



# The COVID-19 Vaccination Playbook



**#COVID  
ActionCollab**

 **Swasti**  
THE HEALTH CATALYST

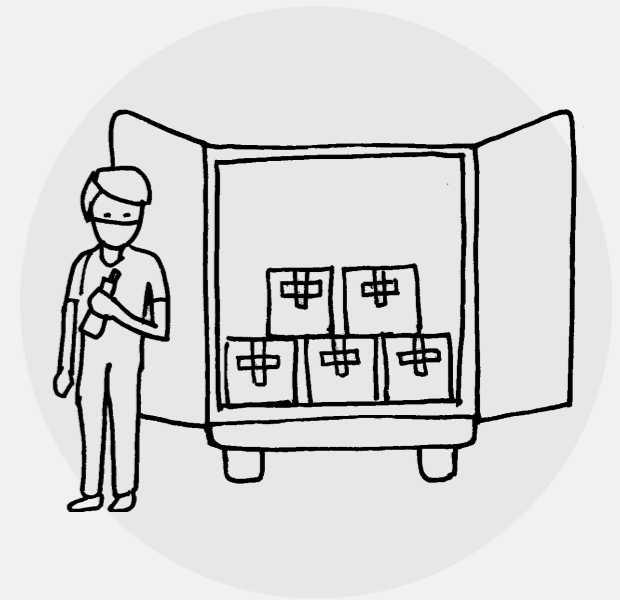
*With Support From*



The  
**ROCKEFELLER  
FOUNDATION**

# Contents

<b>What is a Playbook?</b> .....	<b>1</b>
<b>Executive Summary</b> .....	<b>2</b>
<b>Vaccination Hesitancy</b> .....	<b>4</b>
<b>Plot: Problem Statement</b> .....	<b>5</b>
<b>Purpose and Objective</b> .....	<b>6</b>
<b>People</b> .....	<b>8</b>
Who are the People? .....	<b>9</b>
Team Role Matrix .....	<b>11</b>
Places .....	<b>14</b>
Process Workflow .....	<b>15</b>
<b>Act 1 - Scene 1 The Planning Phase</b> .....	<b>18</b>
<b>Act 1 - Scene 2 The Pre-Vaccination Phase</b> .....	<b>22</b>
<b>Act 2 - The Vaccination Phase</b> .....	<b>26</b>
<b>Act 3 - The Post Vaccination Phase</b> .....	<b>28</b>
<b>Stage Direction</b> .....	<b>30</b>
<b>Readers' Note : Community Institutions</b> .....	<b>35</b>
<b>Tips &amp; Tricks</b> .....	<b>36</b>
<b>Pull Out Pages</b> .....	<b>39</b>
<b>Closing Note</b> .....	<b>45</b>
<b>References</b> .....	<b>46</b>



# Foreword

The last few years have been unprecedented and challenging across the world. The global pandemic has marked its moment in history with the severe losses nations and citizens have endured. Many will talk about the tragedy but we must also talk about resilience. The courage to manage the spread of the virus and to march towards the future, together. As we look towards a hopeful tomorrow, it is important to remember that it is being built by collective effort with science at the forefront. For the past 100 years, The Rockefeller Foundation has been pushing the boundaries of what's possible in terms of tackling the world's greatest challenges. We are driven by our mission of identifying and accelerating breakthrough solutions, ideas, and conversations to improve the well-being of people everywhere and solve global challenges with lasting impact.

This impact is only possible with partners like Swasti, The Health Catalyst and the #CovidActionCollab (CAC). The collaborative stands united to provide relief, recovery and build resilience among the most vulnerable communities in the aftermath of the Covid-19 pandemic. It's true success lies in its unique approach in building community resilience by designing solutions for public health challenges that address socio-economic realities with cultural context. We owe a special gratitude to the community leaders and their partners on the ground to tirelessly champion resolutions for public service delivery gaps.

The vaccination playbook is a critical resource for the sector to surpass ambitious vaccination targets and keep communities safe. This playbook reiterates the importance of vaccines and the role all of us have to play to prevent further spread of this disease. With CAC's focus on inclusivity, this resource addresses the needs of mostly overlooked communities such as trans-people, female sex workers among others. Any public health solution that aims to be successful must solve for the diverse populations that inhabit the planet. It is my fervent hope that readers will find value in understanding the process followed and replicate the best practices to be united in our action towards ensuring a healthy future for all.

***Deepali Khanna, Vice President, Asia  
The Rockefeller Foundation***



@deepalikhanna





Scan the QR code to watch this video



VaxNow in Bommanahalli!



# What is a Playbook?

A playbook includes “process workflows, standard operating procedures, and cultural values that shape a consistent response—the play.”

It borrows from some of the Aristotelian elements of the play -

## **Plot**

The arrangement of events or incidents on the stage.  
The plot is composed of “clearly defined problems for characters to solve.”

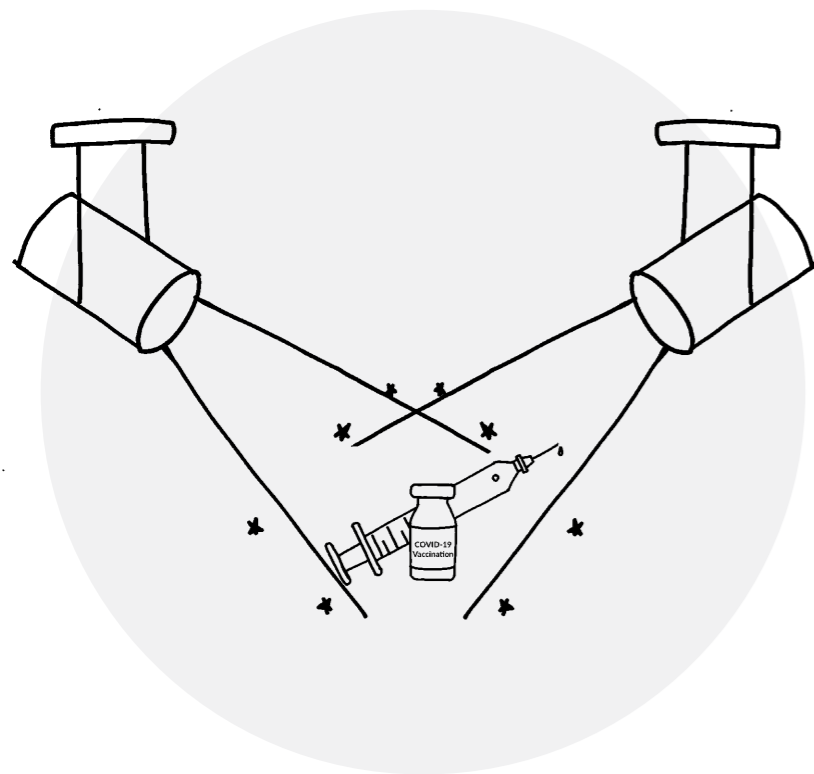
## **Character**

The agents of the plot. The People.

## **Theme**

The reason for the play. The Purpose.

**3 of the 6 Aristotelian elements of the play**



# Executive Summary

This COVID-19 Vaccination Playbook is a result of critical learnings surfaced by - Swasti, a global public health agency - around taking COVID-19 vaccination to the most marginalised at the last mile in India.

This Playbook structures how COVID-19 vaccination can be made accessible to the most marginalised.

It is intended for scalability and replication.

NGOs, CBOs, governments, international aid agencies may use the lessons learned and integrate them into future interventions and programs.

The Playbook addresses the problem statement or in the word of plays - the plot and breaks down the how and the why for each step. Like many other playbooks, this traces the 4 Ps - Plot, Purpose, People and Places and spans 3 Acts - here 3 Phases - Pre Vaccination Phase, During Vaccination and Post Vaccination

The annexure provides a range of Tools and Notes that cover Checklists, Forms, Using Tech and Training Documents.

The pull out pages contextualises the playbook for People living with HIV (PLHIV), Transgender and Non-Binary folks (TGNB), Marginalised Women and People With Disabilities.



Covid-19 is a monumental event as for the very first time in the history of Indian healthcare there has been a need to prioritise vaccinations above all else on such a large scale.

India is a diverse country with a large population residing in different hard-to-reach pockets. The success of the vaccination drive cannot be solely dependent on Primary Health Centres (PHCs) due to various geographical, demographic, socio-economic, cultural and language barriers.

**Accessibility to Vaccination Centres:**

PHCs are static centres with a fixed time and limited supplies.

Hence, unsurprisingly, a small group of local population with a privileged socio-economic background find them more accessible as opposed to other community members.



“ I find it extremely difficult to step out of the factory and travel during work hours.

“ I am a migrant worker. I stood in line at the PHC for so long but the locals came after me and got vaccinated before me.



“ I travelled so far to get vaccinated but by the time I reached the PHC ran out of resources and vaccines. I do not think I can compromise on another day's wage for this!



“ I am a woman and I cannot travel to the camps alone. I have heard stories of eve-teasing. I will only be able to step out when I have someone to accompany me.

# Vaccination Hesitancy:

Many community members are also hesitant to get vaccinated due to lack of sufficient knowledge dissemination and awareness and an inability to access nuanced, trustworthy information about genuine questions and concerns. A few reasons that lead to increased hesitancy and indifference are misconceptions, negative messaging, fears, social and gender barriers.



“

I am old and live with my grandchildren who are very busy and don't have time to take me for the second dose. I came here with help from a neighbour but now I don't have a phone and the OTP has gone to my grandson who is not responding. I will have to return without vaccination. I am not sure if I can come back again.



“

I am a woman. I do not have permission to get vaccinated from my family. We are unsure of its long-term impacts.

“

I am not sure of its safety. My friend fell sick after getting the shot. I would like to observe first.

“

My mother had a heart surgery six years ago and I am not sure if I should take her to get a vaccine. I don't know if it will react with her current medication or make her condition worse



# Plot: Problem Statement

Marginalised Communities are most likely to be left behind when Vaccination Outreach Programming is top-down and designed for the general population.

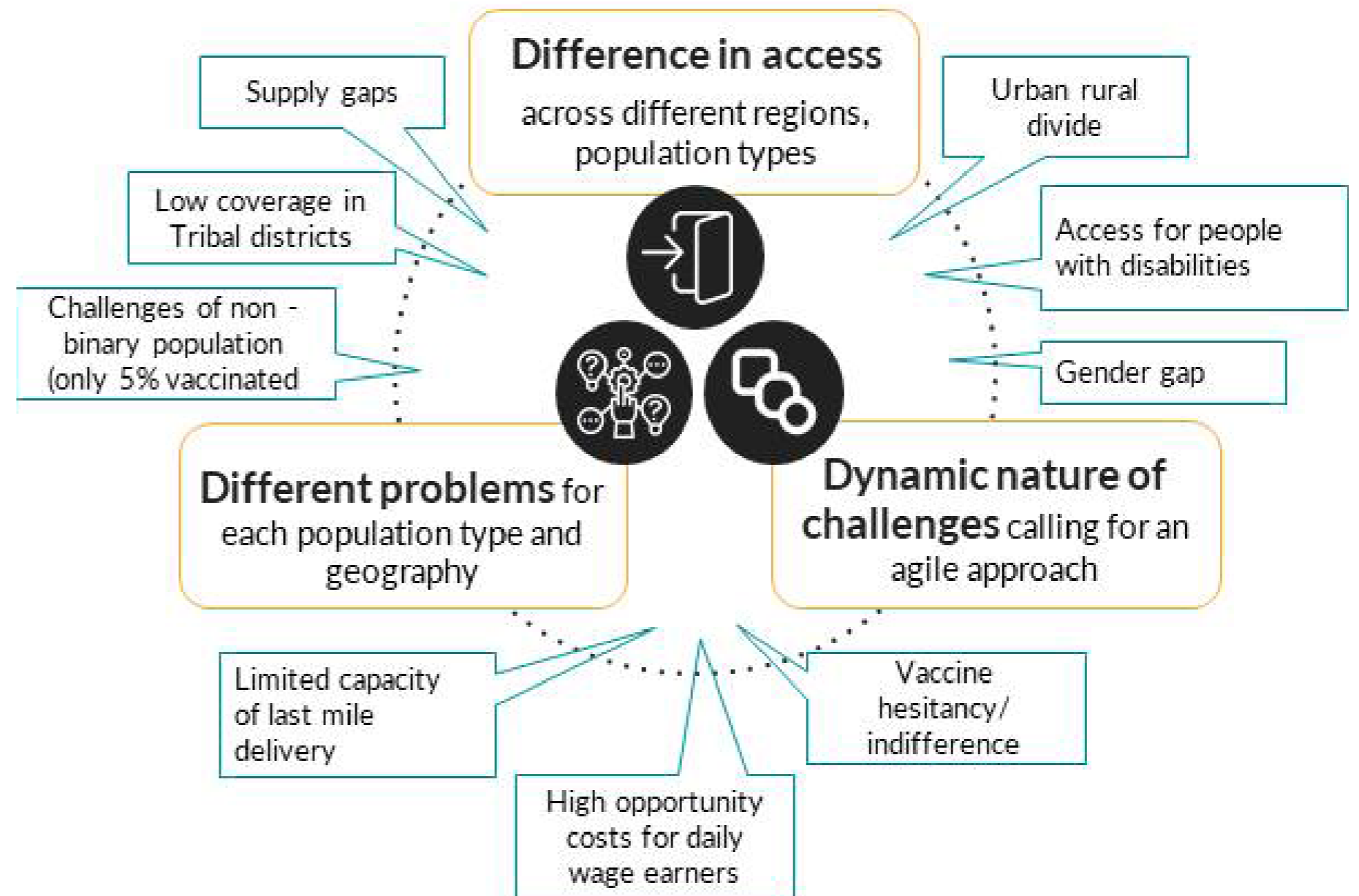
A large proportion of the population needs protection and access but also special considerations and an enabling environment for that access to be experienced.

