group vaccination coverage (April 2022)

Challenges and fears in vaccination of 12-17 age group

Rising doubts about effectiveness of vaccine doses particularly from instances of people getting infected even after completing two doses, lack of dissemination of information by frontline health workers about the importance of vaccination, persistent fear of aftermath, parents' perceptions regarding unforeseen circumstances that vaccine might have long-term ramifications on their children, and overall, the concerns about potential unknown long-term effects including side effects of vaccine restrained parents from getting their children vaccinated. Besides parents worrying about how Covid19 vaccine may affect their children, children themselves were afraid of taking vaccines - there had been instances of children not attending school in fear of getting vaccinated. However, as the implementing partners specifically mentioned, even though the children of daily wage labourers are keen to take vaccines, they were unable to as there was no one at home to take them to the vaccination centres. Presence of child labour too hindered the scope of those working children to get vaccinated. Myths and misconceptions regarding the vaccine affecting menstrual cycle, reproductive capacity, leading to kidney failure within six months acted as barriers to girls' vaccination.

With regards to the systemic challenges - untimely arrival of vaccine vials leading to shortage of vaccine, lack of coordination among local bodies, crowd and long queue outside vaccination centers and mismanagements were some of the key disabling factors for 15-17 years children's vaccination. Absence of mobile phones in every financially unstable family has been a barrier to vaccination because in most cases people are more in numbers in one family whereas only four people can be registered with one mobile number.

Actions on ground

Successful collaborations with panchayat, block and district level stakeholders including sarpanch, panchayat representatives, ward members, teacher-in-charge/ principal of upper primary and middle schools, ASHA, ANM at PHC paved the pathways for intervention. The block/ district level education and health department officers approved partners' applications and extended support in organising vaccination camps within school premises. With partners' immense efforts, out of school children have also been vaccinated. Apart from regular Covid infection and vaccination awareness meetings with children and their parents in schools, AWCs and villages - innovative techniques were adopted by the implementing partners to spread awareness and sensitize communities on vaccination promotion and Covid Appropriate Behavior (CAB). For instance, children's cycle rallies in Gujarat and creation of posters by children in Tamilnadu need special mention. Special awareness meetings were also organised with parents as in many instances, they were hesitant to get their children vaccinated. Door to door awareness visits by PHC health workers assured people of any kinds of post vaccination health issues. This encouraged few parents to immediately take their children for vaccination.

Consent Letter

Schools in many parts of the country are asking parents to fill consent forms for the vaccination of their children. Parents point out that they fear the entire responsibility for vaccine side effects being put on them

Drop Out Children

COVID has led to many children dropping out of school. As vaccinations are being rolled out in schools, it will be important to target drop out children in vaccination drives.

Fears & Myths

All locations reported the myth of the link between vaccines and infertility (particularly of women). While adults took risks for themselves, they were hesitant for their unmarried children (particularly daughters).

Mobile Registration

Many families do not have smart phones to access the COWIN app. The limit of 4 members on one number is an additional challenge for large families and locations with few smart phones.

Challenges with vaccination of adolescents across 11 states

"While vaccination camps for school and college going students can be organised within the respective institutional premises, camps for school dropout children can be organised in collaboration with the local panchayats. One of the strategies would be to first list out school and college going students and school dropout children and then approach the relevant stakeholders."
- Naupada district, Odisha

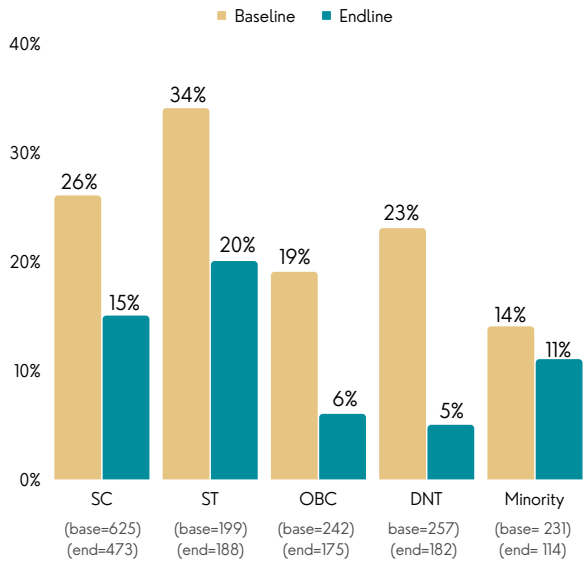
Vaccination among vulnerable groups

Throughout the programme, there has been a keen focus on vulnerable groups within the marginalised communities, to make sure that no one was left behind. Findings from the baseline survey revealed that a large percentage of pregnant women, trans and non-binary persons as well as persons with disability were unvaccinated. Following which, the programme focus was additionally steered towards these vulnerable populations within the marginalised communities.

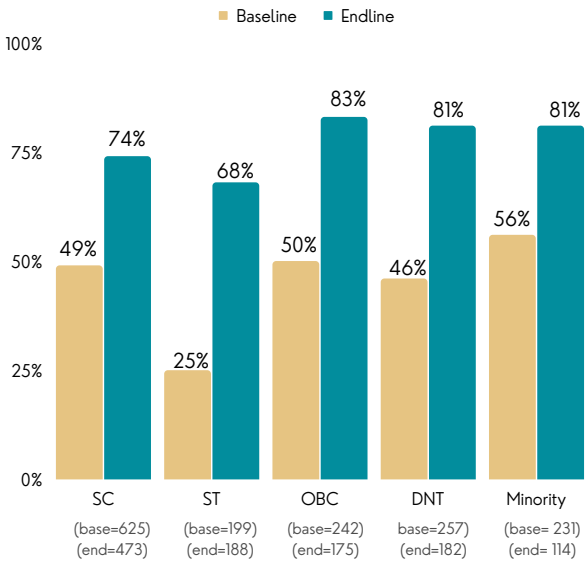
Persons with Disability

At the beginning of Covid pandemic, WHO had identified the groups that would be most affected - in this disability was at the top of the list. This is because 'touch' is a very important factor related to Covid infection and especially for persons with disabled. They are highly dependent on others, hence has a direct relation to the impact of Covid as well, since it can spread through touch. Despite the fact that disability is a priority risk factor and many individuals with disabilities are at a heightened risk of infection, severe illness and even death due to Covid-19 because of their existing medical conditions - the states were not responsive towards arranging special infrastructural provisions for persons with disabilities.

