‘Win with Vaccines’

Mid Term Report (August to October 2022)

Implemented by: IPE Global Centre for Knowledge and Development

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ABOUT IPE GLOBAL CENTRE FOR KNOWLEDGE & DEVELOPMENT

Our Vision

IPE Global Centre for Knowledge and Development (CKD) is a not-for-profit, knowledge-driven, community-focused, partnership-building, forward-thinking organisation. We relentlessly pursue building the agency of women, adolescents and children by providing equitable access to health, nutrition, education and 21st-century skills, livelihood and employability. With a commitment to leave no one behind, our fundamental principles of diversity, equity and inclusion drive all our goals.

Our Commitment to Women and Children

Our mission is to co-create sustainable, cross-disciplinary solutions that are effective and scalable. Our commitment drives us to preserve diversity and ensure equity and inclusion, keeping women and children at the centre of our focus. We make dedicated efforts to alleviate barriers to the agency of historically disadvantaged groups.

CKD Goal

Create an alliance of engendered and mission-aligned partners to support 20 million women and girls to realise their full potential by 2040

ABOUT NATHEALTH

The Healthcare Federation of India (NATHEALTH) has the vision to become a credible quality and unified voice in improving healthcare access. To build the healthcare industry's future, NATHEALTH brings diverse voices, engaging perspectives, and meaningful dialogues to accelerate the pace of transformative care. NATHEALTH's mission is to foster innovation, bridge the skill and capacity gap, shape policy ecosystems, and enable the environment to fund long-term growth.

ABOUT – 'WIN WITH VACCINES'

A PUBLIC EDUCATION CAMPAIGN TO TACKLE VACCINE HESITANCY

Supported by NATHEALTH, Win with Vaccines is a CKD initiative to build COVID-19 vaccine confidence in five low-coverage districts across Assam and Haryana. According to a recent study[1], vaccine hesitancy is still dominated by myths and beliefs, as shown below (Fig 1). We intend to build a favourable environment and address issues of diffidence in vaccination. We will debunk myths and misconceptions and engage government and private stakeholders to increase coverage of COVID-19 vaccines. The CKD-NATHEALTH campaign will primarily focus on the Left out, drop-out, and Resistant (LODOR) populations across all age groups to raise awareness and build confidence in vaccination. The districts of Nuh in Haryana and Baksa, Chirang, Udalguri & South Salmara in Assam have been selected due to drastically low vaccination coverage. This project focuses on conceptualising and undertaking a campaign that can ensure uptake in vaccination numbers.