There are typically 2 pronged issues:

- ♦ Significant and real inequities in Access
- ♦ Information asymmetry leading to low vaccine demand and hesitancy due to
  - Low perceived need for vaccination
  - Low perceived risk of COVID-19

As a result, entire communities may remain unvaccinated and this in turn creates further barriers to life and livelihood, causing deeper slippages into poverty and unabated cycles of poverty, illiteracy and violence.

....significant and real inequities in access



## It is imperative to consult with community representatives - at every step, at every phase.

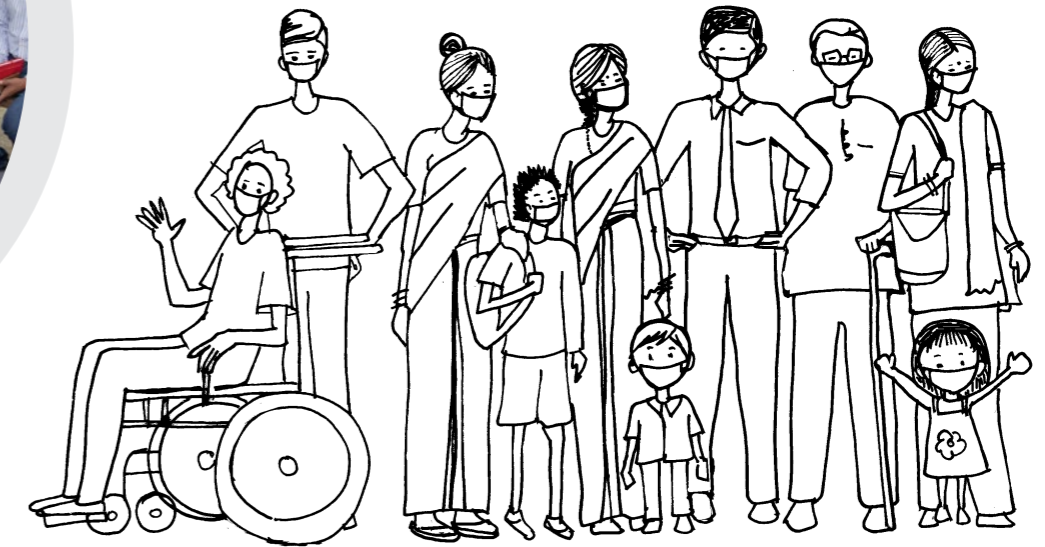
In order for marginalised communities to have access to health care, the following conditions must be met:

1. Ensure safe and affordable transportation to access healthcare services - in this case, COVID-19 vaccination centres
2. Use vaccination camp to conduct regular health checkups and referrals
3. Community Systems Strengthening for Health Systems Strengthening

## Definition of community representative

A community representative is a member of a community who has been nominated by the said community to represent its interests.

The role of the community representative is to represent the interests of the community and involve the community in decision-making processes, for instance, by attending local committees and advocating for the communities needs and wishes for change (Goswami, 2020).



We have learnt that the best and most effective ways of planning for and rolling out Vaccination for the most marginalised is to ensure that the design is

- ♦ Community-centric and localised.
- ♦ Able to direct the flow of resources (e.g., people, money and materials) where they are most required.
- ♦ Attentive to fluid and frequently changing ground scenarios and address information management and coordination.



# Purpose and Objective

The Vaccination Drive Playbook offers guidance to help community organisations implement the vaccination drive for vulnerable populations at the local level in partnership with other NGO/CBOs, Medical/Clinic teams, volunteers. The document outlines the steps required for conducting the community vaccination drive and details out the activities that can be undertaken for smooth planning and rolling out of the vaccination drive.

In the playbook you will find:

- ♦ Set of activities to conduct the vaccination drive
- ♦ Summary checklist
- ♦ Team role matrix
- ♦ Tips and tricks

The playbook divides the entire process into 3 Acts, which are as follows:

- ♦ **Act 1**
  - **Scene 1 : Planning phase**
  - **Scene 2 : Pre-vaccination phase**
- ♦ **Act 2 : Vaccination phase**
- ♦ **Act 3 : Post-vaccination phase**





**PEOPLE**

# Who are the People?

## COMMUNITY MOBILISERS

### Role:

- ♦ Correcting the information asymmetry
- ♦ Generating trust
- ♦ Matching demand and supply
- ♦ Identifying the most vulnerable who are likely to fall through the cracks

### What do they need?

- ♦ Build their trust in the vaccine
- ♦ Train to be able to relay key messages about vaccines and have nuanced conversations with those that are hesitant
- ♦ Reliable information on where and when and how many vaccine doses are available
- ♦ Connection to resources for availing services for special needs cases (also helps improve their standing in community and generate trust)
- ♦ Digitally savvy to support online registrations if needed

## Who can they be in your community?

- ♦ Youth volunteers
- ♦ Religious leaders
- ♦ Frontline CBO/NGO workers with close community ties
- ♦ Self help group members
- ♦ Ashas and angan vadi workers
- ♦ Teachers from local schools known to parents
- ♦ Panchayat members

## LEVERAGING COMMUNITY CONNECTS

Local leaders, youth groups, religious spaces (if not contentious) can be leveraged as resources and their involvement could help mobilise individuals who otherwise would not access care at health centers. Local resources for transport for those that can not afford it can also be mobilised.



## CLINICAL TEAM:

**Who are they:** Doctors, Nursing staff, Ambulance staff

### What do they need to know:

If the clinical teams are not used to working with vulnerable populations it's important to have sensitisation sessions (importance of providing respectful care and its impact)

- ♦ Not assuming people have all the information or able to find it and therefore providing pre and post counselling on what to expect (fever, flu like symptoms etc.),
- ♦ When to come back for the next dose, ask if there are any questions and respectfully answer any questions or concerns, however basic they may seem.
- ♦ For special populations such as elderly, people with disabilities, sex workers, trans population that have specific health related questions and poor experiences interacting with health systems, clinical teams should be briefed on how to answer them most sensitively.
- Due to COVID many people have not accessed clinical care even if they needed it so if special population camps are being organised, having additional areas where general clinical concerns can be addressed could be very beneficial for these populations.



*Many of those with alcohol dependency returned from the vaccination camp without taking the vaccine because their questions about reactions with alcohol were not answered or they were told that they could not drink for long periods if they took the vaccine.*



## NON-CLINICAL STAFF:

**Who are they:** Local volunteers, Frontline staff from NGO/CBOs, Self Help Group members, Youth Club volunteers, Civil defence staff such as home guards and others can perform critical functions such as crowd control, data entry, supporting those with special needs, ensuring safety of VPs and respectful treatment, ensuring COVID appropriate behaviours etc.

### What do they need to know:

- ♦ Importance of providing respectful care
- ♦ Digital literacy for those doing data entry
- ♦ Both male and female volunteers should be available at camps
- ♦ Understand how to escalate any issues
- ♦ Familiar faces and trusted volunteers are key for making sure very marginalised populations feel comfortable





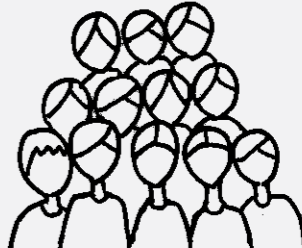
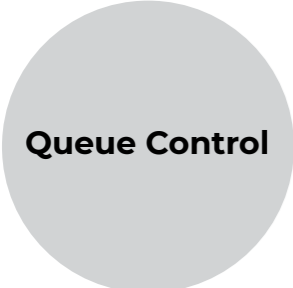

### Situationally aware camp management:

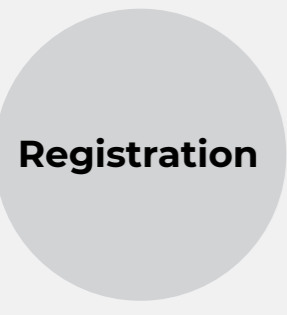
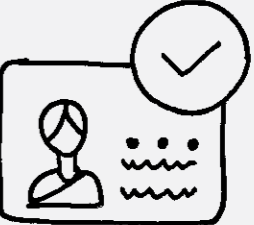



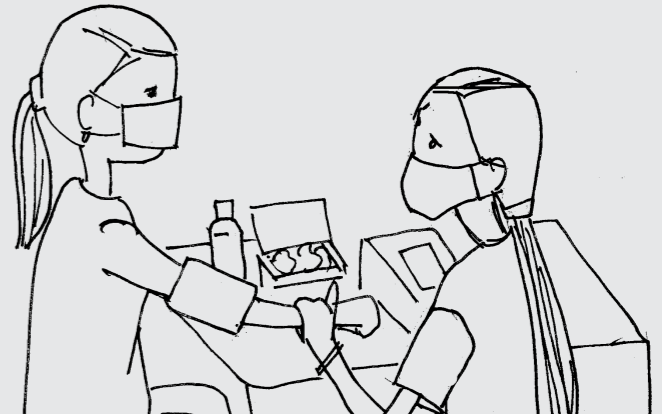
Anticipate interference and disturbances and have community leaders and senior managers at hand who can handle issues as they come up.

**Security:** Using or alerting local police or other security agencies during large camps is key to ensure safety of staff and beneficiaries.




Dynamics of certain populations with security forces must be considered to ensure people do not avoid camps due to their presence.

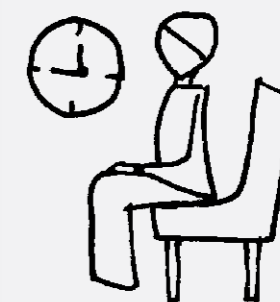
# Team Role Matrix

Role Title	Station/ Number of People	Responsibilities	
 <p><b>Community Mobilisation</b></p>	-	<ul style="list-style-type: none"> <li>♦ Provide information on vaccine drive in communities - date, location, which vaccine, eligibility, etc.</li> <li>♦ Address vaccine hesitancy and or any related concerns</li> <li>♦ Collect the required information from the interested members in a predesigned format</li> </ul>	
 <p><b>Crowd Management</b></p>	At the gate - 2/3	<ul style="list-style-type: none"> <li>♦ Identify the beneficiaries based on the list and identity proof</li> <li>♦ Ensure the member is wearing a mask and wearing it properly (covering the mouth and nose completely, ideally double mask)</li> <li>♦ Direct the member to sanitise their hands or guide them to the washing station</li> <li>♦ Educate about COVID safety protocols to be observed in the location</li> <li>♦ Inform and guide the walk-in member based on the contingency plan</li> <li>♦ Guide the member to the next station or room.</li> </ul>	
 <p><b>Queue Control</b></p>	2/3	<ul style="list-style-type: none"> <li>♦ Ensure that the people waiting for registration or vaccination are following covid appropriate behaviours - social distancing, wearing masks properly, etc.</li> <li>♦ Guide them to the next station</li> </ul>	

Role Title	Station/ Number of People	Responsibilities
 <b>Registration</b>	2/3	<ul style="list-style-type: none"> <li>◆ Collect the identity proof of the member and register on CoWIN</li> </ul> 
 <b>Verification</b>	1	<ul style="list-style-type: none"> <li>◆ Verify the member on CoWIN against their identity card</li> </ul> 
 <b>Medical</b>	<p>Medical professional - 1</p> <p>Vaccinator - 1/2</p>	<ul style="list-style-type: none"> <li>◆ Ask the member about any existing health issues to understand whether they are contraindicated for vaccine</li> <li>◆ Explain the reason to the member and guide them to the coordinator, if they are not eligible</li> <li>◆ Incharge of providing vaccination for the members</li> <li>◆ Educate the member about side effects of vaccine and adverse reactions associated with COVID-19 vaccine</li> <li>◆ Guide them to the observation room or station</li> </ul> 