During the baseline survey, it was found that 25% out of the 1137 persons with disabilities surveyed were not vaccinated, and only 45% had been fully vaccinated. Besides the structural barriers, many families were not keen on getting members with disabilities vaccinated. Though persons with disabilities are more likely than others to have chronic conditions and higher risk of weakened immune system, families perceived vaccination to be unnecessary for them since they do not need to go out of the house. Often the taunting like 'burden' caused a lot of additional emotional and mental anguish among them that discouraged them to take vaccines. Fear of death and worsening health conditions also stopped them from getting vaccinated. In few cases there were no family members at home to take them to vaccination centres, while for others, absence of Unique Disability ID cards made the mobile registration a difficult process as stated by the partners from Bihar, Madhya Pradesh and Gujarat. Based on these findings, fellows across the different hamlets paid special attention to the vaccination of persons with disabilities and making the vaccine accessible to this population. Following the programme intervention, in the endline survey, it was found that 75% of the 870 persons with disabilities surveyed were vaccinated.



Unvaccinated Person with Disability



Fully vaccinated Person with Disability

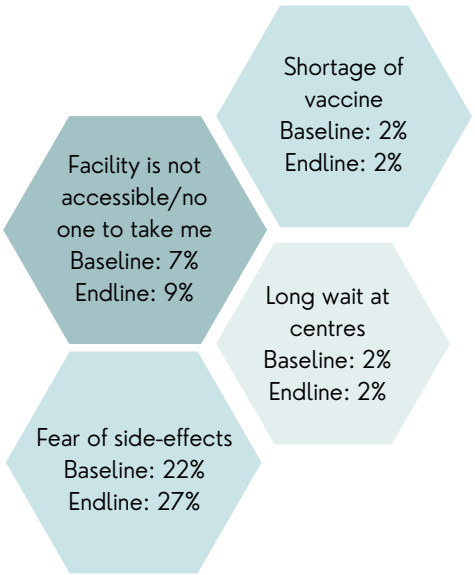
Actions on ground

Partners from all states observed that long queues without safe waiting places and absence of ramps in vaccination centers created accessibility issues, thus making it difficult for this vulnerable group to get vaccinated. During the initial phase of programme intervention, the community fellows made home visits and supported persons with disabilities to reach the vaccination centres. Besides doorstep awareness campaigns and community meetings, the partners sought support from panchayat level duty bearers including AWW, ASHA, ANM and panchayat and ward members for community mobilisation, collaboration in awareness campaigns and organising vaccination camps in village or panchayat. Community mobilisation processes gained momentum with due recognition of the initiative by panchayat and block level government officials who extended their support and joined hands in ensuring village level special camps as well as doorstep vaccination services for those who had been unable to access the same. Those who didn't have Unique Disability ID cards or other relevant documents for vaccination were issued the same, for instance, in Tamilnadu the cards were issued in the special camps itself. One of the sarpanchs from Hanumangarh district of Rajasthan arranged a vehicle that took persons with disabilities to vaccination centres and dropped them back home. Similar initiatives were taken in Gujarat where persons with disabilities were on the vaccination priority list and rickshaws were arranged for them to access vaccination centres. Frequent visits and follow-ups with relevant departments including ward members and health officers worked as a successful strategy in Tamil Nadu, Rajasthan, Gujarat and Telangana to ensure every disabled person is fully vaccinated. Social media forums and whatsapp groups have also been extensively used by the implementing partners to raise awareness about vaccination especially among persons with disabilities.

"We went door to door to discuss about Covid appropriate hygiene behaviour and importance of vaccination. This encouraged a few people to take vaccines. In the next phase, we worked closely with ANM and AWW who helped organise some small camps at the anganwadi centre located within the village. As distance was less, few more persons with disabilities were able to access vaccine. The third phase was an initiative by the government called "Ghar Ghar Dastak" - which means knock every door and identify those who need doorstep vaccination service. We have been able to vaccinate at least 95% persons with disabilities through this initiative. We have also suggested to form block level committee or groups of persons with disabilities that can act as an intensive discussion platform for their issues related to access to entitlements, livelihood, provisions for pension, etc." - Bhagalpur, Bihar

30%

increase in vaccination of Persons with Disability



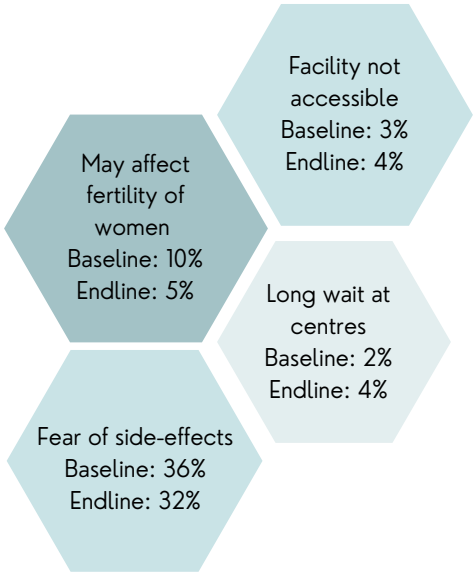
"I was reluctant to get vaccinated, I was afraid it might have negative consequences. Pramila didi (fellow) came to my home multiple times and told me about the benefits of vaccination. She even got the ASHA didi to speak to me on the issue. Because of this I finally agreed and got vaccinated. I am waiting for my second dose"- a person with disability, Sundergarh, Odisha