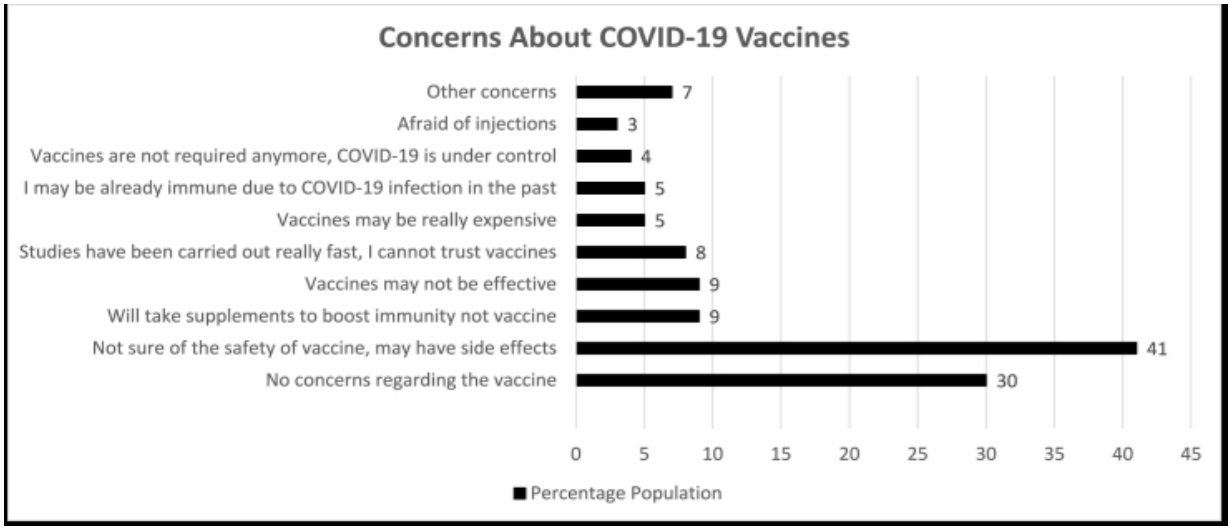


Figure1: Reasons for Vaccine Hesitancy

[1] Chandani S, Jani D, Sahu PK, Kataria U, Suryawanshi S, Khubchandani J, Thorat S, Chitlange S, Sharma D. COVID-19 vaccination hesitancy in India: State of the nation and priorities for research. Brain Behav Immun Health. 2021 Dec;18:100375. doi: 10.1016/j.bbih.2021.100375. Epub 2021 Oct 19. PMID: 34693366; PMCID: PMC8523306.

EXECUTION PATHWAY

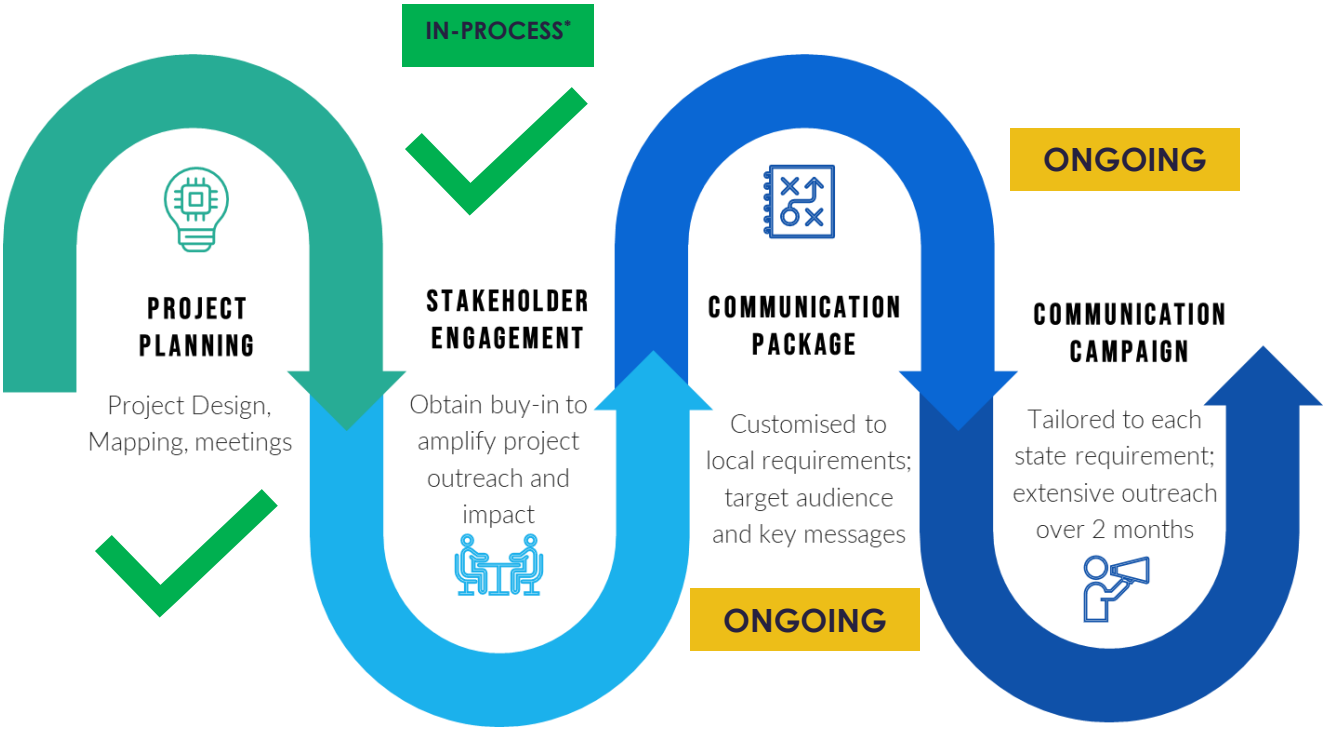


Figure 2: Execution Pathway

** In-Process - This section is a continuous process that will take place throughout the project's lifespan. However, the essential components to establishing constant operation have been set up.*

MID-TERM PROGRESS UPDATE

The mid-term report provides an update basing the execution pathway as a skeleton framework.