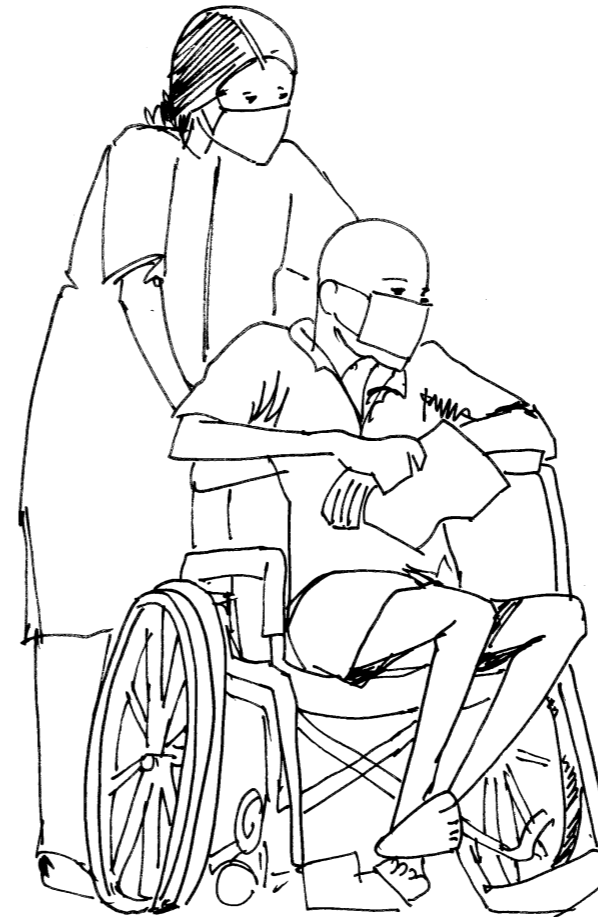
Role Title	Station/ Number of People	Responsibilities
 <b>Observation</b>	In the waiting room or station - 1/2	<ul style="list-style-type: none"> <li>♦ To oversee the waiting members</li> <li>♦ Provide them the vaccination certificate or token</li> <li>♦ Ensure social distancing is maintained</li> <li>♦ Address their concerns and questions</li> <li>♦ Provide group counselling on key information for vaccination such as the date of second dose, common and normal to have fever, body ache, diarrhoea for two days after vaccination etc. (use script)</li> <li>♦ Provide screening for common NCDs such as diabetes and hypertension when people wait, if possible</li> <li>♦ Guide and report them to the medical team in case of any adverse reactions or side effects</li> <li>♦ Provide contact information for follow-up support</li> </ul>
 <b>Coordination</b>	1	<ul style="list-style-type: none"> <li>♦ Ensure the end-to-end coordination of all activities on the day of the vax drive - mobilisation through completion of vaccination</li> <li>♦ Ensure documentation happens properly - registered vs vaccinated, segregated data, ineligible members, etc</li> <li>♦ Coordinate with the local departments in the event of any contingencies</li> <li>♦ Ensure that adequate food and water are provided for the field teams</li> <li>♦ Ensure that the location is sanitised after the drive ends</li> </ul>
 <b>Safety</b>	1	<ul style="list-style-type: none"> <li>♦ Ensure the site is a hazard-free environment</li> <li>♦ Ensure that emergency exits, fire and other hazards safety measures are in place</li> <li>♦ Ensure that other members of the staff are aware of the safety measures and guidelines</li> <li>♦ Stop or prevent any unsafe acts that seem dangerous or unhealthy</li> </ul>



# Places

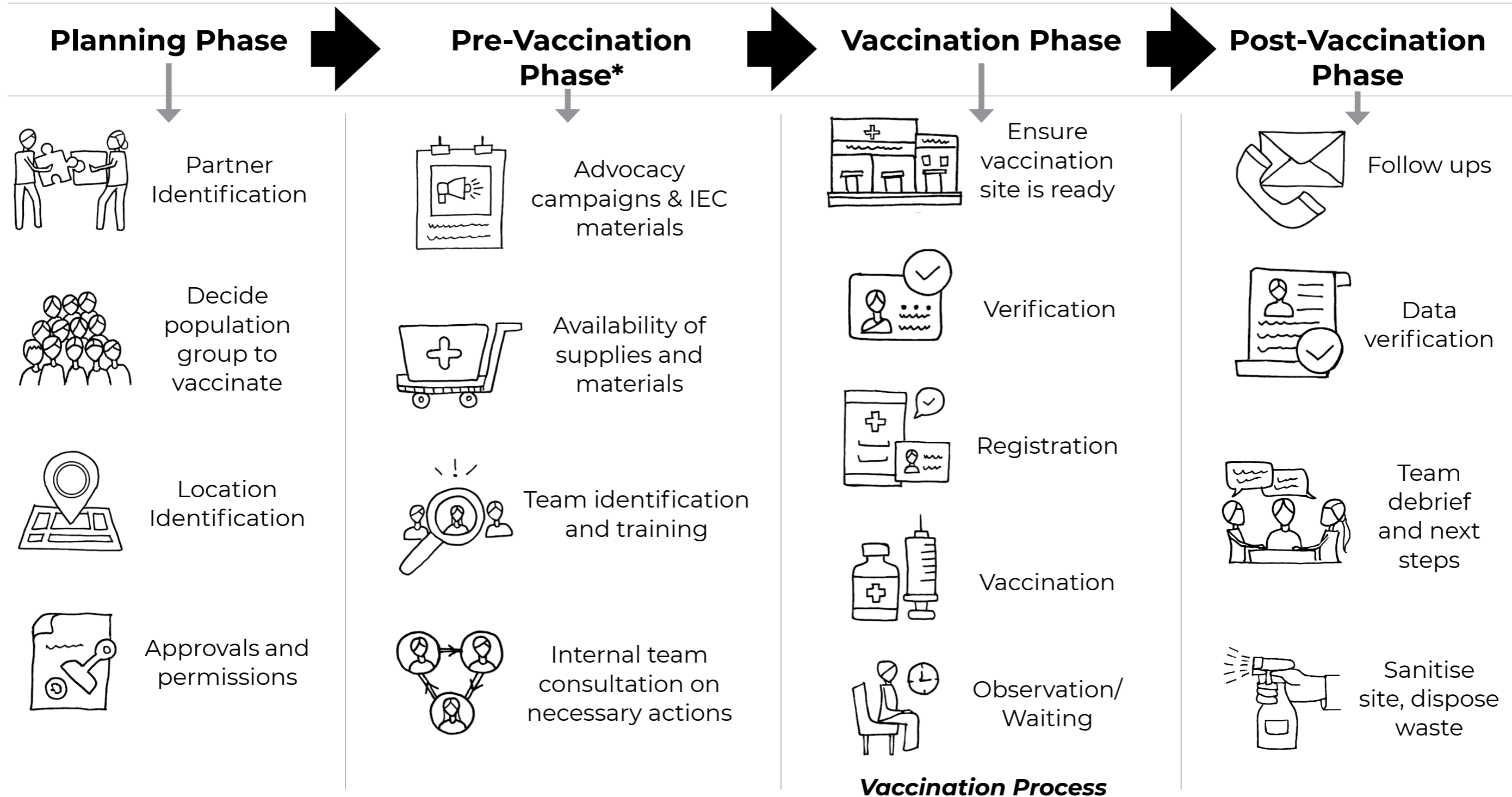
## How to choose the right place to set up a vaccination camp?

- ♦ In partnership with community representatives, choose the location of the vaccination centre that is most convenient and safe for them.
- ♦ The centre should also have an accessible drinking water facility, medical care, privacy curtains and washroom.
- ♦ If the centre is not within minimal walking distance of the community, ensure that the centre is accessible at the lowest possible fare. This may involve looking at local transport solutions such as shared autos/tuk-tuks, cycle rickshaws, tempo traveller vehicles and others.
  - Travel schedules, pick up and drop locations - will need to be discussed with the community members to ensure the timing is suitable for the community and loss of wages is minimised. Coordinators will need to be identified to ensure the smooth operation of the travel plan.
  - Contact details of coordinators will need to be shared for coordination with the community representatives to ensure fast, efficient, safe, and cheap transportation.
- ♦ Ensure that both the transport and centre are accessible for people with disabilities. If that is not possible, alternative arrangements need to be made - this may involve discussing with the Medical Officer at the vaccination centre to explore alternatives such as Mobile Vans.



I am a person living with disabilities and I move on my hands and knees to go from one place to another. I sell vegetables and I needed to get vaccinated to continue my business. But there was no way that I could reach the Vaccination Centre in my area. The Vaccination Camp organised by the Community Institution in my area had volunteers who made sure I could get my dose.

# Process Workflow

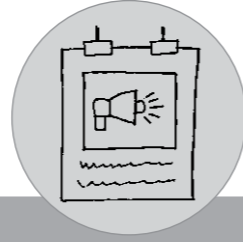


*\*Listed activities doesn't have to occur in same sequence and can even occur simultaneously*



## Planning

- ◆ Partner identification
- ◆ Decide target population to be vaccinated
- ◆ Estimate numbers that can be mobilised and methods of mobilisation
- ◆ Location identification
- ◆ Approvals and permissions from local authorities



## Pre-Vaccination Phase

- ◆ Internal team consultation
- ◆ Advocacy campaigns and targeted demand generation
- ◆ Finalize and prepare IEC materials
- ◆ Team identification and role designation
- ◆ Team training.
- ◆ Ensure availability of required infrastructure
- ◆ Provision for Shamiana and other arrangements



## Vaccination Phase

- ◆ Team arrives in advance/ on time
- ◆ Camp site is ready to conduct operations supplies, labels, materials are in place, etc.
- ◆ Verification at entry
- ◆ Registration on CoWIN app
- ◆ Verification post registration
- ◆ Vaccine administered

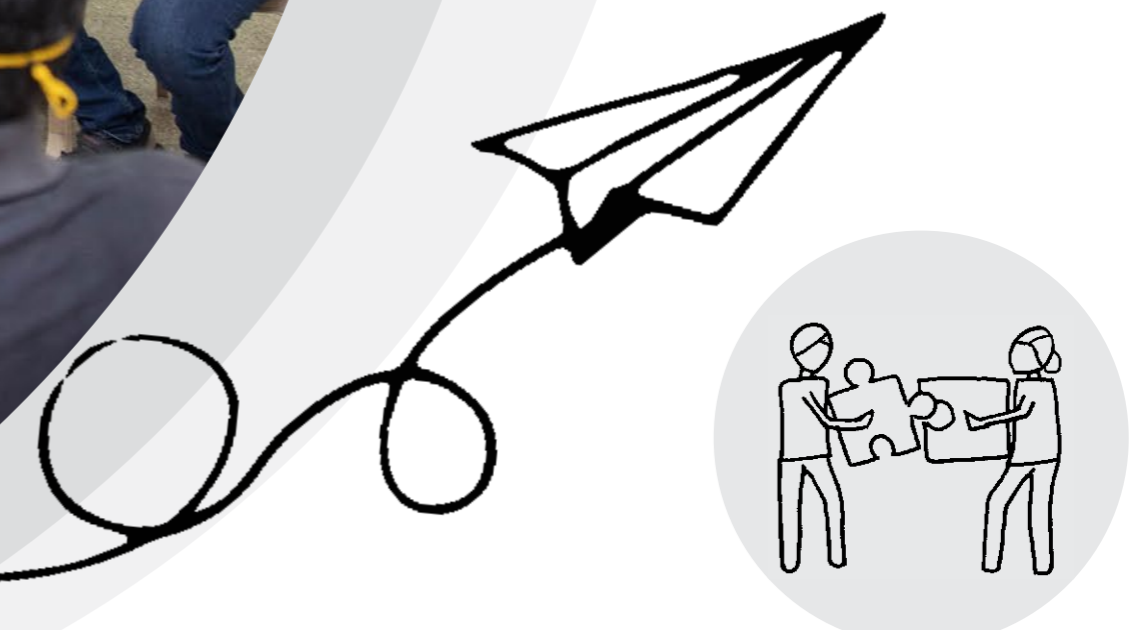


## Post- Vaccination Phase

- ◆ Site cleaned and sanitised
- ◆ Waste disposed/ handled as per protocols
- ◆ Debriefs with the team
- ◆ Verification of the data
- ◆ Follow-up to check for side effects, other support required







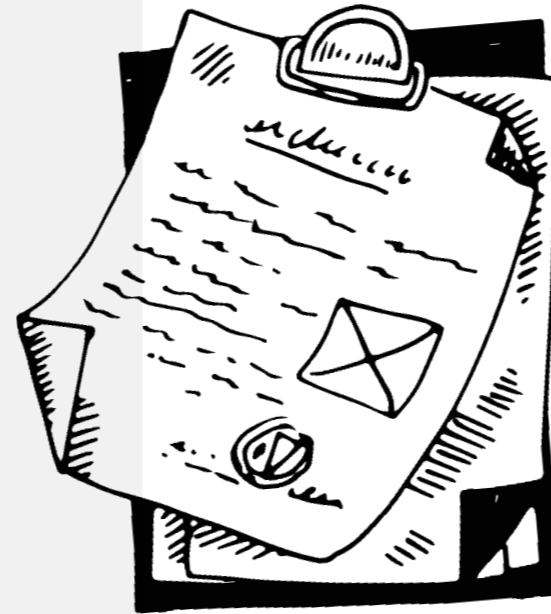
# ACT 1 - SCENE 1

## THE PLANNING PHASE

# Planning Phase

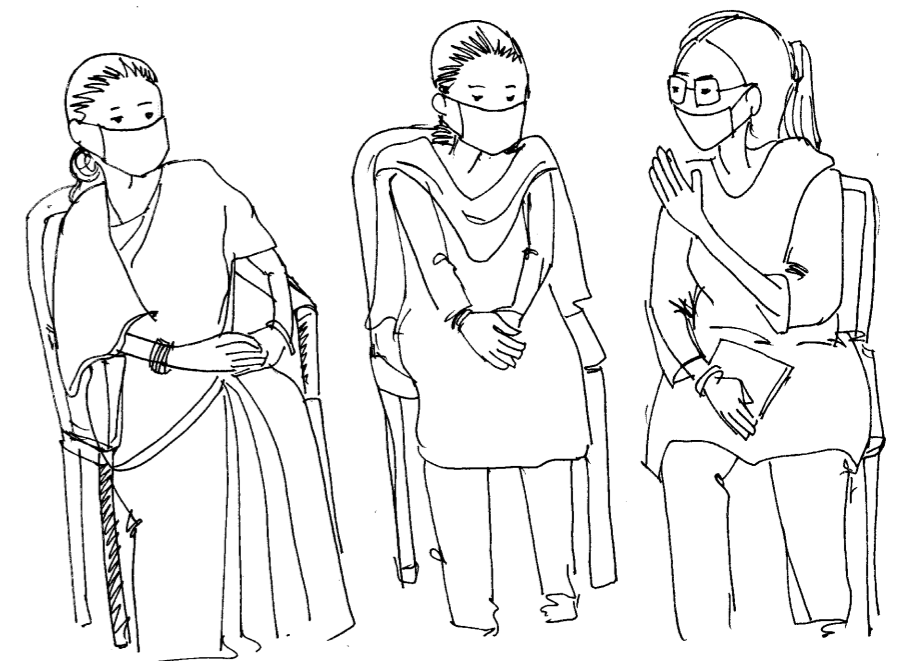
## 1. PARTNER IDENTIFICATION - Identify collaborating partners to conduct the drive

- Consult the partner to discuss and finalise the scope of the drive - dates, locations, vulnerable population categories, size of the camp (minimum and maximum participants), verification measures, etc.
- Establish clarity on what the role of each stakeholder will be - vaccine procurement, vaccination, community mobilisation, facilitation and management of camps, etc.