Pregnant Women

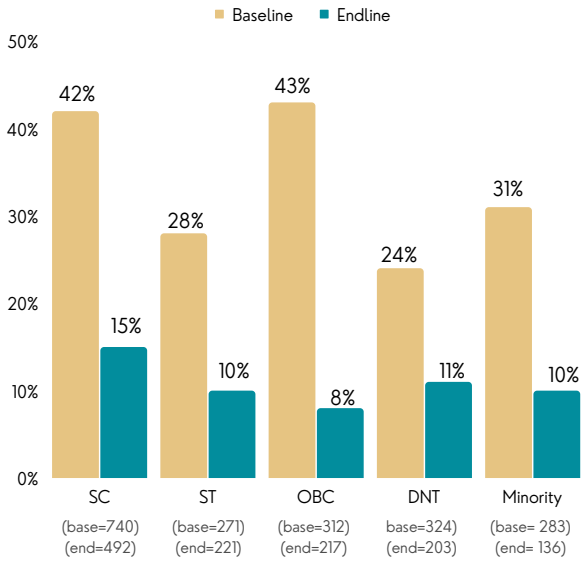
The barriers to vaccination acceptance among pregnant and lactating women were related to vaccine safety, myths and misconceptions due to less knowledge about significance and effectiveness of vaccines. The primary reason associated with refusal to vaccination was fear of side effects on the fetus. Other reasons pertain to - fear of vaccination affecting the fertility of women, fear of miscarriage as well as delivery of pre mature baby, parents and in-laws fear of vaccination impacting the growth of the fetus, unwillingness of women with first pregnancy to get vaccinated, lactating women's fear of inability to breastfeed their children as vaccination is perceived to be affecting their ability to make milk and 6 months post-delivery is perceived to be a safer period by their in-laws, fear of side effects of vaccine impacting the new born child, apprehension regarding the decision of vaccinating pregnant and lactating women while earlier this population subset was left out from vaccination, illiteracy leading to misconceptions and apprehensions regarding vaccination where in few cases ASHA and ANM were threatened for their outreach visit.

43%

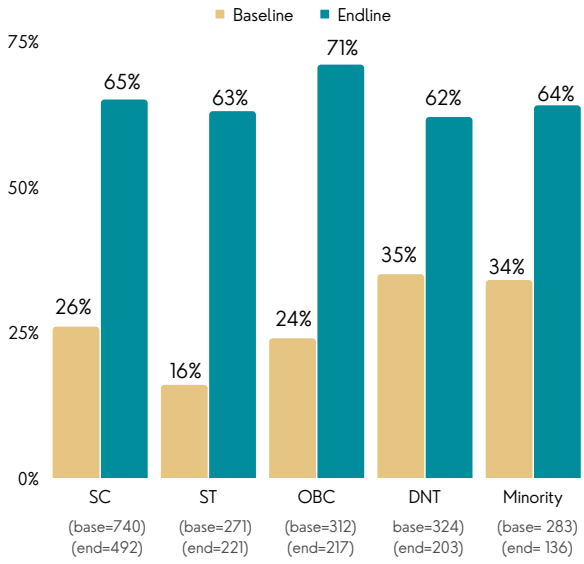
increase in pregnant women vaccinations



Findings from the baseline study conducted with 1398 pregnant women, there were only 23% fully vaccinated, while 40% reported that they had not been vaccinated. Key reasons were the fear of side effects, which included the belief that the vaccine would affect the fertility of women. This high percentage of unvaccinated women demanded a keen focus on working towards these myths. Focused sessions with doctors, community meetings, IEC material were all used by the fellows to dissipate fears. The endline survey, covering 957 pregnant women revealed that 66% women were now fully vaccinated, while the unvaccinated population reduced significantly to 12%. There was also a significant reduction in the proportion of pregnant women who believed that the vaccine may affect the fertility of women and the fear of other side effects.



Unvaccinated Pregnant women



Fully vaccinated Pregnant women

Actions on ground

Though the government declared vaccination to be safe and can be provided to all citizens which includes pregnant and lactating mothers, certain myths and apprehensions were restraining them from taking vaccines. But the teams' efforts in intervention locations had shown remarkable differences in their thought process at a later stage. They individually met the husbands as well as family members to explain to them the efficacy and safety of Covid vaccination. As the teams were trained by doctors on vaccination related knowledge and oriented to spread the learnings among communities, they helped them understand the science behind that clinical trials of Covid vaccine suggest no harm on embryonic development. The teams in Tamil Nadu and Madhya Pradesh also arranged counseling sessions by doctors for husbands and other family members to clarify prevailing myths and doubts on vaccination during pregnancy. Counseling of husbands helped in influencing and mobilising other husbands of pregnant and lactating women. Being a sensitive issue and young children involved, multiple rounds of discussions took place with both the women and her family members. Continuous engagement with the target group and dissemination of positive news about vaccinated neighbours helped to mobilise them for vaccination. The frontline health workers i.e. ASHA and ANM also played a significant role in building awareness and mobilising pregnant women for vaccination through home visits. Teams' extensive effort in community outreach through the intervention of panchayat, block and district administration representatives to promote the vaccination agenda brought in notable success.