A. Project Planning

The project planning took place in a phased manner, wherein the following steps were taken:

1. Team Onboarding & Orientation
2. Stakeholder Mapping & Analysis
3. Finalisation of Blocks & Villages
4. Key Beneficiaries Defined

These four components were crucial aspects of our project planning and establishment process, setting the stage for the next phase of our execution strategy.

1. Team Onboarding & Orientation:

This project's team comprises of partners, stakeholders and core team personnel working together to achieve meaningful results. The core team, based out of Delhi, has taken up project management responsibilities for the district of Nuh, in Haryana providing continuous guidance and support to the District Coordinator. Voluntary Health Association of Assam (VHAA) team has been onboarded as a partner for the Assam wing of the project. VHAA has extensive experience in working across the intervention districts on various health and development projects. They have recently undertaken projects on routine immunisation, within which they also worked on COVID-19 vaccination. Their exemplary work, has led to them being nominated as members of the State Task Force for Immunisation. VHAA is provided technical support and guidance on project strategies and implementation from the national team. A team of district coordinators have also been onboarded for the final implementation of the project. All coordinators were shortlisted and selected due to their experience working on COVID-19 hesitancy projects and as members of the targeted local communities. The national team has virtually oriented the team, followed by a detailed orientation in Assam. The Nuh district coordinator was oriented in the Delhi office, following which the team has trained him by guiding and close handholding during field visits. All the district coordinators are briefed and guided by the Delhi team almost daily.

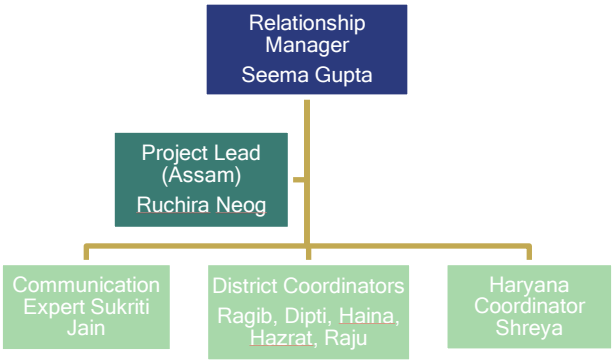


Figure 3: Team Personnel

2. Stakeholder mapping:

The fields of **Health, Education** and **Self-help groups** were identified as ideal pathways to gain quick inroads into spreading our campaign on tackling vaccine hesitancy credibly. Each field has allowed for stakeholder mapping, key-beneficiary identification & outreach. Stakeholder mapping was **feedback-driven** and operated through information obtained from various touch points. Engaging with the stakeholders as they were mapped has allowed other relevant stakeholders to be identified and subsequently engaged with. Within the first month of the project, we successfully mapped all relevant partners,

Figure 4: Preliminary Stakeholder Mapping

stakeholders and beneficiaries. Post this; we have continuous engagement with these members as it is necessary throughout the project's lifespan. Figure 4 showcases the flow of our project planning.

As part of our initial mapping process, government officials in health, education, livelihood departments, and the administration were approached as the primary **stakeholders** in this project. These ranged across national, state and district levels. This was done to collaborate, gather approval and partner with them, and gain inroads into the communities we aim to impact. Through our outreach and planning process, we could effectively engage in tandem with these officials. The following showcase some of the key officials at the state, district and block levels who were mapped and subsequently engaged with.

Figure 5: Components of Project Plan

Department	Designation
Health - District Health Department, including the National Health Mission	DIO (District Immunization officer)
	Chief Medical Officer (CMO)
	Joint Director of Health Services
	District Program Manager (DPM)
	Block Program Manager (BPM)
	Assistant Block Project Manager (ABPM)
	Senior Medical Officer (SMO)
	Medical Officer (PHC)
	Block Data Manager (BDM)
	Community Health Officer
State Rural Livelihood Mission	Block Program Manager (BPM)
	District Program Manager (DPM)
	BC (Block Coordinator)
Education	District Science Specialist
	District Inspector of Schools
	School Management Committee (SMC)

They also provided us access to crucial ground-level stakeholders in the form of **ASHA (Accredited Social Health Activist), Anganwadi and ANM (Auxiliary Nurse and Midwifery)** workers.