## 2. DECIDE AND MAP TARGET POPULATION - Decide the vulnerable population category to be vaccinated

- Make a list of the vulnerable populations in different locations from different categories well in advance (at least 2 days before)



**3. INTERNAL TEAM CONSULTATION** - Conduct internal team consultation to discuss the following:

- Scope of the vaccination drive & partner's expectations
- Target setting
- Team allocation
- Community mobilisation and demand generation mechanisms including strategies to address vaccine hesitancy and related concerns
- Make plans to address situations like walk-in members, fights, and other political situations (map possible risks and threats and possible plans to deal with them)

**4. APPROVALS AND PERMISSIONS** - Coordinate and obtain the required permissions from the local authorities

- ♦ Setting up a helpline where factory workers can directly speak with someone from the vaccination center to get information about rush hours and footfall in order to increase their convenience. This information might help reduce reluctance to step out of their workplace, navigate and get vaccinated.

## Overcoming the “Mobility” hurdle

Accessibility to centers due to mobility issues is primarily faced by PwDs, elderly people with specific medical conditions and women in certain cultural contexts and communities.

**Solutions:** Prior identification of such cases and enabling transportation for certain groups in the district/area might help in ensuring vaccination coverage.

# Learning Vignette

## Overcoming the “Time” hurdle

Many daily wage earners, farmers and factory workers find it increasingly difficult to show up for vaccinations at the centers as the timings of the vaccination centers clash with their work schedules every day. In rural settings, by the time vaccination centers begin to operate most of the residents have left to work on the fields.

### Solutions:

- ♦ Setting up two separate shifts for vaccinations in rural settings:
  - Morning shifts (7:30 - 11 A.M.)
  - Evening shifts (staying till 7:30 P.M.)



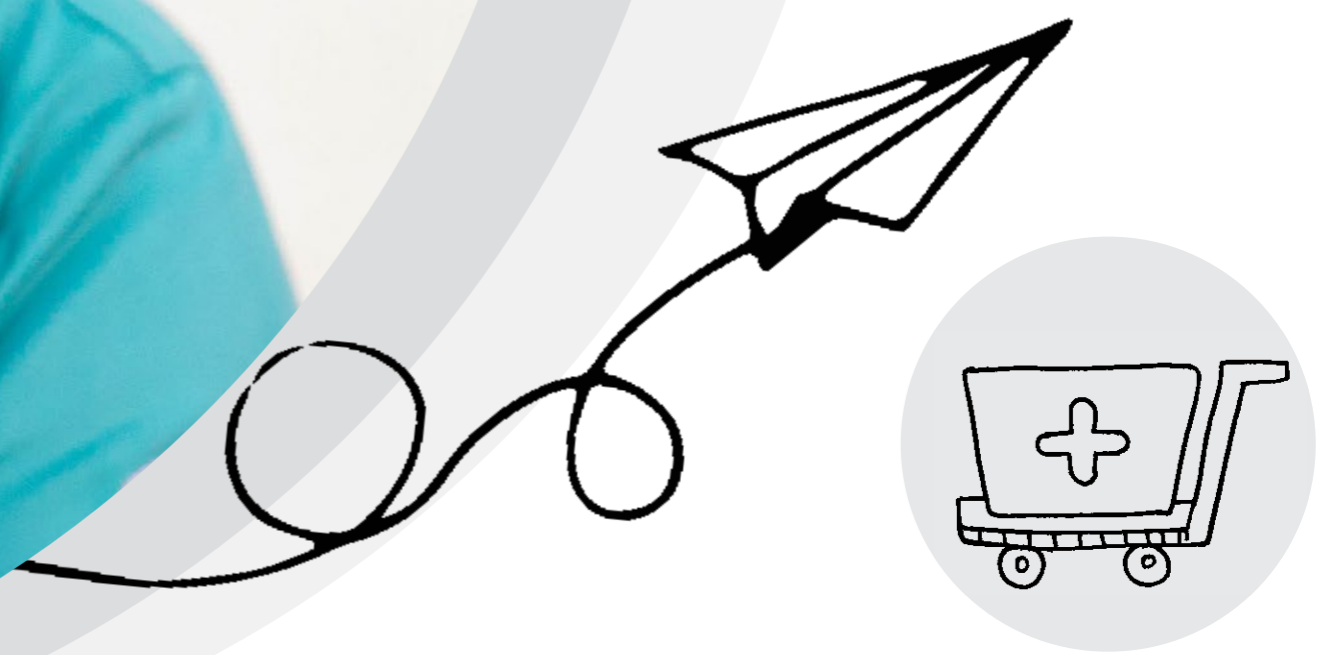


## Scattered to Saturated:

The original approach of having one ANM (Auxiliary Nurse Midwife) visit 40-45 villages and spend a day each at every village resulted in low vaccination rates due to similar issues mentioned previously. The vaccination rate goes down to 10-15 people per day. It takes the nurse another 40 days to complete a round and revisit the village.

**Solutions:** A team comprising more members could visit the same set of villages for 4-5 saturated days and help gather momentum to generate demand. This might snowball into higher vaccination rates and keep the motivation levels of the community up.





ACT 1 - SCENE 2  
**THE PRE-VACCINATION PHASE**

## 1. LOCATION IDENTIFICATION

- Identify a well-ventilated location for conducting the drive with the following:
  - Accessible restrooms and waiting areas
  - Adequate entry and exit points
  - Capacity to adhere to IPC and COVID-19 safety protocols
  - Adequate set-up space to accommodate operations
  - At least 3 waiting areas:
    - ♦ Pre vaccination waiting and registration
    - ♦ For the actual vaccination
    - ♦ Post vaccination waiting area for people to wait 15-30 mins (this needs to have comfortable seating and good social distancing)

## 2. TEAM IDENTIFICATION AND TRAINING

- Identify and designate team members for implementing each activity during the vaccination drive. (see team role matrix towards the end)
- Train the teams (12-15) on the different aspects of vaccination - mobilising communities/ demand generation (3-4), verifying and registering using CoWIN (3), crowd management (5), etc.
- Train the teams to ensure IPC practices and COVID-19 safety protocols are followed

## 3. AVAILABILITY OF SUPPLIES AND MATERIALS

- Ensure adequate furniture is available in each station or room such as desks and chairs.
- Shamiana and other arrangements are made for the teams as well as communities to rest (as required).

## 4. ADVOCACY CAMPAIGNS & IEC MATERIALS

- Conduct advocacy campaigns to address vaccine hesitancy and other concerns in the community. Provide details around double masking and shielding to protect yourself at the vaccination camp from infection and other IPC key to prevent infection.
- Ensure vaccination camp posters and other IEC materials are ready to be displayed on the day of the drive. Put up posters in pre-vaccination and post-vaccination waiting areas with the date of second dose in bold large letters for those that arrived at the camp that day - this is to trigger memory for the next dose.



# Learning Vignette

## Demand Generation and Mobilisation

### What works:

- ♦ Planning with local partners and champions
- ♦ Behaviour change campaigns through local leaders and partners along with the media in order to build confidence and address fears
- ♦ Effective use of technology along with a helpline number to provide information and navigation support
- ♦ Target group wise communication strategy rollout
- ♦ Volunteer assisted enrollment done on a door-to-door basis prior to the camp
- ♦ Enable transportation for the differently-abled and elderly
- ♦ A strict first-come first-serve strategy for carrying out vaccinations

“

The community institution, and the community leaders and volunteers orchestration vaccination camps with a unique strategy.

Two days before the actual camp, the teams went door to door, identifying eligible family members who are yet to be vaccinated and maintained a list.

The day before vaccine, this list was printed and posted outside the wellness center. The community was already intimated about this system, so people knew to come and check for their names on the list for the camp next day.

**Sanjeevani Kalyan Samiti**, a Community Institution of Urban Slum Women





We identified and targeted the willing members first. We addressed accessibility issues by making the vaccination process more mobile and shifting them to their locations to ensure that they get vaccinated. These community champions are our partners! They then helped us reach out to the hesitant sections. During the course of which we were able to identify some of the local leaders and influencers who played an instrumental role in reaching out to the remaining. This is how our framework was able to address the three layers and generate demand on ground. -

**Taaras Coalition**; a Coalition of Women in Sex Work in India





ACT 2 -  
**THE VACCINATION PHASE**

## 1. ENSURE TEAM IS PREPARED AND READY

- Teams should arrive at the vaccination site well in advance.
- Ensure that other teams - the medical and verification team arrives at the site at the right time.
- Ensure staff is wearing identification (vests, shirts, caps, etc.), and/or other identification, as appropriate.
- Team members to be stationed at their respective stations or rooms before the drive begins.

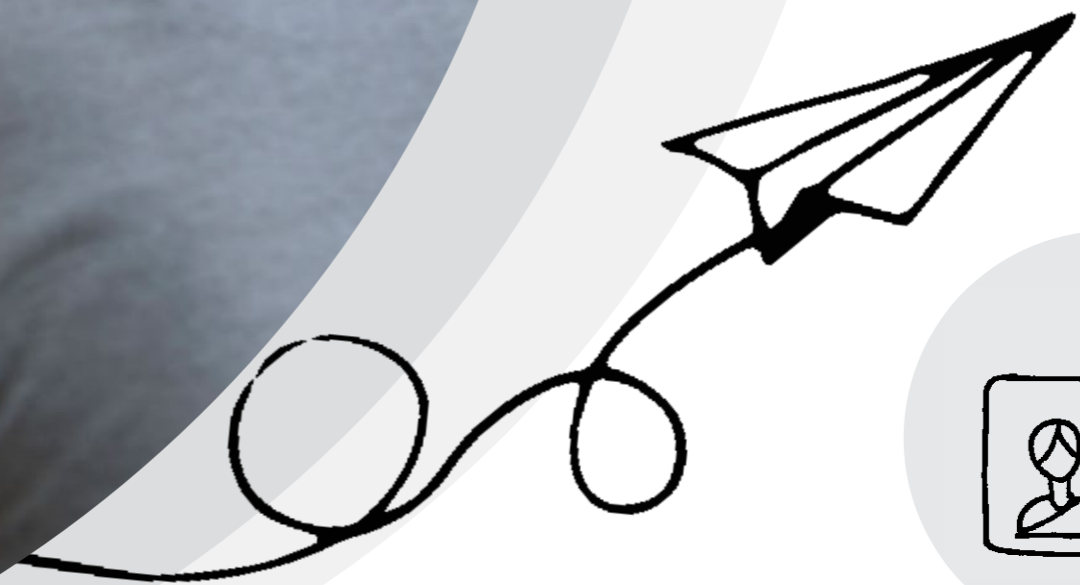
## 2. ENSURE THE SITE IS READY - Prepare the facility to ensure the following things:

- Posters and other IEC materials are displayed.
- Separate rooms or stations for registration/verification, vaccination, and waiting post-vaccination.
- Clean and tidy rooms or stations.
- Appropriate quantity of PPE is available for the staff.
- Provision of drinking water in all 3 waiting areas.
- Sanitizing materials are available for each room or station.
- All COVID safety protocols are followed - social distancing compliant seating arrangements or standing queues, waste segregation mechanisms for each room or station (as required).
- Ensure all fire safety protocols are followed and there are no blockages in entry and exit.
- Facilities to ensure cold-chain mechanisms and vaccine safety are in place.
- Each station/desk is labelled clearly.

## 3. VACCINATION PROCESS - Guide the members arriving at the location in the following order:

- Verify at the gate - Sit or stand in queue for registration (CoWIN) - verification (CoWIN)- vaccination - observation/waiting.