"One of the significant strategies we implemented was to disseminate doctors' and health officers' advices regarding common after effects of vaccination that do not have negative impacts on pregnant and lactating women's health. It is important that government spreads information about common after effects of vaccination as to reduce the unnecessary fear amongst people" - Gujarat

"Korwa community in Chhattisgarh have apprehension that vaccine would impair the growth of the child. They are afraid of pregnant women being unable to give birth to a healthy child if vaccinated" - Chhattisgarh

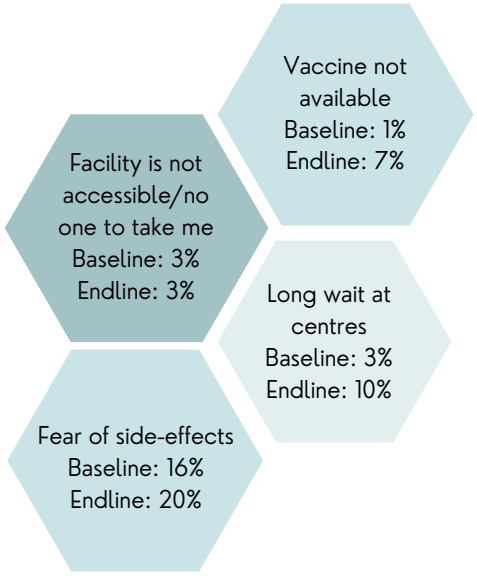
Transpersons/Non-binary persons

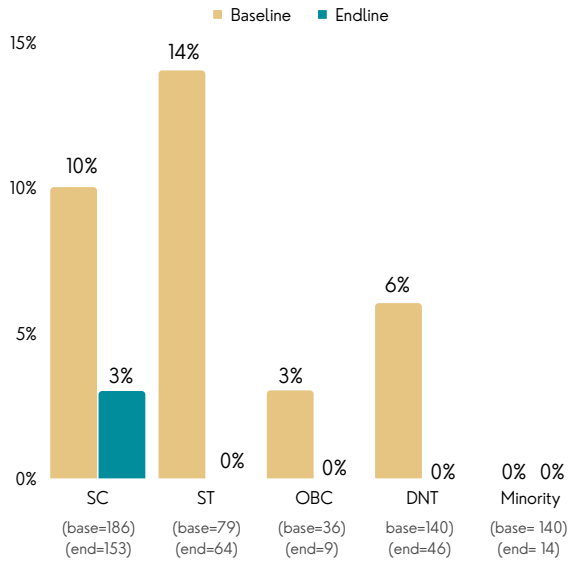
A total of 335 transgender/binary people were a part of the study during the baseline, while 230 were part of the endline survey. The data shows that there was a substantial increase in the proportion of vaccinated disabled people as it increased from 59% in the baseline to 89% at the end-line. The vaccine coverage for the non-binary people at 89% can be considered to be very significant as it lies very close to universal coverage. However, 8% of non-binary persons were still found to be "not vaccinated" in the end-line data.

The major reasons for the lack of vaccination were "second dose is not due", "fear of side effects" and the fact that vaccines were not available everywhere. The long wait lines at centres was also a deterrent as many mentioned that they were losing time to earn when standing in these lines. The discrimination by authorities was another concern for trans and non-binary persons, who highlighted that many people would pass comments or taunt them about taking the vaccine. Another key concern was the lack of proper documentation/ID cards, making the process more difficult for trans and non-binary persons.

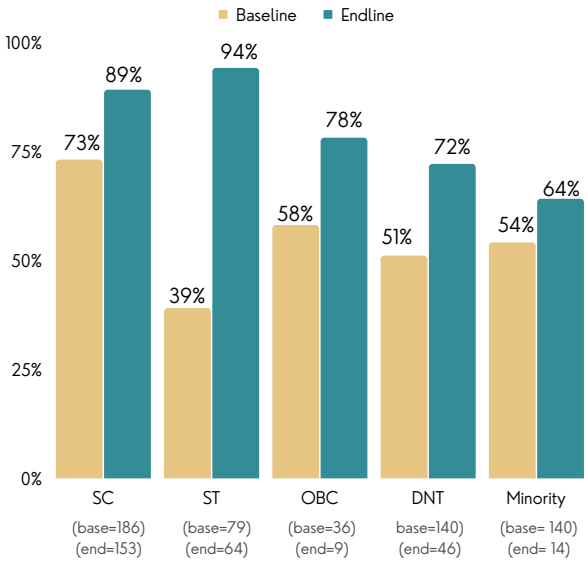
30%

increase in pregnant women vaccinations





Unvaccinated Trans/Non-binary persons



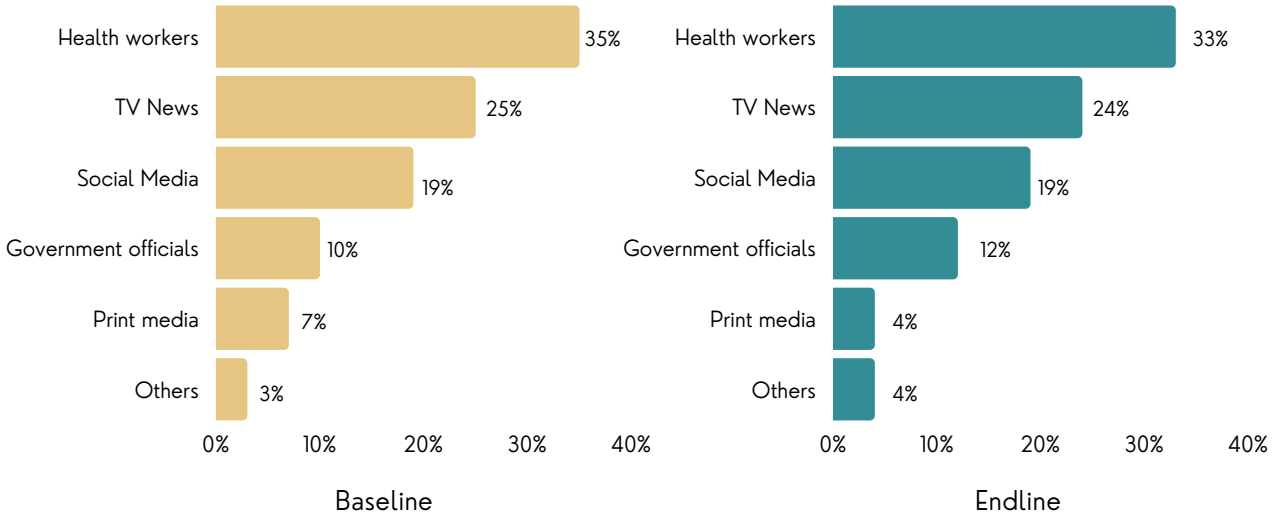
Fully vaccinated Trans/Non-binary persons

Decision making about vaccination

Regarding decision making, it was found that the highest frequency was of the household head - male, closely followed by individuals decision of each family member.