Beyond this**, approvals** to operate and impact in the relevant districts were obtained from the relevant authorities, such as the **Deputy Commissioner, District Immunization Officer, Chief Medical Officer, Joint Director of Health Services** and **District Education Officer.** Apart from providing approvals (attached as separate files), these officials assisted in selecting blocks and villages to target for our outreach. After gathering these insights from our engagement, we were able to categorise our stakeholders into **Government officials (at various levels), Self-Help Groups and other CBOs,** and **Community level Influencers.**

Influencers: Mapping and Mobilization

Our engagement with the community-level stakeholders was possible predominantly due to our engagements with various levels of government stakeholders (from preliminary mapping). They directed us to block-level and village-level officials from administrative, health and education departments, who assisted in expanding our stakeholder engagement at the ground level.

At the community level, we mapped the influencers within each village and briefed them in person on our program goals and strategies. These influencers are a critical component of our program design and will be the final medium of disseminating our campaigns in terms of ground-level person-to-person outreach. The buy-in of the majority of these influencers have been secured, and they have committed to supporting our outreach and dissemination activities.

District	No. of Influencers	Types of Influencers
Udalguri	15	Members experienced in community mobilisation, Religious leaders, Vaccinated Person, ASHA worker, Youth Member, Youth Member, ASHA worker, Vaccinated Person, experienced in community mobilization programme, NHM, Social Worker,ASHA worker, Jeevika Sakhi
Nuh	31	SARD NGO Mobilizer, ANM, ASHA, AWW, Community Leader, Doctor, Government Doctor, Government Teachers, Head IA, Local Leader, Mobiliser, Parent of Immunized child, Social Worker, Teachers, Village Head
Chirang	18	ANM, Asha, CHO, Jeevika Sakhi, Primary Secretary, Sakhi Mitra, Teacher and Local Head, BCDC Member, Village Head, Mobiliser
South Salmara	15	Village head, Asha, Jeevika Sathi, Teacher, Vaccinated Person
Baksa	43	Community Leader, PRI Chairman, Teacher, Vaccinated Person, Village Head, Asha
Total	106	

A Glimpse of our engagements

3. *Finalisation of Blocks & Villages*

The five districts that have been selected have been done based on its low coverage of COVID-19 Vaccine. These five districts are tribal dominated and have religious minority communities who have shown an extreme resistance towards the Covid Vaccine because of widespread myths. **The government stakeholders identified through our preliminary mapping and engagement were instrumental in advising and directing us towards the blocks and villages with high vaccine hesitancy**.

Haryana:

The absence of movement outside Nuh is a major reason for the community's limited impact of COVID-19. Thus, the need for the vaccine has not been fully realized. Our entry point in the community was through the **District Immunisation Officer** who had advised CKD that Punhana should be taken up as the intervention block. We were then guided by the **Public Health Centres** of Punhana to a list of 15 villages with the least number of vaccines administered. We have received a sign off on these villages from the **Chief Medical Officer**.

Assam:

The target villages with high vaccine hesitancy and low coverage due to difficulty in access were identified with the help of the district and block health authorities of the **National Health Mission** and **the District Health Services** units. We were able to correlate these villages to having LODOR communities due to several reasons. The reasons are varied and range from lack of awareness, low literacy levels in the selected villages, plenty of myths and misconceptions and remote locations in hard-to-reach pockets, especially referring to the riverine areas (in South Salmara) and the areas bordering forest area.

Once the concerned health officials specified the blocks, the **Block Program Managers** were consulted for the names of the specific villages. Subsequently, the **District and Block Coordinators,** with the guidance of the community level health workers like the **ASHAs, ANMs and AWWs**, cross check and map out the details of the specific villages. Upon multiple verifications, the final list of select villages was shared by the health department. This exercise while exhaustive, is essential since many villages have the same name but may be in different pockets. It must be noted that the concerned health officials recommended 2 blocks in each district, wherein we have selected 15 villages each where the government has been unable to achieve the desired coverage (Total 30 villages in each district of Assam).

4. *Defining Key Beneficiaries*

Our experience in implementing similar 'Risk Communication and Community Engagement initiatives for COVID-19 Vaccination, has provided us with learnings in the form of best practices in these contexts. Our strategy has always been to cover those

areas/pockets which have a visible need due to reasons- such as remote access, tribal and minority population, migrant labourers, low literacy and lack of awareness. Our engagement with our stakeholders allowed for crucial exchange of information and resources, which made it possible for our strategy to be implemented with expressed support from the state.