ACT 3 -

# THE POST VACCINATION PHASE



## 1. CLEAN AND SANITIZE SITE

- Sanitise and clean the camp location.
- Ensure the medical waste and general waste is handled/disposed properly.

## 2. TEAM DEBRIEFS AND NEXT STEPS

- Debrief team on the camp - what went well, what were challenges, what could be improved etc.
- Discuss and decide on the next steps - organizing camps for those who could not be managed to vaccinate, etc.

## 3. DATA VERIFICATION - Verify data collected on the vaccinated members.

## 4. FOLLOW-UPS - Conduct follow-up for community members to know about vaccine-related side effects, adverse reactions, or any other support required.

## 5. Ensure plans are in place and teams are available for camps planned on the subsequent days.





# STAGE DIRECTION

This section covers the concept of collocating screening for Non Communicable Diseases at Vaccination Camps, Partnering with Community Institutions, Tips and Tricks for Crowd Control, Learning Vignettes and References for further reading.

*(noun. an instruction written into the script of a play, indicating stage actions, movements of performers, or production requirements).*

## Co-Locating Vaccination Camps & Screening for Non-Communicable Diseases

### Why is screening for Non-Communicable Diseases critical to COVID-19 prevention & response?

Individuals with Non-Communicable diseases (NCDs) are at a higher risk of severe illness or even death from COVID-19 infection. Common NCDs that lead to COVID-19 complications are diabetes, hypertension, coronary artery disease, and chronic obstructive pulmonary disease.

Screening for NCDs can help individuals understand their health risks and induce a greater emphasis on following COVID-19 prevention practices (Bojola et al., 2022).

Screening and diagnosis of NCDs can also lead to better health outcomes for a community through increased access to medical care and disease counselling through referrals and the subsequent treatment and management of the disease.

Having a diagnosis can also help medical staff better understand how to proceed with treatment in case of COVID-19 infection and grants priority to intensive care for those categorised as high-risk patients (WHO, 2020).

The data collected from screenings for NCDs is also useful to inform COVID-19 response measures that focus on NCD control and management (Kluge et al., 2020).

*Use vaccination camps to conduct Non-Communicable Disease screening, regular health checkups and referrals.*



The formal health system is utilised as a last resort for the poor, especially as it often means a loss of daily wage.

Marginalisation and poverty affect health-seeking behaviours, which results in little or no preventive health measures being practised by individuals.

- ♦ This often further results in
  - repeat episodes of illness,
  - undiagnosed conditions,
  - resistance to treatment,
  - early death,
  - the high burden of morbidity and significant out of pocket expenditure (OOP) is as high as 60% in India.

The inability to practice health-seeking behaviours, in turn, exacerbates the risk of myriad health issues with or without COVID-19 for the most marginalised.

*By co-locating Non-Communicable Disease screening, regular health check-ups, and referrals at Vaccination Camps happening in community locations - marginalised communities can access critical screening for underlying health issues, receive a consultation that addresses the same and/or referrals to secondary/tertiary health institutions without further loss of time.*

**This approach:**

- ♦ Improves access to preventive and promotive health among the marginalised,
- ♦ Prevents underlying health conditions being experienced by the community members from getting potentially fatal by early identification and diagnosis,
- ♦ Helps appropriately triage and reduces the burden on health systems
- ♦ Is a key determining factor in protecting from long term illnesses.



**Therefore,**

- ♦ Vaccination Centres / Camps for the marginalised need to have a set up for NCD screening, regular health check-ups and referrals.
- ♦ Once marginalised community members are screened for symptoms of COVID-19, they should ideally be counselled about the importance of and the set up of NCD screening, regular health check-ups and referrals at the Vaccination Centre/Camp.
  - Members of marginalised communities should be encouraged to avail of this facility of a quick Non-Communicable Disease (NCD) screening and (if required) Communicable Disease (CD) screening (HIV/STIs) at the Vaccination Centre/Camp making optimal use of the waiting time before/after the vaccination shot.
- ♦ As a post - NCD Screening, Regular Health Check-Up, Referral - process, it is important to ensure that they have access to essential medical check-ups during the lockdown.
  - Patients should be counselled to inform them of the health and social security schemes available to them, to refer them for further care, and advice on how to integrate lifestyle changes that benefit their NCD (change in diet, exercise, others).
- ♦ Treatments should be affordable or, if possible, even free (Melendez & Pinto, 2009; Pandya & Redcay, 2021b, Ministry of Health and Family Welfare, 2020).

*To support the community's continued access to medicines for Non-Communicable Diseases, map the Jana Aushadhi Kendras in the area and share their details with the individual. The Pradhan Mantri Jana Aushadhi Yojana (PM-JAY) is a Government of India scheme to make healthcare accessible and affordable to every citizen by providing low-cost generic medicines and commonly used surgical consumables through its PM-JAY kendras.*

## **Partnering with Community Institutions**

Community organisations, institutions and networks have the edge over other systems in their hyper-local nature, in interaction with affected communities, are able to respond quickly to community needs and issues, and engage with affected and vulnerable.

Swasti consciously partners with communities in strengthening and capacitating their community institutions of marginalised women and TGNB individuals - these may be SHGs and their federations, community co-operative banks, community organisations and/or other institutions.

This, in turn, ensures that in times of exigencies such as with COVID-19, when communities require contextual, localised, relevant support, their community institutions are able to step up and deliver meaningfully and become the liaison between the community and other institutions, including government agencies and philanthropic donors.

The Community Institutions take the lead in setting up vaccination centres/camps, ensuring access, mobilising the community and undertaking all required steps to ensure the health, wellbeing and safety of the most marginalised.



## **Capacitating Community Institutions pivots around three vantage points.**

- ♦ **Organisational and leadership strengthening** – including management, accountability and leadership for organisations and community systems. These organisations take up facilitation or services with the public and private agencies and complement them where gaps exist. How can community organisations get involved in monitoring and planning, thus actively engaging with the larger ecosystem, is another area of capacity building.

- ♦ **Enabling environments and advocacy** – including community engagement and advocacy for improving the policy, legal and governance environments and affecting the social determinants of health.
- ♦ **Community networks, linkages, partnerships and coordination** – enabling effective activities, service delivery and advocacy, maximising resources and impacts, and coordinated, collaborative working relationships.

## Learning Vignette

To improve access to COVID-19 vaccination camps for marginalised communities in far-flung areas in India, teams from Swasti COE partnered with local Community-Based Organisations (CBO) and Non-Governmental Organisations (NGO) to develop tailored approaches.

When the COVID-19 Vaccination Drive in rural and peri-urban India was being undertaken solely at Primary Health Centres - state-owned rural health care facilities - ground CBO and NGO teams mobilised 5 to 10 community members, hired the first available local small to medium-sized transport and shared rides to the Primary Health Centre.

However, this solution was not workable for individuals who had accessibility and mobility challenges or were at enhanced risk due to health conditions - such as older adults, people with disabilities, people living with HIV and ground CBO and NGO teams used two-wheelers / access modified vehicles to ply as transport for them.

Once the Government allowed for Vaccination Camps to happen in Villages and within Community Spaces, the CBO and NGO teams scheduled fixed time periods for community members, mobilising them and working extensively on community-level myth-busting and stigma reduction.

Given that in villages and peri-urban areas, the local CBO and NGO teams and the community representatives played an active role in facilitating vaccination, they were able to partner with the Frontline Health Workers at Vaccination Camps to improve access for individuals who were bedridden or were unable to access the Vaccination Camps in their community spaces for reasons such as old age, disability, pregnancy. This was prior to Har Ghar Dastak - the Government Of India's campaign for door to door vaccination.

At Self Help Groups, members were motivated to convince others in the group to seek vaccination with late evening or early morning camps to ensure the timings did not cause a loss of daily wage.

These approaches were not limited to people interventions only. In Urban Poor settings, the local Community Health Institution partnered with Design Innovators to put in place plastic barriers in Auto Rickshaws owned or operated by community members. This is the preferred local transportation of the community for safe transportation to access clinical services. This helped protect the Auto Rickshaw drivers as well as the passengers - while making it a COVID-19 safe and comfortable transport to access health institutions. See this 90-second video here where Purosottham, whose daughter is a frontline worker at Swasti's Community Health Program, discusses setting up the Auto Partition and why it was important to him- Auto Partition Video.

# Readers' Note : Community Institutions

## OF THE COMMUNITY | FOR THE COMMUNITY

To take COVID-19 vaccination to the most marginalized communities, to the most vulnerable, to the last mile - it is critical to listen to and work in partnership with Community Institutions.

Differentiating Community Institutions from other entities is possible if we use the lens - “of the community, for the community”.

Questions to ask oneself are:

- ♦ Who is representing whom?
- ♦ Who makes decisions and with what mandate?

Ideally it is the same answer for the above questions:

- ♦ The Community Institution is serving the Community.
- ♦ The leadership from the Community drives the institution.

Typically in any location, we will find Community Institutions that categorize themselves as :

Community Organization (CO) or Community Based Organization (CBO) are based in geographically and culturally bound communities. They come together based on their community connection and self identification or in response to a problem they want to resolve in collaboration within the community and in partnership with other private and public sector entities and may / may not register themselves as a legal entity. A residents welfare association is as much a community organization as a transwoman network.

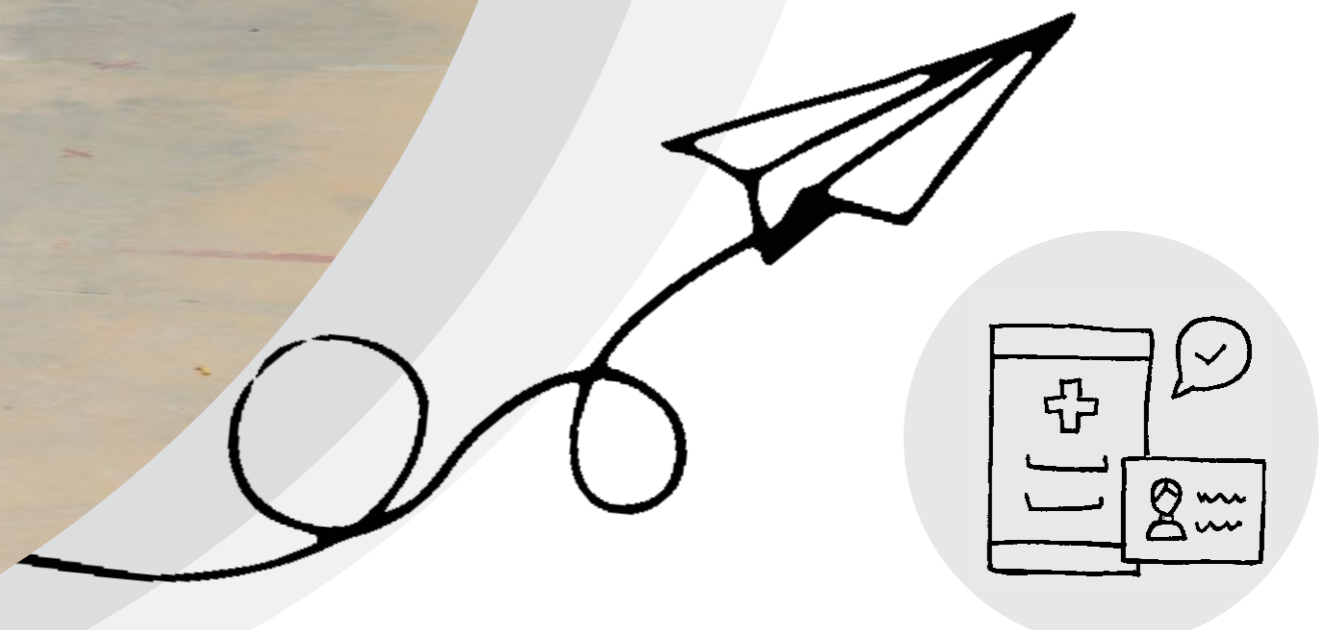
A Cooperative on the other hand is a legal entity - it is an autonomous / self governed association of persons who come together voluntarily to meet their common economic, social,

**Note:** Community Institutions may or may not be registered bodies. This means it can also be a platform, a coalition, a movement or a network. While in India, many Community Institutions register themselves as a Trust, or a Society, or a Cooperative - this is not an essential filter. Community Institutions may or may not provide services or buy or sell products to the community and beyond but typically are often engaged in community work, community projects, community development, community empowerment, community building, and community mobilization.

and cultural needs and aspirations through a jointly-owned enterprise. Employees of a company can form a cooperative to meet their welfare needs or farmers can come together as well (AMUL is a well-known brand of the Gujarat Cooperative Marketing Federation Ltd).

Self-help groups are informal groups of people who come together to tackle a common issue - it could be to do with finances or health or sanitation or all of it together. Self-help groups can also rotate funds within their members and enable access to formal financial services. The crux of Self Help Group is the principle of mutual support – one for all - and all for one. Self help groups often come together to create a federation and/or a Cooperative.