Individual decision of each family member	Household head - Male	Household head - Female
Baseline: 37%	**Baseline: 44%**	**Baseline: 9%**
Endline: 40%	**Endline: 43%**	**Endline: 9%**

Source of Information for vaccination



With regards to the source of information about vaccination it was found that in both the rounds of survey, health workers remained the main source of information for most people. Social media as a source has remained at 19% across both rounds. It is important to note that social media (whatsapp, facebook, etc.) has been responsible for spreading both information and misinformation during the Pandemic. During the intervention the team made sure to circulate government-approved information via WhatsApp and messaging and encouraged fellows to use these as their source of information when talking to community members. They were warned about the misinformation and also played a key role in informing other community members about misinformation.

There has been an increase in the percentage of people who reported government officials as their source of information, which is an encouraging sign, showing that people are slowly developing a dialogue link with local administration during this process.

Key recommendations

In addition to learnings from the ground, there were also recommendations made by community members. Based on the programme initiative, community discussions, feedback and support for COVID-19 vaccination, the following is a list of recommendations from various community members across the 11 states:

Awareness initiatives for elders and youth: This could be done through various creative mediums, such as street plays and door-to-door visits, or collaborations with the government including conversing with health department officials and local panchayats. IEC materials should be circulated in local dialects or a few role models from ST and DNT communities who have received vaccines should be brought forward to encourage vaccination drives. It is important to raise awareness about vaccination for PwDs and pregnant women in collaboration with representatives of PRI, block, and local panchayats , district administration.

Vaccination camps in schools and colleges: government or school authority should provide leave for the two days following vaccination to encourage more children to get vaccinated.

Managing crowd at vaccination centres: collective action (with support from local NGOs and panchayats) is required. The number of people at the registration desk at the vaccination centre should be increased from two to four to reduce the delay.

Vaccination for out-of-school children: Those who do not have an Aadhaar card should be made available with a recommendation letter from a block/district level officer. A common space is required for a village level vaccination centre so that people do not have to visit PHC/CHC, and special camps are required for minority communities or people who go to work on a daily basis.

Support with vaccination: ASHA and ANM workers can assist the elderly and persons with disability with post-vaccination issues and organise vaccinations at home for those with mobility issues. Involving credible representatives for which support can be taken from teachers and influential people or religious leaders. Block level committees/groups that involve differently abled people should be created to ensure they are represented and their issues are discussed with

Focus should be on people with co-morbidities to be vaccinated in conjunction with proper consultation with doctors.

Financial support can be provided for commuting to vaccination centres

Organising special camps or working in close conjunction with ANMs and AWWs who can help in organising special camps and issuing id cards.

Making provisions for differently-abled people at vaccination centres - such as ramps, information in sign language and braille, and prioritising their vaccination.

Creating role models from ST and DNT communities who have received vaccines to encourage vaccination drives.

Counselling of (to-be) mothers, persons with disabilities, and other vulnerable groups as well as other family members, especially husbands with regards to safety of vaccination.

Community Level Survey on Social Protection Schemes

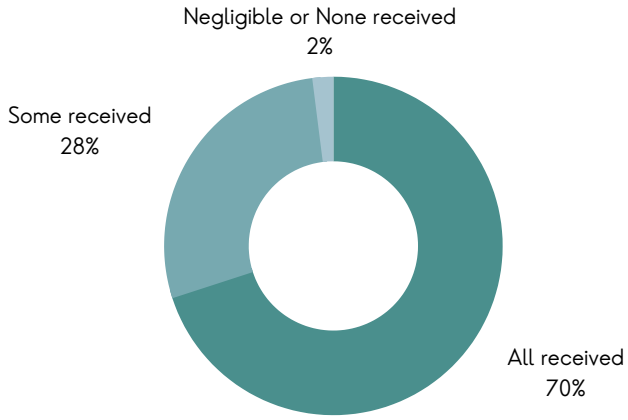
The study was conducted in 11 states. The data was collected from 566 focused group discussions from 547 villages in 396 panchayats of 151 blocks from 71 districts spread over the 11 states chosen for the survey. The maximum districts were chosen from Bihar and Uttar Pradesh, whereas the least number of districts were chosen from the Telangana state. There were 23% hamlets with a predominantly Scheduled Caste community, 32% with Scheduled Tribes and 13% with Other Backward Classes. In addition to this, there were 23% hamlets that were predominantly inhabited by Denotified and Nomadic Tribes and 17% with a predominant minority community.

	State	Districts	Blocks	Panchayats	Hamlets
1	Andhra Pradesh	3	11	18	23
2	Bihar	11	28	57	85
3	Chhattisgarh	7	12	41	54
4	Gujarat	6	13	34	42
5	Madhya Pradesh	5	10	27	40
6	Odisha	9	10	29	72
7	Rajasthan	5	7	24	37
8	Tamil Nadu	9	21	62	72
9	Telangana	2	5	14	16
10	Uttar Pradesh	10	27	74	80
11	West Bengal	4	7	16	45
	Total	71	151	396	566

Scheduled caste	Scheduled Tribe	Other Backward Classes	Minority	DNT
53%	32%	13%	23%	17%

Access to Ration - Public Distribution System

In terms of the access to the PDS and the dry ration in schools, about 70% of the hamlets reported that the PDS distribution was effectively taking place, there were 2% of the hamlets reported not having received ration.



Access to Ration (n=566)

Access to Nutrition

The proportion of hamlets receiving the nutritional benefits for the children and women was high, with more than 50% of the villages responding in the affirmative to the provision of nutrition across the categories. It is important to note however that there were still 20% hamlets where it was reported that none of the children between 3-6 years had received food, while 12% hamlets reported that no children between 0-3 received nutritious food from the Anganwadi centre.