Haryana:

In case of Nuh since it is majorly inhabited by the Meo-muslims, who have very limited interaction with other communities of the region, therefore their mobility is also restricted. This makes it especially difficult to cover and track vaccinations, alluding to their vulnerable status in this context. The Meo Muslims have community congregations generally around religious activities, therefore, religious leaders play a very important role. Thus, the Imams and Maulvis are a major stakeholder in our project as they have the capacity to influence a huge population of followers unquestionably. Through our community level mobilization, we are utilizing the existing network of the Imams and Maulvis for our information dissemination.

The Meo-women are restricted to the private sphere therefore knowledge and information spread is also limited among them. Our outreach plan among the women is through the Livelihood Mission along with the health facility touch points, wherein, we are reaching out to the women through the **Self-Help Group Meetings**. The **Village Level Federation** formed by the **Haryana Rural Livelihood Mission** is extremely instrumental as a part of our communication plan. The Health Department have assisted us through mobilization at all levels, especially trough the **ASHAs, ANMs** and **the Anganwadi workers** who have direct contact with the women of the villages.

It was noted that the vaccination coverage among the adolescents is low among the **12-17 age group**. The schools are, therefore, an important medium through which we are reaching out to the adolescents. The education department assisted in exploring vaccine coverage for adolescents, through schoolteachers who were mobilized to actively take up sensitization of their students.

Assam:

The Communities in the target villages were a mix of indigenous tribes like the Bodos and Rabhas and migrant populations such as in the riverine pockets of South Salmara district and Bengali/Nepali speaking groups. As most of these communities are very close knit, we have targeted village/community leaders – influencers as our first line of communication brief. For e.g., the support of the village Pradhan, village leaders, religious leaders in the intervention villages have been secured. The church priests, self-help group leaders are also being targeted to amplify our message in the communities.

Other key beneficiaries fall in the category of pregnant and lactating mothers since this group is still hesitant to take the vaccination, despite the government having issued notifications for the same. The third and very important group of beneficiaries is the students, children and youth in the age group 12 to 17 who are reluctant to take the vaccination.

This was specifically made aware to us in our meetings, interactions, and discussions with the **Director Health Services (FW)** and their team including the **State Immunisation Officer (SEPIO)** and **the Jt. Director, Covid Vaccination**.

B. Stakeholder Engagement:

In our initial level of mapping and engagement, stakeholders were able to direct us, provide us with contextual insight that influenced the rest of the project planning strategy. Identifying key beneficiaries, and at-risk blocks and villages, were important aspects of our planning. It ensured that sufficient efforts were put into reaching these vulnerable sections of the population. It also allowed for the identification of on-ground, i.e., community level stakeholders, whose localised expertise was crucial to reach the population and convey our campaign. We were able to access these stakeholders at the community level due to the inroads provided to us by the district and state level government officials. Through these process and feedbacks, we were able to **map more diverse and localized stakeholders,** some of whom have been tabulated below.

Figure 6: Localised stakeholder Mapping

Stakeholder	Category	Engagement
ASHA (Accredited Social Health Activist)	Community Level Government	ASHA workers assisted us in accessing women and children, as they have the community reach up till the households.
Anganwadi workers	Community Level Government	AWW have direct access to parents and children, a crucial target group of our campaign. Assisting us in dissemination through this means
Auxiliary Nurse and Midwifery (ANM)	Community Level Government	ANM workers have significant access to pregnant and lactating mothers, a vulnerable target group. Assisting us in dissemination through this means
Self-Help Groups	Community-Based Organisation	Women's Self-Help Groups are an important avenue of accessing women for outreach. They are also helpful in dissemination as the SHGs possess access to various community spaces and households.
Religious and Tribal Leaders	Community Leaders	Community-based leaders have a strong voice which has reach and effect on communities. Leveraging these leaders for outreach and dissemination is an important facet of our campaign. They are also crucial in identifying groups within villages, who were vulnerable in terms of vaccine coverage.