Coalition & Networks - The terms “Coalition” and “Network” are used interchangeably. However - the difference lies in the details. In the lens of Community Institutions, networks are typically a loose association of people or groups brought together by a common interest - for example - frontline workers living in urban slums and working in COVID-19 response may have a network and this network may pursue various interests at various points without necessarily convening for one specific goal. On the other hand, a coalition is in pursuit of a specific goal - which is often the umbrella goal. Community coalitions are often formed around shared vision around a shared identity for example a coalition of women in sex work to realise their fundamental human rights and access entitlements.



# TIPS & TRICKS



## Tips & Tricks: Crowd Control and Registration

**01** Have a team of at least **10-12 volunteers** for a camp size of ~300-400 people, to manage the crowd and do registrations. Within this it is essential to allocate 2-3 experienced members who can deal with contingencies, politicians, break up fights and others.

**02** If it is a private vaccination or specific to a particular group, ensure there is a large poster at the gate of the vaccination center displayed saying the same to discourage others from trying to walk in.

**03** Place at least 2-3 people at the entry gate to welcome, check and verify that individuals are eligible for the camp so there is no overcrowding inside the venue.



**04** Provide queue numbered wait coupons at the gate and use these numbers to call people for vaccination. Ask them to be seated as per the coupons but if seating is more informal and outside then the coupons serve as the queue while people wait and try to social distance.

**05** Make pre-marked chalk squares/circles with social distancing to mark where people should stand while waiting in queue. Enforce this with the help of volunteers.

06

If the queue is large, the staff managing crowd outside must know of the availability of the vaccines inside and inform people once the coupons/doses of vaccines run out. Reduce wait times for people who will not be able to get a dose on that day. Inform them of the next camp date.

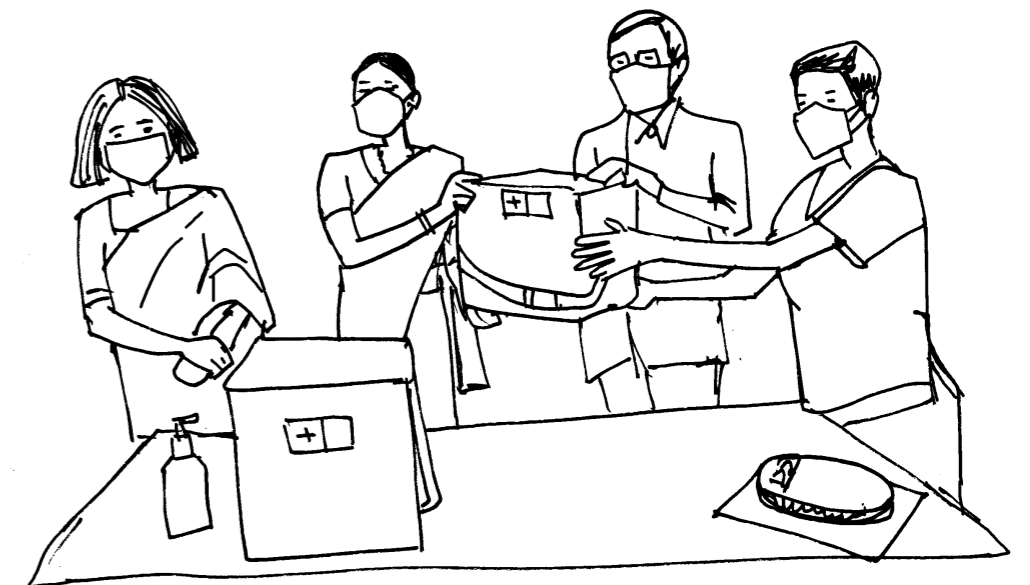
07

Have roving volunteers at the gate and in the queue to identify if there is anyone who is ill, old, pregnant etc. and/or can't stand. Provide them with a chair and a comfortable waiting space or bump them up in the line if possible.



08

Bulk of people are likely to arrive in the beginning of the camp (or there might be surges in people at a given time) so need to be prepared to register them on CoWIN quickly so that is not a bottleneck. Assign additional people for registration as needed. Once people have come inside the venue and are waiting in line for registration on CoWIN have 2-3 people at a desk but also a few roving volunteers in the line registering people on their phones as they wait, asking them to take out their IDs etc.



09

Inform local police station and consider having police/home guards presence if anticipating large crowds or working in tricky areas.

10

Have the staff wear similar vest/t-shirts to make it convenient for people to identify them as part of the team and spot them in the crowd.

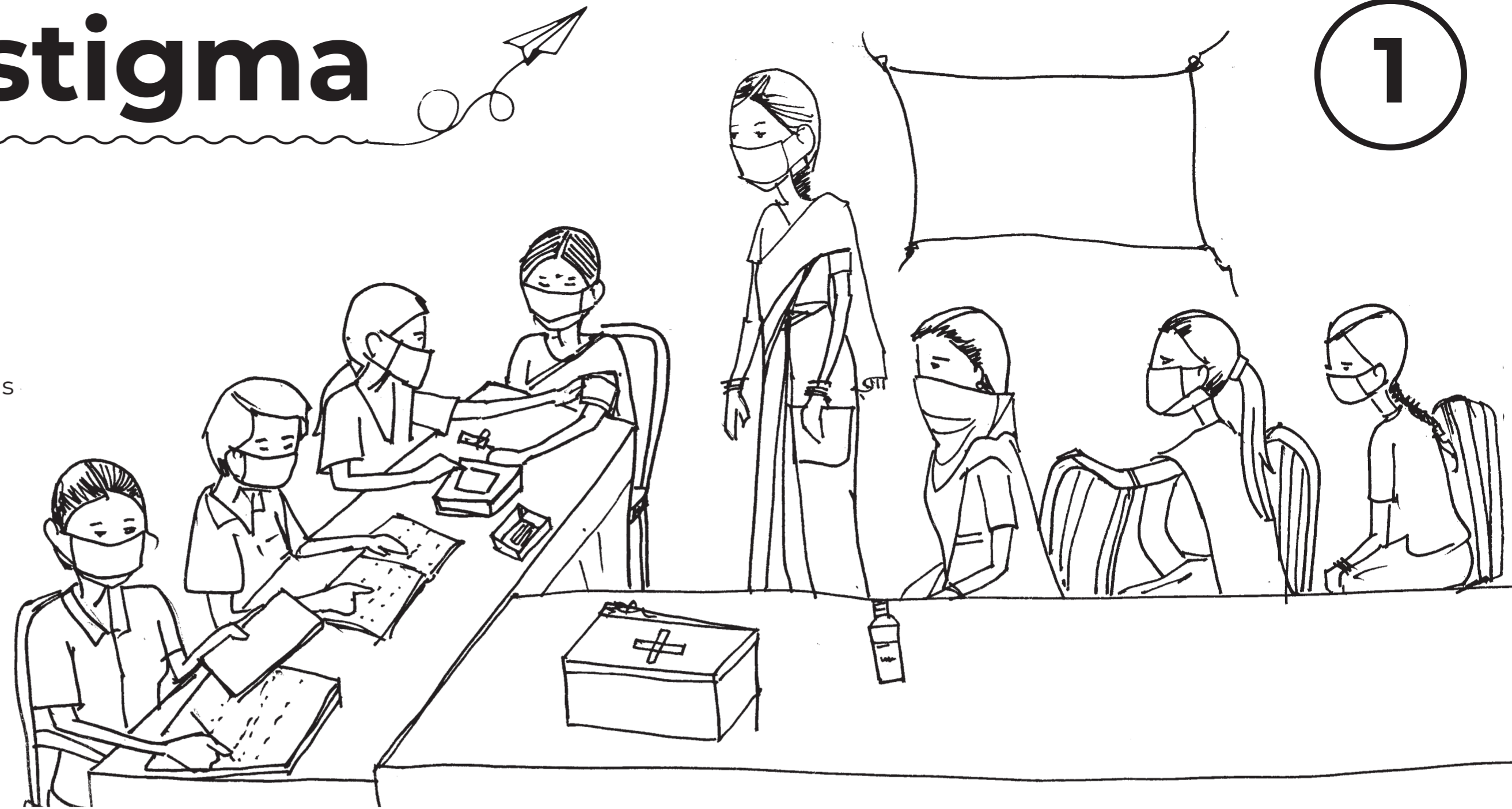
# Working around stigma

1



## Sensitization Training for Health, Community, and Outreach Workers

- Healthcare workers, community and outreach workers should be provided with sensitisation training in order to understand and empathise with the intersectional oppressions faced by marginalised communities as well as provide a safe space for them. This can foster vaccination, COVID treatment, and other health-service uptake.



## Information, Education, and Communication (IEC) and Information, Technology, and Communication (ICT):

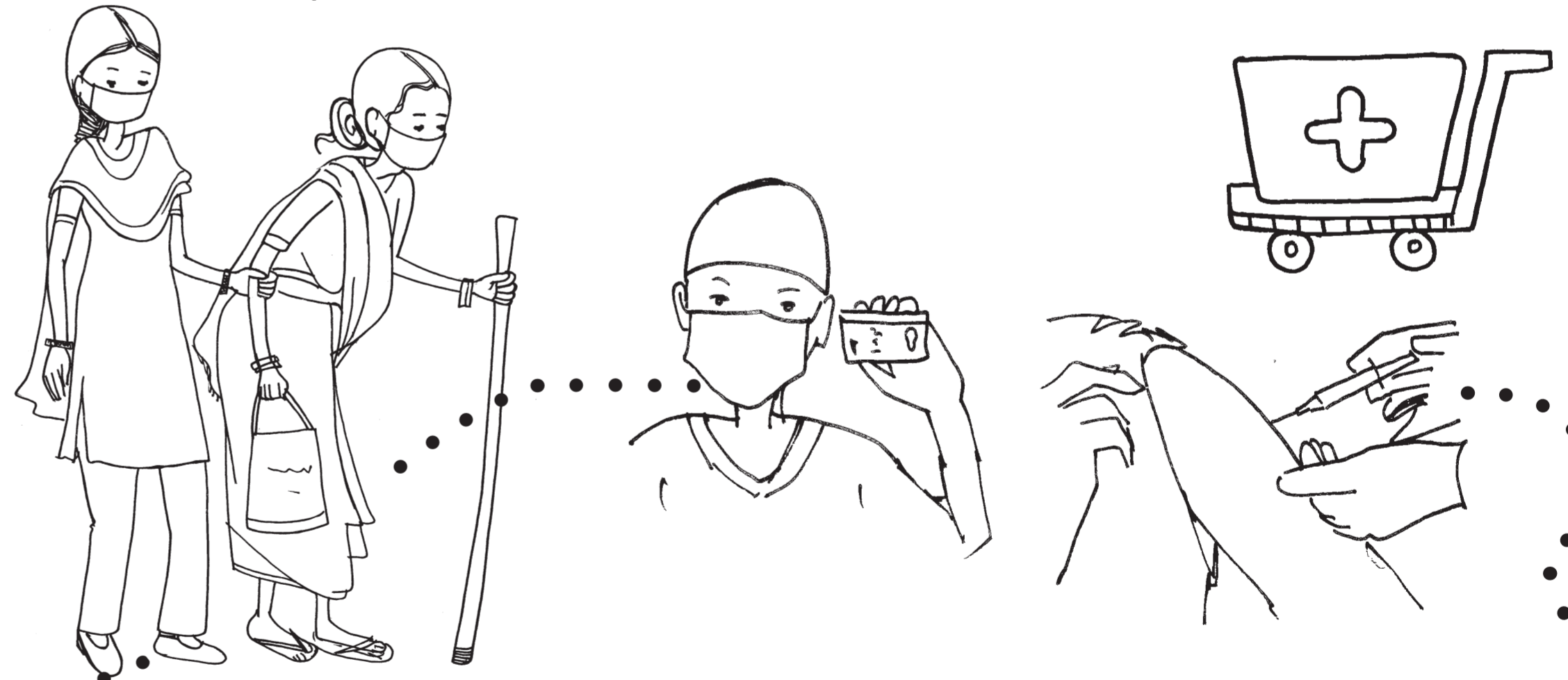
- IEC and ICT modules should be utilised to help marginalised communities acquire essential knowledge about sanitation measures, HIV related healthcare, COVID-19, general health, mental health, the interaction of vaccines with ART medication, and other needs.
- ICT modules can be used to seek knowledge online, through social media use and/or seek healthcare by contacting providers online or via phone.

a. Information needs to be designed using simple and discrete language and images and distributed as flyers, posts, posters and pamphlets at locations where marginalised community members often visit or pass by, including online.

Information should also be provided through word of mouth, such as during in-person meetings (e.g., Self Help Groups (SHG)).

b. Communication tools should be customised to marginalised communities specifically.

For instance, to address vaccine hesitancy, a special section in the vaccine awareness communications should be included regarding the safety of vaccines for the specific marginalised community population.