	Pregnant Women (n=566)	Lactating Mothers (n=566)	Children (0-3 years) (n=566)	Children (3-6 years) (n=566)
All received	60%	57%	54%	51%
Some received	33%	35%	33%	27%
Negligible or None received	5%	7%	12%	20%
No eligible households	2%	1%	1%	2%

Access to Pension

In terms of the pensions, the survey studied the access to the old age pension, widow pension and the disability pension. The hamlets that reported complete coverage of the pensions was around 40%-43%, while a substantial proportion of hamlets reported that some of the beneficiaries had received the pensions.

	Old Age pension (n=566)	Widow pension (n=566)	Disability pension (n=566)
All received	40%	43%	42%
Some received	49%	45%	36%
Negligible or None received	9%	9%	9%
No eligible households	2%	3%	14%

Access to Schemes

On the question of the access to government schemes, the complete coverage was the highest for Jan Dhan Yojna at 48%, however, it was quite low for the other government schemes including Ujjwala, Ayushman Bharat and MNREGA with the complete coverage for these schemes being reported by 10% to 20% of the hamlets. However, the proportion of villages that reported that some of the eligible people got access to the schemes was found to be quite high as compared with the proportion of hamlets reporting complete coverage.

	Ujjwala Scheme (n=566)
All received	14%
Some received	48%
Negligible or None received	17%
None have access to the schemes	18%
Not needed	3%

	Ayushman Bharat (n=566)
All received	14%
Some received	36%
Negligible or None received	11%
No one has applied	9%
Do not know about scheme	30%

	MGNREGA (n=566)
All received work	18%
Some received	45%
Negligible or None received	27%
MGNREGA Not Applicable	7%
Work not needed	3%

	Jan Dhan (n=566)
All have account	48%
Some have account	46%
Negligible or None have	6%

Status of 3 poorest households in hamlet

The survey also reports the situation of the three poorest households in the hamlet in terms of the access to government schemes. The findings reported the maximum penetration for all the three households was in the PDS and the Jan Dhan Yojna, whereas, it was the lowest in the Ayushman Bharat and Ujjwala Yojna.

The poorest families in 32% hamlets reported that they do not know about the Ayushman Bharat scheme, while in 25% hamlets these households did not have Jan Dhan Yojna accounts. There were still 21% hamlets where the 3 poorest households did not have access to the Ujjwala scheme.

	PDS
Only 1 HH received	8%
2 HHs received	15%
All 3 HHs received ration	56%
None of them received	8%
Do not have ration cards	13%

	Pensions
Only 1 HH received	18%
2 HHs received	19%
All 3 HHs received	31%
None of them received	19%
Not Eligible	13%

	Ujjwala
Only 1 HH received	16%
2 HHs received	16%
All 3 HHs received	20%
None of them received cylinder	27%
None have access to the scheme	21%

	Jan Dhan
Only 1 HH has account	16%
2 HHs have account	18%
All 3 HHs have	41%
None of them have	25%

	Ayushman Bharat
Only 1 HH received	12%
2 HHs received	7%
All 3 HHs have	15%
None of them have access	17%
Have not applied	17%
Do not know about scheme	32%

Access to online education

In terms of the access to online education for the children in the hamlets, about two thirds of the hamlets reported that only some of the children could access online education, whereas, only 7% of the hamlets reported complete access to online education for children. The study of access to online education in the 3 poorest households shows that only 13% of the hamlets saw all the 3 poorest households having access to online education.

	Online education (n=566)
All children could access	7%
Some children could access	64%
None of the children could access	29%

	Online education (n=3 poorest)
Only 1 HH could access	11%
2 HHs could access	11%
All 3 HHs could access	13%
None of them could access	65%

Social Issues

The study also enquired on the status of distress and violence in the post-Covid situation, the variables studied under distress and violence were physical/domestic violence, child abuse, indebtedness and discrimination in vaccination.

	Domestic Abuse (n=566)	Child Abuse (n=566)	Indebtedness (n=566)
Yes	33%	23%	71%
Same	12%	9%	10%
No	47%	61%	13%
Don't Know	8%	7%	6%

	Discrimination in Vaccine (n=566)
Better	50%
Same	47%
Worse	3%

Access to Health facilities

The survey looked at the hamlets' access to the health facilities. It was reported that there were still 49% hamlets where not all children were immunized. In terms of the health centers (sub-center, community center, District hospital), the FGDs revealed that they could be accessed but the people were not satisfied with their services. Especially in case of sub-health centers, 27% of the hamlets reported that sub-health centres were not existent. 26% hamlets reported that Community Health Centres were difficult to access, while 36% reported that District Hospitals were difficult to access.

	Immunisation (n=566)
All children	51%
Some children	42%
None of the children	7%

	Sub-Health Centre (n=566)
Accessible	47%
Accessible but not of good quality	5%
Accessible with good quality treatment	22%
Not existent	27%

	Primary Health Centre (n=566)
Accessible	39%
Accessible but not of good quality	2%
Accessible with good quality treatment	21%
Not close by	37%

	Community Health Centre (n=566)	District Hospital (n=566)
Difficult to access	26%	36%
People are able to go	47%	30%
People are able to go and has good quality treatment	24%	33%
People are able to go but not of good quality	3%	1%

Social Accountability

Social accountability is a community led system wherein an informed group of community members take initiative to generate information on access to some key social security programmes and use the information to generate demand for inclusion vis-a-vis particular entitlements. This initiative is unique in terms of evidence-based data approach, participation of marginal groups and engagement with local administration with regular follow-ups to seek accountability and action. Overall, the focus has been on creating a system at community level to engage with local administration on periodic basis.

As part of the initiative, 10 districts have been covered in an intensive approach. 10 district fellows and 80 hamlet fellows from these 10 districts have been leading the action through participatory engagement methodology to create a group of informed individuals at hamlet level to map needs and follow up with local administration on regular basis.