Meeting with High SchoolTeacher, Ferangirchar, S.Salmara, Assam

National Team meeting with Anganwadi workers, ASHA and ANMSs at an Anganwadi Centre, Sikrawa, Nuh, Haryana

SHG meeting under Amteka area at Sessa Bazar, Chirang, Assam

Leveraging other partner networks:

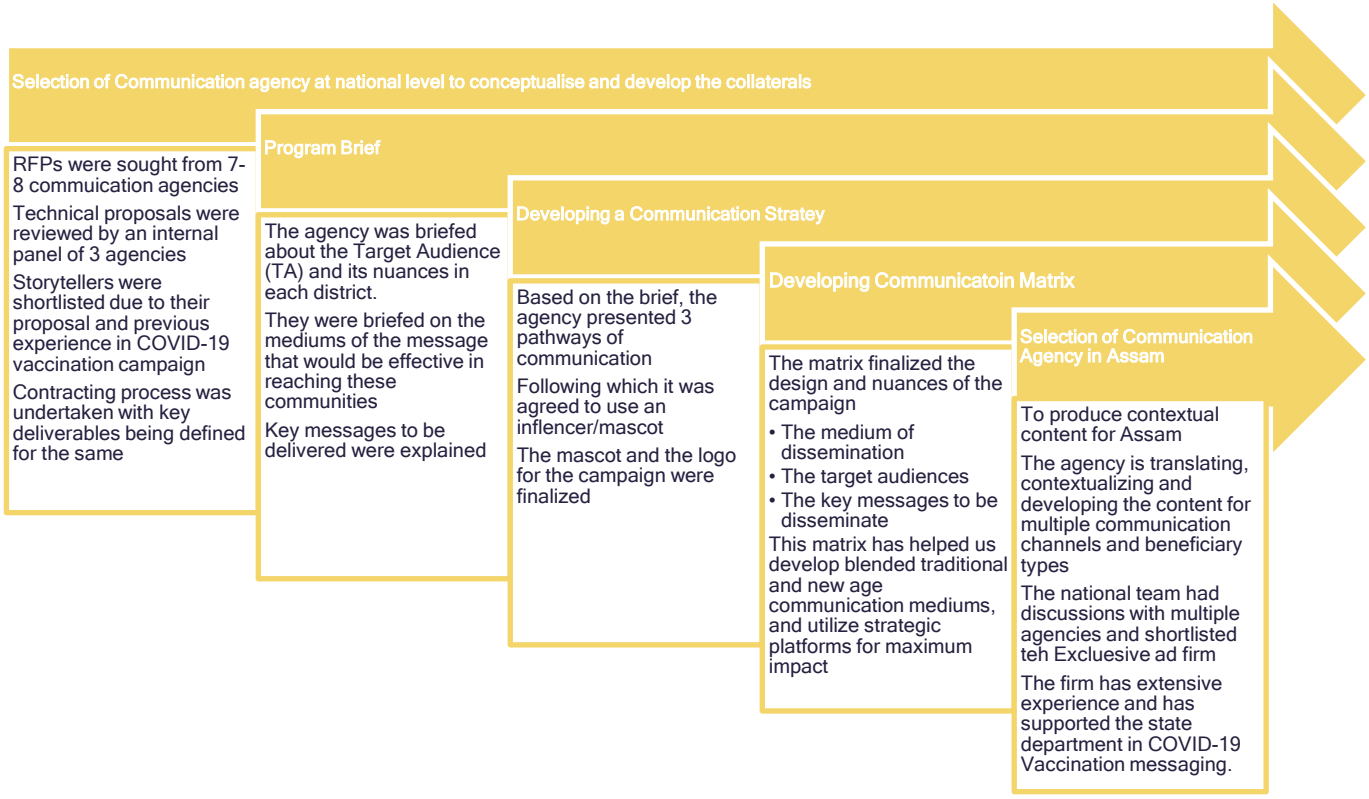
Beyond our mapping of government stakeholders, we have engaged with several non-governmental stakeholders to leverage their resources and expertise for achieving better results in implementation. Local partnerships also provide additional inroads ensuring that our campaign is contextual, locally accepted and has prolonged retention within the communities. These are some of such organisations and local NGOs we have engaged with:

Figure 7: Non-Governmental Partners

State	District	Block	Block level NGO/CBO
Assam	Chirang	Sildli and Boro Bazar	IGSSS
	Udalguri	Udalguri	Astha NGO
	Udalguri	Udalguri	Orai Thulunga
	Baksa	Tamulpur	Gramya Vikash Manch (GVM)
	South Salmara Mankachar	Gazarikandi	North East Zone Welfare Development Society
	South Salmara Mankachar	Gazarikandi	Ramdhenu Society
	South Salmara Mankachar	Gazarikandi	Jeuti
Haryana	Nuh	Punhana	SARD
	Nuh	Punhana	J-PAL
	Nuh	Punhana	C-GPP
	Nuh	Punhana	CRS
	Nuh	Punhana	Smile Foundation

c. Communication Strategy – Conceptualisation and Operationalisation

To have a tailored, and contextual campaign, a detailed communication strategy was created before initiating the material. The national team, undertook an extensive exercise to achieve this, the details of which are given in the image below.



The project lead in Assam, will coordinate with the Assam communication agency and ensure accurate translations. The agency will also be responsible for dissemination across some mediums like wall paintings, printing collaterals. One of the flagship features from our campaign is the creation of a **Mascot**. The role of the mascot is to act as an identifiable, relatable, and visually appealing medium of communication and dissemination, for the campaign. The mascot has been customised and curated to appeal to the community sensitivities, such as language and other cultural characteristics. The mascot for Assam and the one for Haryana share mannerisms and certain features, but have distinct visual and communicative characteristics that can make it recognisable in both of our dissemination contexts. These characteristics also ensure maximum outreach dissemination

D. Behaviour Change Communication (BCC) Campaign

Figure 8: Wall Painting in Hindi

Figure 2: Demo poster design for Assam

Based on our strategy and planning for communication, the following set of communication packages have been compiled as part of our campaign. As evidenced below, the campaign has elements that had to leverage local talent groups and other on-ground communications mediums. Here are the different mediums of outreach that our campaign is using to target certain population groups

Figure 30: Snippets of Communication Matrix

Campaign type	Relevant Population Group	Excerpts of Key Messages
Fliers (2)	For Resistant/dropouts/left-out adults; Parents of 12-17-year-olds; Teachers at school/ Sarpanches/ Anganwadi workers	- Stressing the importance of children coming back to school/continue attending school without fear of infection - "You are not safe until you take both vaccine doses and 1 booster", "All vaccines are available for free at your nearest healthcare centre"
Posters (5)	For Adults missed by govt. coverage; Dropouts after 1 dose; Children 12-17 years; Hesitant PLWs (pregnant and lactating women)	- Stress that the vaccines are available for free - Clarify that COVID 19 is not gone - Many people in your community who have weakened immunity can be at a higher risk of infection
Wall Paintings (3)	For school-goers; resistant adults, especially women and elderly people; Vulnerable groups like PLWs/Disabled/ elderly	- "I protect you - you protect me! Get yourself vaccinated (2+1). " - "Keep your school, your community and your environment COVID-free" - "Irrespective of the age, caste, disability, your family member needs to be protected from Severe COVID. Please help them get vaccinated."

Miking messages	For Working adults, especially migrant workers	[Preferably musical/jingle] Let's use all the tools available to us to stop the spread of COVID-19 so that it does not rob us of our ability to live and earn a living once again. - Clarify that COVID 19 is not gone - Remind people to return to get the next dose, by raising awareness on the intervals between two doses - Assuring them that the vaccine is safe to use and being upfront about the mild/temporary side effects to expect
FAQ videos	To be used by ASHAs/ANMs/Anganwadi workers and other health providers & health facilities	It's important for all to take, so that the entire community is safe and protected
Video Testimonials		The video will feature a person who speaks about their vaccination experience and coming out on the other side hale and hearty.
Banners	For all dropouts; Parents of school-going children during school functions; All attending Durga Puja/Any other religious function	"Durga puja is here, so is COVID. It hasn't gone away Enjoy your festival fearlessly by getting yourself and your family fully vaccinated " - Reminding parents of how much they do for their children - asking them to add this to the list
WhatsApp Messages	For Parents of 12-17-year-olds; Resistant/dropouts/left-out adults; For Students going back to school; To be used by Influencers like ASHA/ Sarpanch. Etc Religious leaders	- 5 ways in which they can change minds and behaviours, influence actions and thereby increase uptake of vaccine in their community
Social Media Static Posts/GIFs/ Infographics	For Resistant groups, School Teachers and Parents of unvaccinated children; Dropouts after 1 dose; School and collegegoers; Vulnerable groups like PLWs/disabled or elderly persons For sharing project updates/key features with donors/partners/ horizontal learning	- Testimonial video of community influencer formatted for Facebook Stories/Feed - Photo or memorable quotes carousel based on the state consultations, workshops - Content to showcase the project progress, success, key elements
Radio Jingle	For the entire community, reiterating the need for complete vaccination	It's important for all to take, so that the entire community is safe and protected

Progress so far

The district coordinators have used the first two months to strategically gather and finalize touch points for the BCC dissemination that will be done in the second half of the project.