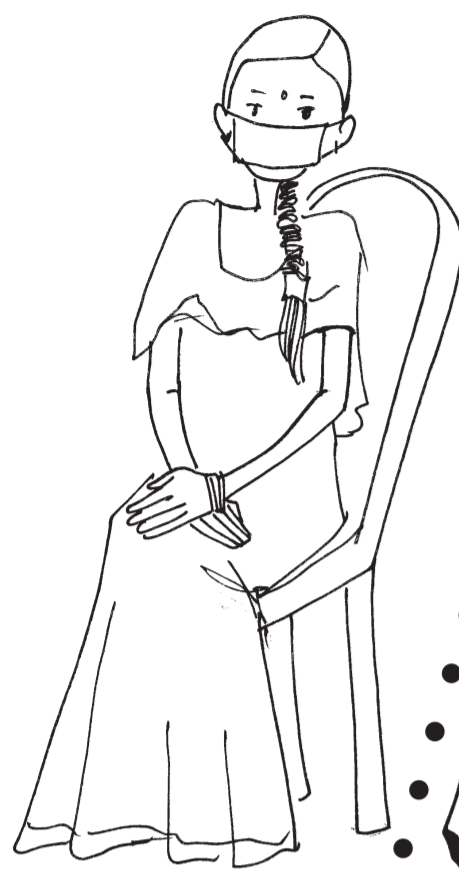


The communication channels, as well as the content in them, is often not optimised for the special needs of communities like marginalised community population.

Hence an inclusive communication and Knowledge transfer strategy needs to be adopted that caters to their needs.

c. There should also be the availability of onsite or telemedical counsellors to speak about specific concerns marginalised community population might have about the vaccine.

# Working around stigma

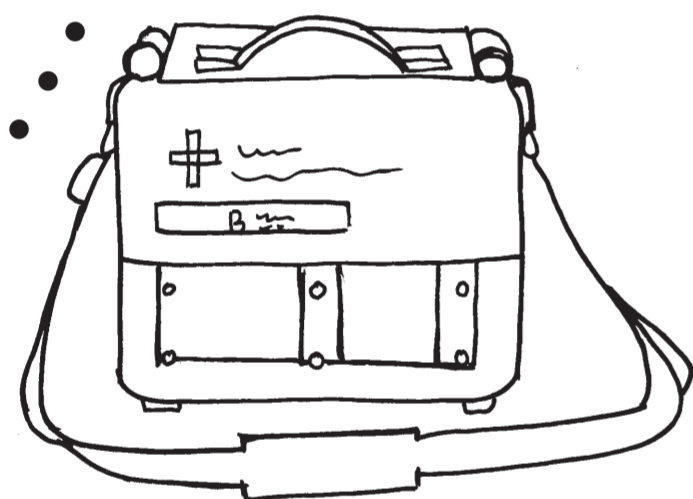


## Access to Healthcare, Medicines, and Vaccines

⌘ Equitable healthcare access, including general health services, SRH services, HIV treatment and medicines, COVID-19 vaccine, and mental health care should be ensured for marginalised communities through outreach programs.

a. COVID-Protection kits should be provided, either for pick up in vaccination camps, health centres, or NGO and CBO offices.

They should contain masks (with information on how to wear them properly and safely dispose of them); surface and hand-sanitisers (with information on how to use them properly); antigen self-tests (with instructions on how to use, read them and dispose of them). The kits should also contain additional sanitisers for surfaces, masks and self-tests due to them being at a higher risk of infection, and condoms.



b. Vaccination camps should be set up in marginalised communities.

Vaccination camps should be used as an opportunity for taking regular health checkups targeted at monitoring the well-being of marginalised communities. Post-vaccination, members of the community should be encouraged to have regular medical check-ups to discuss their health habits and overall well-being. This can also be an opportunity to educate them on the proper care they should be taking as well as new medicines and forms of treatment.

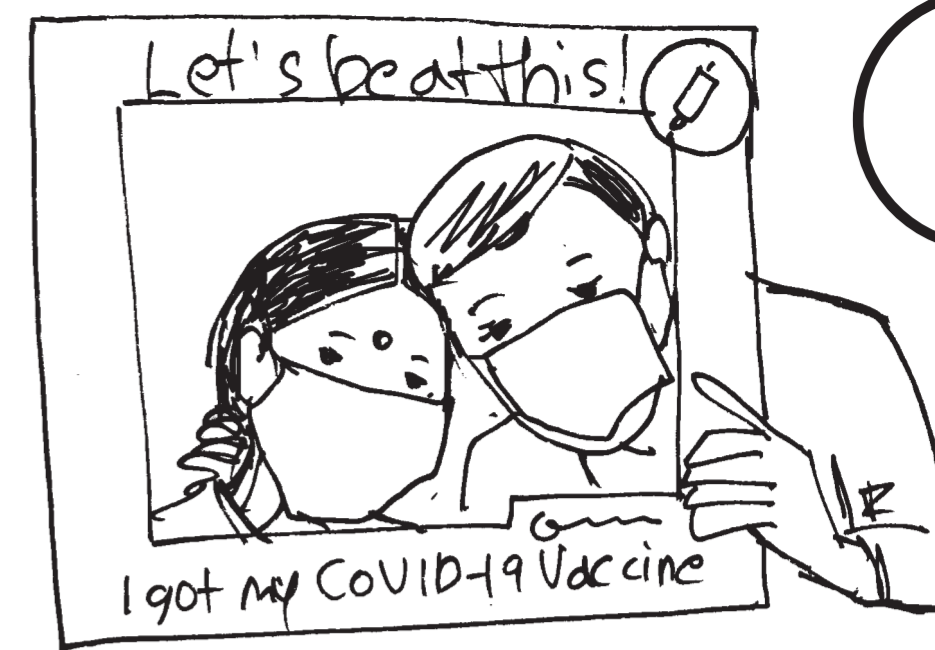
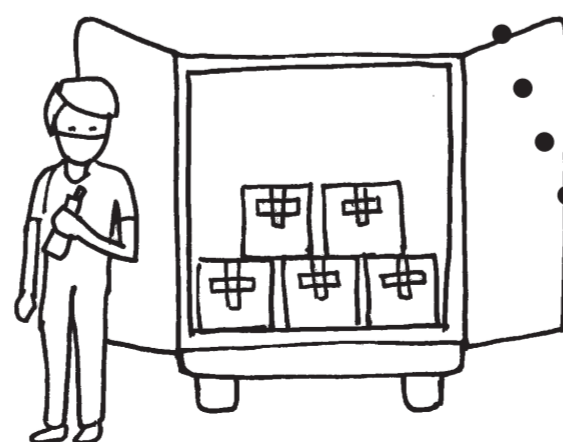
c. There should be medical care access to follow up post-vaccination to address concerns about any side effects of the vaccine. Side effects can be a major source of panic and stress, especially for the members of the marginalised community. Hence post-vaccination medical follow-ups, as well as medical counselling via Tele-Healthcare, should be introduced focusing on the issues faced by the community especially after getting their vaccine doses.



d. Sensitization training, telecare, telemedicine, and mobile clinics, should be used to address different concerns in access to healthcare such as stigma and discrimination, distance, time, and cost of travel.

## Transportation Support

⌘ Members of the marginalised communities often face long distances to health care facilities, cost of travel, time of travel, fear of going with strangers, risk of infection with COVID, fear of stigmatisation, fear of discrimination, fear of violence, and other challenges in their reaching healthcare facilities, which leads to a non-regular adherence of HIV medicines and other health requirements falling short. Therefore, marginalised communities should be supported with transportation support to and from the health care and vaccination centres, both in rural and urban areas



## Things to remember when we design, disseminate and redesign Information Education and Knowledge (IEK) products catering to the community

In order to tackle dangerous misinformation that has led marginalised groups, such as the TGNB and PLHIV community, to put themselves at risk of infection; it is essential to continuously design, disseminate, evaluate, remove, redesign and disseminate knowledge and information products with up-to-date and verified facts. However this material needs to be packaged appropriately and target the particular questions and myths pervasive in the community:

- ⌘ Information should come through sources trusted within the community, videos and posters should include trusted people from within the community speaking about vaccinations
- ⌘ Should address the common fears regarding stigma and discrimination
- ⌘ Should address questions around reactions with hormone replacement therapy, de-addiction medication, HIV medications etc.
- ⌘ Posters should be installed at locations that the target group often visit or pass by.
- ⌘ Involve community leaders to ensure that information reaches many "hard-to-reach members through their networks and by word of mouth" (Reza-Paul et al., 2020, p. 105).

# COVID-19 Vaccination for People Living with HIV



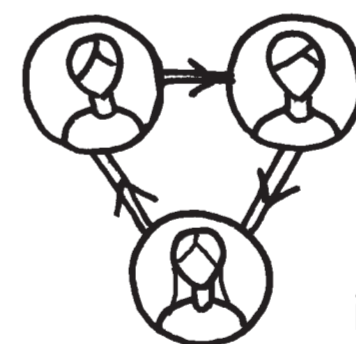
*The key reason behind vaccine hesitancy among PLHIV was the lack of awareness about the interaction of the vaccine with the immunity of the patient as well as its interaction with their existing medication. Also, there are various sources of misinformation exacerbated by the reach of social media. Hence a credible source of information is needed to be set up that is considerate of the special needs of the community.*



People living with HIV (PLHIV) are one of the most marginalised communities in India and represent over 2.1 million people (Parikh et al., 2021). The COVID-19 pandemic poses a significant threat to PLHIV's well-being, healthcare and livelihoods.

Although PLHIV has increased sanitary practices and ART (Antiretroviral Treatment) adherence, the nature of the pandemic poses greater risk to their wellbeing.

PLHIV would benefit from income and employment support and nutrient-rich food programs to alleviate financial drain and risk-taking. Mobile Vaccination Camps and including nutrient rich food distribution for PLHIV in vaccination camps have proved to be useful.

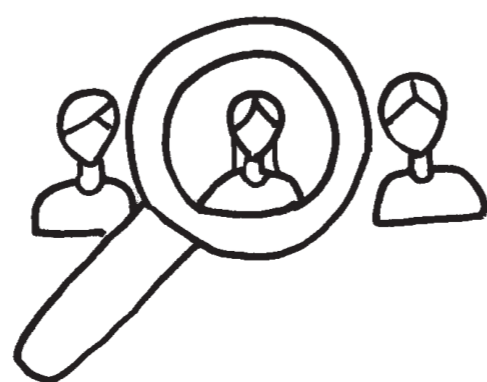
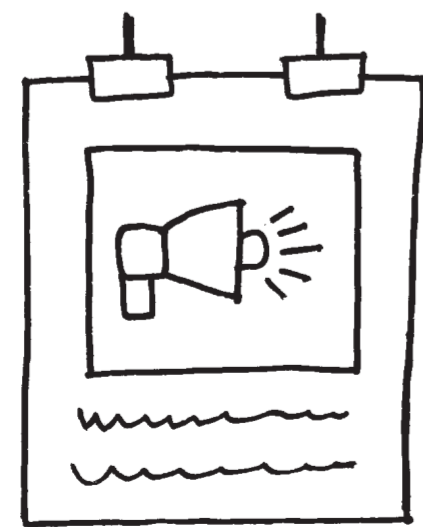
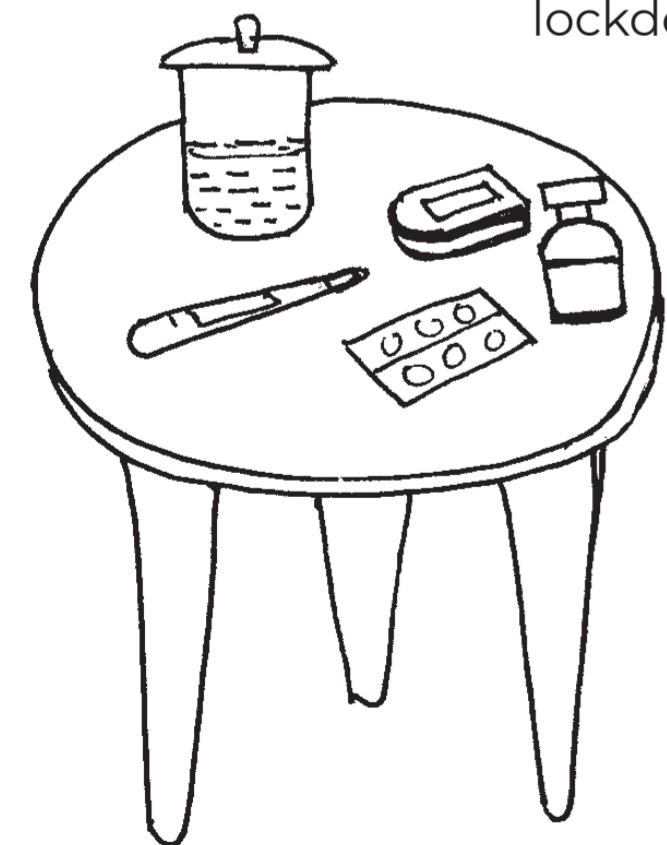


PLHIV face an identity crisis due to a lack of recognition and respect as to who they are in the community. PLHIV are deeply affected by the stigma and judgement that surrounds them in society. Therefore, it is necessary to reach out to PLHIV and offer psycho-social support. Telecare should be utilised to provide support to as many PLHIV as possible without putting them at risk and adding the burden of reaching healthcare centres. This approach should especially be utilised with hard to reach communities such as rural PLHIV. To be of maximum benefit, telecare should be free of cost, available 24/7, and advertised in target communities. Additionally, psycho-social support in the form of counselling should be offered at vaccination camps and mobile clinics. Moreover, psycho-social support should also be made available and accessible to PLHIV to address the stress, anxiety and confusion related to the vaccine.