Focus and Programme Initaitive

A set of discussions were held with all 10 district teams to understand their thematic capacities and their rapport with the local administration, which acts as an added advantage in addressing the selected schemes/issues. The social accountability measures were primarily focused across three categories, (a) supporting the community to access rights-based entitlements such as Public Distribution System, social security pension, Mahatma Gandhi National Rural Employment Guarantee Scheme, (b) registration under various services such as e-Shram portal, Ayushman Bharat cards, Swasthya Saathi and finally (c) application for identity documents such as Aadhaar. Apart from these there were a few areas of intervention chosen by few districts teams that were different from above mentioned, for instance supporting work on Forest Rights Act in Chhattisgarh, Mukhya mantri Balsahayata Yojna in Uttar Pradesh and Child Protection scheme in Bihar, these decisions were made based on the expertise of the partner organisations, who were well-equipped to work on these issues.

As part of the initiative, district fellows and the hamlet fellows sensitised the community on the selected schemes and began by identifying households and individuals who were eligible for a specific entitlement or service, but have not been able to access the same. However, before initiating community level meeting on the identified schemes, all hamlet fellows of the respective districts were thoroughly oriented on the respective schemes. Experts and practitioners were invited to guide the fellows on the schemes and application process.

Regular community meetings were held at the respective hamlets where along with sensitising the community on vaccination promotion and Covid Appropriate Behavior (CAB), respective hamlet fellows focused on discussing scheme related information and the steps to access the same.

Rayagada, Odisha: After initiation of the programe, the district fellow of Rayagada, Odisha, Ms Bimala Bardhan along with her team members met the respective Sarpanch in the intervention Panchayat. The team members also had meetings with different block level officials including the Block Development Officer, Block Programe Manager- National Health Mission, Medical In charge of the Community Health Centre in the intervention blocks. The team members appraised the officials on the UNICEF programe, its role in promotion of CAB and vaccination along with social protection programe. The outreach by the team helped in developing a rapport between the team and the responsible officers. It has also helped the team highlight the implementation challenges in front of the officials and seek their necessary support.

The district teams then helped the community members who were particularly excluded from the selected schemes in preparing the relevant documents for applying under the specific schemes and supported them in the application process. In the process, the hamlet fellows got the relevant application forms and helped the eligible but excluded community member with their application. District teams also adopted a strategy to orient community members, especially local youth who had experience in maneuvering internet, in the application process.

In many cases, in order to make sure all members in the community got access to schemes, the district fellows had to reach out to the Panchayats members and local administration. This, in many cases, involved sensitising the respective Panchayat members, especially the Sarpanch, on the nitty-gritties of the community's situation, the schemes or services and on their roles and responsibilities relating to the same. District fellows also took up the issues with the respective Block Development Officers or the concerned officers at the block level and also at the district level.

Challenges in access and accountability from the lens of marginalised groups

1. Lack of necessary identity proof: Applying for majority of the schemes requires identity proofs and Aadhaar is one of the major documents that is required. It was found that across many of the districts, the most marginalised, especially the aged and differently abled didn't posses ration cards, making it difficult for them to apply for other schemes as well. Also, non-availability of residential proof with the eligible community members played a hindrance in applying for specific schemes.

2. Non- availability of bank account: The application for social security pension schemes as well as e-shram card and in some states PDS required submission of bank account details. It was observed during the application process that some of the community members didn't posses bank account.

3. Unavailability of necessary certificates: For accessing few schemes such as disability pension, it is necessary for the eligible person to have the disability certificate with her. Similarly, persons suffering from Silicosis need to produce the certificate of them suffering from the disease. It came out during the application process that many of the eligible persons didn't have the certificates.

4. Caste based and class-based discrimination: The community members (particularly from Pratapgarh district, UP) who had applied under some schemes faced with caste-based discrimination when they go for verification and follow up at the block level due to which it takes several months to receive response.

5. Online application process: In most of the states, application process for various social protection schemes have gone online, along with online payment requirements. The digital literacy and access to internet among the marginalised community in these districts is extremely low, leading to them finding it difficult to access many schemes and applications. In those cases, hamlet fellows helped the community members in accessing the online application process, and youth in the community in many of the districts was mobilised to support and learn about this online process.

6. Misuse: When it comes to application of MGNREGA and work allocation for the workers who applied for work, it was found that large scale labour displacing machine were used by contractors which is prohibited under the Act. This makes it difficult for the work to get work even after applying for the same.

Impact of Social accountability initiative

Enhanced community awareness of schemes and services: The hamlet and district fellows ensured that the community was sensitised on the schemes as well as the application process before providing them necessary support. In the process, primarily the youth from the community was oriented on the application process who can in turn support the community.

Emerging community leaders: Another crucial aspect of the programme has been to facilitate community mobilisation through local community fellows/volunteers. The positive aspect of this is that the mobilisation will be grounded locally and sustained. The regular engagement with community helps in building collective leadership who are aware of various programes and grievance mechanisms. They also meet various officials and other stakeholders demanding for their rights. Being at the forefront brings solidarity among the groups and helps them work together towards their goal of accessing their rights.

Working with the local Panchayat: The Panchayats are an important institution in the rural India and play an important role in application, verification and allocation process under various scheme. From the beginning, district fellows made it a plan to interact with the Panchayats, orienting the members on the schemes and their roles. This not only built rapport between the two, it also played an important role in organizing camps for vaccination, application for e-shram cards etc., at the Panchayat with Sarpanchs taking interest and putting pressure on the responsible officials.

Follow up on access to schemes: The district and hamlet fellows not only helped community members in the application process also followed up regularly for ensuring that the eligible persons get through their entitlement. During the short time, fellows were able to support members of the community access schemes.