Vendor identification and onboarding has been initiated to disseminate the communication campaign. The ground has been set for communication bursts via different mediums. Additionally, in all five districts the health department has expressed support of the team and requested us to layer our initiative in other ongoing activities of the department.

Durga Puja in Eastern and North-eastern India is a revered festival. After 2 years of restrictions, due to COVID, this year in 2022 the communities were allowed to celebrate Durga Puja and organize pandals where the communities gather. Seeing this opportunity, the team hastened the communication work to launch the campaign in Assam across all four districts. Albeit, this was not in the original plan, this was a golden opportunity for disseminating the message to large sections of the community in a religious, culturally accepted setting.

MONITORING AND EVALUATION

This is an ongoing part of the program, as a part of the design we have feedback loops that guide the project design and implementation. National team visits the field and engages with all stakeholders and other local leads. We have undertaken monitoring and evaluation in three different kinds, which we have detailed below.

Technical Monitoring

- The national team makes regular visits to the field.
- 2 visits have been undertaken to Assam by the national team
- weekly visits are made to Nuh by the national team.
- District coorinators are briefed and guided on a daily basis.
- Weekly updates are review are undertaken with the Assam and Nuh teams.

Evalucation Agency

- There is close coordination of resources with the Evaluation Agency. We provide the necessary reports, subject material andfield excerpts to the agency
- Support was extended to the evaluation agency for designing monitoring indicators.
- The assam and Nuh visits of the agency was coordinated.
- The team travelled with them to Udailguri, Baksa and Nuh

Project Reporting

- There are matrices for each district, mapping the resources, detailed popoulation metrics, stakeholder related information and vaccine coverage.
- Similarly, other measurement records are shared with the agnecy on a reular basis
- Gantt Charts are submitted fortnightly
- The project lead is also reporting to the NATHEALTH Steering Committee fortnightly.
- Queries from other donors/requirements are adhered to.

CONCLUSION

Till mid-term, we were able to onboard partners whose expertise and contextual knowledge has been highly beneficial. The VHA of Assam showcases the project's capacity to attract and develop using local organisation, who have the ideal experience to effectively problem solve localised roadblocks. This is an important achievement representative of the innovative and knowledge driven practices developing as a product of our extensive strategy and planning. We also have experienced communication partners onboarded. The nature of constant engagement with stakeholders has allowed us to develop deep inroads in all the target villages, with an informative feedback loop being established. This will ensure maximum reach with the campaign, while also inspiring the population to take up such welfare focused activities. We have completed all committed activities and onboard and engage with 106 influencers, and identify several micro-influencers who have been instrumental in the progression of the campaign. With the launch of the campaign in Assam, the ground is set in all districts for the BCC dissemination.

NEXT STEPS

- Complete development of the Communication kit and its translation to Hindi, Bengali, Assamese and Bodo languages.
- Dissemination of campaign collaterals through mediums determined from BCC strategy. The communication matrix is being used to direct these steps.
- Vendor onboarding is being done, for effective dissemination and outreach of the campaign.
- Influencer engagement will continue to take place, to ensure meaningful outreach of the campaign.
- Stakeholder engagement will also continue for the lifespan of the project, to tackle roadblocks and inculcate safe practices within the local systems.
- Coordination and submission of relevant material for, monitoring and evaluation, will continue.
- Documentation of the project will continue, and culminate in the form of a detailed end-term report.


पोषण अभियान

ACKNOWLEDGEMENTS

We would like to thank our **sponsors, GE Healthcare, Charnock Hospital and Fresenius Medical Care,** for providing the support required to execute such a meaningful initiative.

GE Healthcare

FRESENIUS MEDICAL CARE

QUERIES:

For any queries, contact: Seema Gupta,
Advisor, CKD
seema.gupta@ipeckd.org

For more information,
Visit our website: ipeckd.org

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