Rajanandgaon, Chhattisgarh: There has been a visible change in the thinking of people. They were not aware and also did not care about Gram Sabha and its functioning. They thought that all decisions are to be taken by the authority and trickled down towards them, people's needs were ignored. Now, after our intervention and multiple meetings with the community, people are becoming aware and taking their demands to the Gram Sabha level. Community members are themselves becoming active and striving for their rights. Under MNREGA, people got only 20-30 days of work, as opposed to the 100 days promised by the government. Now, groups of people have started demanding that as well.

Virudhanagar, Tamil Nadu: A women's Collective Committee was formed, based on consultations with governmental and non-governmental organizations. The committee consisted of 15 women, who went door-to-door collecting information on vaccination and reasons for apprehensions. The issues and challenges were all documented. This group also held awareness and consultation meetings twice a month to resolve issues. This group of women received good support in the village. Collaboration of field volunteers with panchayat and state bodies helped in smooth functioning of the vaccination process. Our initiative acted as a catalyst in bridging the gap between community and health services as ASHA and ANMs are now regularly visiting the villages and ensuring doorstep vaccination

Key recommendations emerging from the social accountable initiative

Supporting community in its demands: We mostly implement project for which we get resources. With regular meetings and adopting different strategies we tend to get support from the community in that initiative. However, it is essential that the project plays it role in supporting the community in accessing its demands as well. It can be explored through various discussion at the community level. Like in our, social accountability initiative we tried to understand the support community required from our side and the strength we had to support them.

Capacity building of fellows: The fellows that were selected for the programe were from the respective hamlets only. It is essential to ensure capacity building of the fellows on multiple schemes and programe at least the one their community demands the most. This creates an opportunity for the fellows to orient the other local youth and build go-to teams when it comes to helping community for application and other support.

Engagement with Panchayat: Panchayats is one of the important institution government polity and social life in a village. Its growing influence on the local administration needs to be cashed in promoting a behavior change to promoting vaccination, linking eligible person to various social protection program. It is therefore essential to engage with Panchayat in terms of their capacity building and ensuring right persons gets covered under the social protection program. Panchayat can also be an important platform for redressal of grievances.

Using technology: Application and grievance redressal processes are increasingly digitised and done through online mode. It is essential to orient community fellows and community members especially youth on the changing scenario. It is essential that community is oriented on the use of technology and application processes. The capacity building of community volunteers was a very significant component of this initiative. At the time of Pandemic, the challenge is the dependence on digital platforms and this is exacerbated by the fact that the digital divide is often based on caste and gender.

Conclusion

The overall result expected from this current six month engagement was that 100,000 households (and 500,000persons) from most marginalized communities across 11 states would be reached directly, engaged and empowered to safeguard themselves from COVID 19 pandemic and that they would understand more about appropriate behaviours and preventive measures (COVID vaccination).

Overall, the key findings from the evidence generation exercise as well as interactions with community members have been encouraging in terms of results towards this core objective. The six-month engagement has shown a 25% increase in the fully vaccinated population from baseline (December 2021) to endline (April 2022). While the results at aggregate level are uniform for both men and women, considering the socially disadvantaged position of women, these uniform results point to the fact that the programme had been effective with women. Other vulnerable identities such as Persons with Disabilities, Pregnant Women and Transgender/Non-Binary population have reported increase of 30%, 43% and 30% respectively. Among social identities, the highest increase in vaccination has been among the minority community (33%), followed by the ST community (31%) and then the SC, OBC and DNT community.

It is critical to recognise that as an engagement methodology, using a multi-pronged messaging medium along with flexibility at the local level has been critical. The programme deployed multiple strategies across the eleven states . This included trainings with doctors, using IEC and dissemination through local networks, engaging local panchayats and key influencers and mapping and addressing myths through regular follow-ups in community meetings. Engagement with 39 Community Led Organisations (CLOs) provided the scope for building the programme on their core strength. This was also significant for identifying the most vulnerable hamlets and households, which are represented by marginalised identities.

To capitalise on the multi-pronged strategy, door to door engagement complemented with evidence generation surveys were adopted. Over the two rounds of surveys more than 45,000 households were physically visited and direct outreach was done with more than 2 lakh people which included 1.5 lakh adults. These efforts were complemented with 1046 hamlet level meetings, 1166 meetings with frontline workers, 392 meetings with block level officials including Block Medical Officer, 1115 meetings with local influencers and 943 meetings with panchayats. In all, 1117 vaccination camps were provided with mobilisation support.

Though these concentrated efforts have led to positive results in certain aspects, some challenges are still persistent. The denotified and nomadic tribes population group has shown least increase in vaccination and would require intensive engagement to ensure uptake of vaccination as well on awareness related to CAB. Overcoming existing fears is a huge challenge and would require regular follow-up meetings and engagement at community level as it also has bearings on uptake of other programmes and their outreach. Some of the fears around side effects, negative impact on fertility and sense of stronger immunity are still existing. There is a need to now focus on the 12-17 age group vaccination and reach out to the remaining population that is awaiting their second dose and those that are not yet vaccinated. The programme engaged with 576 hamlet fellows and 72 district fellows. Overall there were 322 female fellows involved, and 326 men. A challenge for the current programme was 16% attrition reported among the fellows with 52% of these drop-out fellows being women.

In order to build strong support on the ground, long term engagement is key. Initiating conversations around fears, strengthening knowledge and converting into actions requires short term engagement of at least 2 to 3 years as there is a need to build a supportive ecosystem to influence action. Local health workers have emerged as the key source of information and sustained engagement with them and facilitation of their communication with communities can play a significant role.

In the context of COVID, it is critical to recognise that pre-existing discriminatory practices against marginalised groups has been exacerbated. There should be a more holistic approach towards recovery through access to social protection programmes to ensure a life with dignity. A mere focus on vaccination or CAB may reflect limited results unless the overall ecosystem of citizen governance interaction is not positively influenced to reach out to the most vulnerable. In attempting to ensure this, the engagement with fellows with a focus on awareness building on social protection programmes and support for application process, proactive engagement with panchayats and use of technology can lead to positive results.