# COVID-19 Vaccination for People Living with HIV



Access to medications should also be ensured in order to prevent a break-in PLHIV's treatment and/or having to find alternate (non-traditional) methods to procure medicines (Parikh et al., 2021). Medicine delivery should be made available for PLHIV, either at home or at meeting/collection points. But for some PLHIV, at-home delivery has posed problems due to privacy concerns but PLHIV has been enabled to take home three months' worth of Antiretroviral Therapy (ART), which has been of great support to them during periods of strict lockdowns.



Key aspects to be addressed in the COVID-19 response for PLHIV should include food security and livelihoods. It is important to protect this marginalised group from engaging in risky and dangerous behaviour to create livelihoods, such as prioritising work over healthcare. Therefore, support in the form of grocery and basic necessity distribution for marginalised PLHIV should be provided to support their safety, well-being, regular medication uptake and healthcare-seeking behaviour. Moreover, PLHIV would benefit from income and employment support to alleviate financial drain and risk-taking and promote health. Moreover, as many among the PLHIV work in the informal sector, resources regarding and information about exploitation should also be provided. The Vaccination Camp is a good place to initiate this conversation.

The incidence and severity of HIV infection and opportunistic infections (illnesses that occur more frequently and severely in PLHIV) such as tuberculosis, pneumonia, and Wasting Syndrome are significantly determined by nutritional status and in turn, have severe nutritional consequences. Good nutrition improves the quality of life, supports anti-retroviral therapy, and assists to maintain lean body mass. PLHIV should be enabled to have and maintain healthy diets to ensure adequate energy, micronutrient, and macronutrient intake. PLHIV often require additional vitamins and minerals (such as Vit A, B, C, E, Zinc) to support and strengthen the functioning of the immune system, which should be ensured through a well-balanced diet fortified with nutritional supplements.

# COVID-19 Vaccination for Transgender and Non Binary People

To reduce vaccine and COVID treatment hesitancy, it is important to ensure that the vaccination sites and quarantine centres are welcoming and safe for the TGNB community. It is advised to have healthcare workers there that have undergone sensitisation training on how to provide adequate care to the marginalised TGNB community. They should also be trained to provide care for the additional health needs the TGNB community may have when they come to the sites and centres (e.g., **gender-affirming care**).

## Findings

### Societal and health:

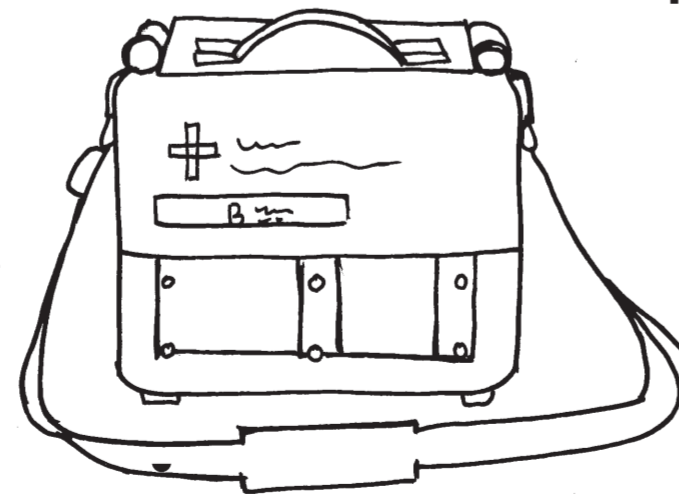
- ⌘ "Second" priority, stigma, social disconnection
- ⌘ Victimization from the traditional social stereotyping,
- ⌘ "Third gender" based discrimination,
- ⌘ Associated factors like poverty and administrative apathy,
- ⌘ Increased dependency and segregation based on age (Banerjee, D., & Rao, T. S., 2020)

### Based on interviews:

- ⌘ High HIV prevalence
- ⌘ Barriers in access to care- fear of persecution, disrespectful care, digital divide
- ⌘ Institutional inequity- distrust, previous adverse experiences

### Learnings:

- ⌘ Most people who don't work with the community don't think about the fact that either the IDs are not available or there is a lot of sensitivity towards \*deadnaming.
- ⌘ The visual and name difference between IDs was also found to be a deterrent in accessing services.
- ⌘ Ensuring that individuals know that this would be a friendly place both during mobilisation and that all volunteers and health care providers are sensitised was key



### Tool kit-

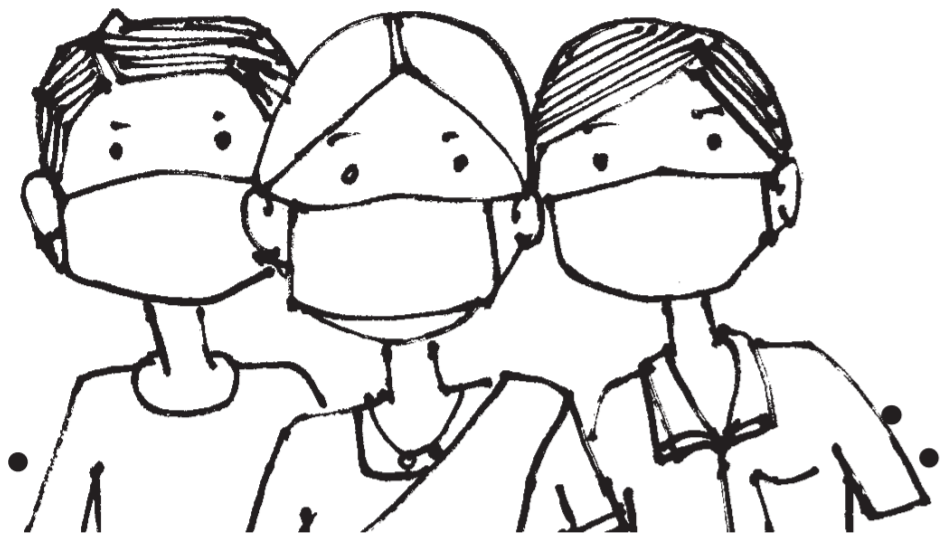
- ⌘ Covid Vaccination and HIV | Trust the Facts, Let's get vaccinated by Safe Access | Kannada
- ⌘ Clinician sensitisation for providing gender affirming care | Kannada
- ⌘ Clinician sensitisation for providing gender affirming care | English

\*Deadnaming is the use of the birth or other former name (i.e., a name that is "dead") of a transgender or non-binary person without the person's consent.

### How to encourage TGNB community for vaccination?

- ⌘ Explain the risk of not getting vaccinated
- ⌘ Interact with the 'gurus' or leaders of the gharanas/ families they are part of. As once the guru is convinced, it is high chance (90%) that other members also get convinced.
- ⌘ Address their concerns regarding HIV, hormone therapy, drugs and alcohol.
- ⌘ Use community based organisations that have built trust capital with the community to mobilise individuals
- ⌘ Consider special camps or special timings to ensure a safe space free of stigma and positive experience

# COVID-19 Vaccination for Transgender and Non Binary People



## Transgender and Non-binary community (TGNB)

### Background and problem statement

- ⌘ Transgender and Non-Binary (TGNB) community, have been exceptionally affected by the pandemic in several ways:
- ⌘ **risk** of exposure to the virus and its adverse outcomes,
- ⌘ delays in access to **gender-affirming care** (the processes through which a health care system cares for and supports an individual, while recognizing and acknowledging their gender identity and expression)
- ⌘ **diminished access** to social support, which is crucial to protecting against the effects of stigma and discrimination.

Source: Columbia Psychiatry, 2020

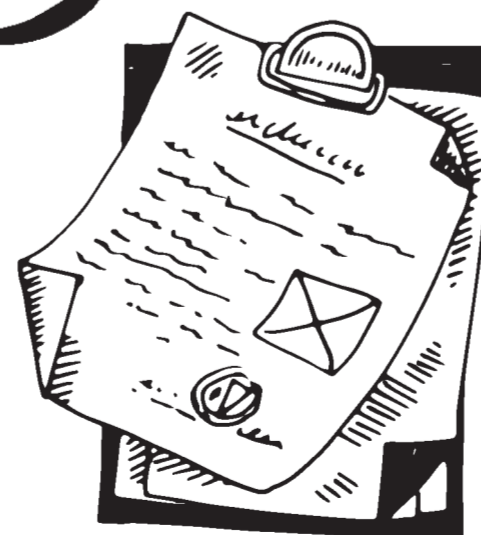
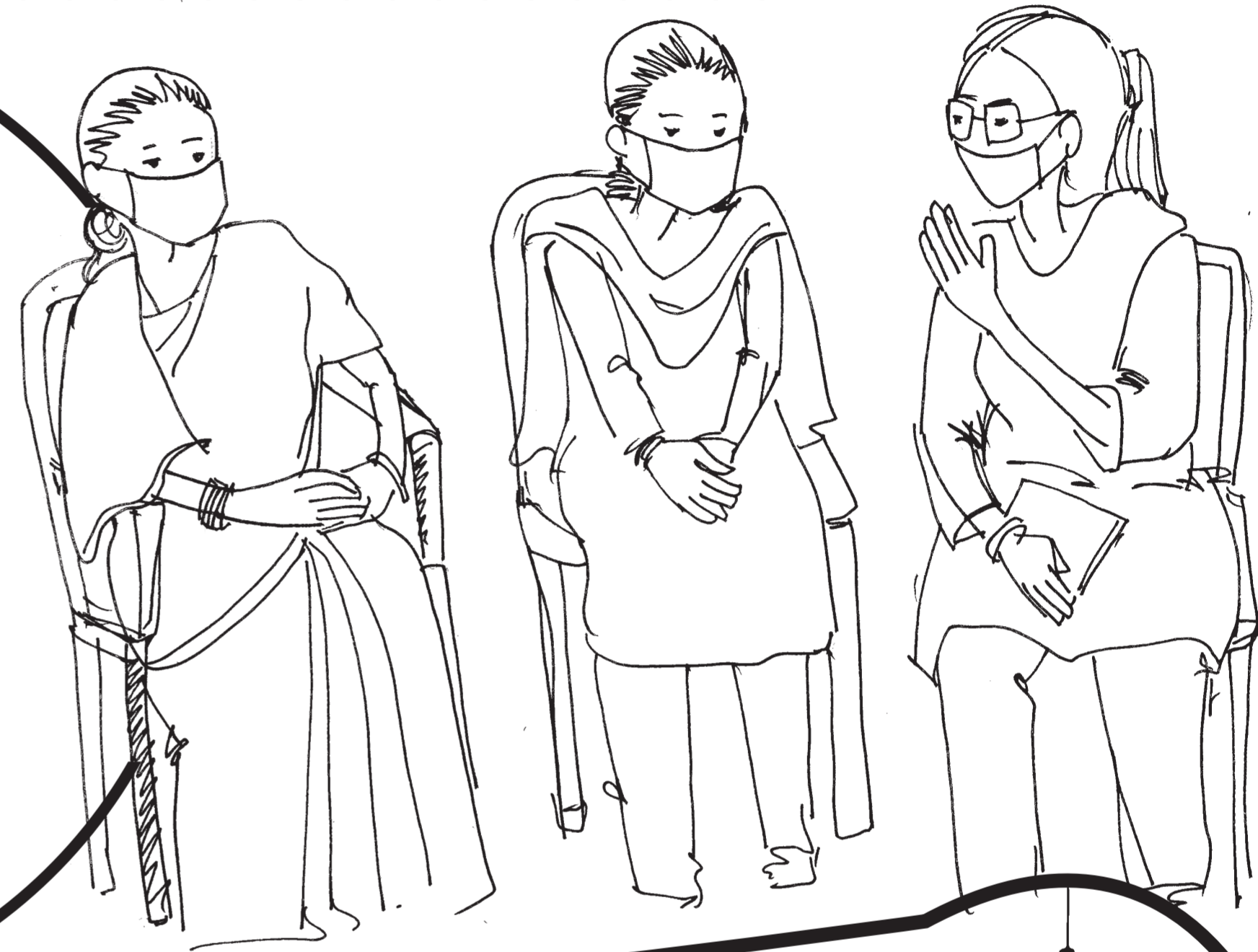
### Other delivery side gaps:

- ⌘ Very poor vaccine utilisation rates, ID and registration issues (ex. name and photo mismatch) CoWin app (operational inefficiencies)

## How to help?

### How to gain trust

- ⌘ Respecting the names and pronouns of others
- ⌘ Gharana- value gender behaviour, expressions, attitudes and emotions
- ⌘ Peer and community support
- ⌘ Develop tools for sensitising providers on addressing individuals, for e.g. - sensitize healthcare individuals and volunteers on how to address non-availability of IDs, visual and name differences between IDs. (Watch: How to address a transgender person respectfully)



### What are the key tips to keep in mind while organizing the vaccination camp for TGNB community?

- ⌘ Ensure the leaders are convinced about the vaccination and not hesitant.
- ⌘ Ensure the camps are organized in a nearby location.
- ⌘ Organize a camp suitable for 100-200 people, not a large camp
- ⌘ Avoid early morning camps
- ⌘ Take support from community organizations for smoother mobilization process
- ⌘ NGOs should ask to understand what % of Trans people living in the state have been vaccinated and ensuring these rates are high.

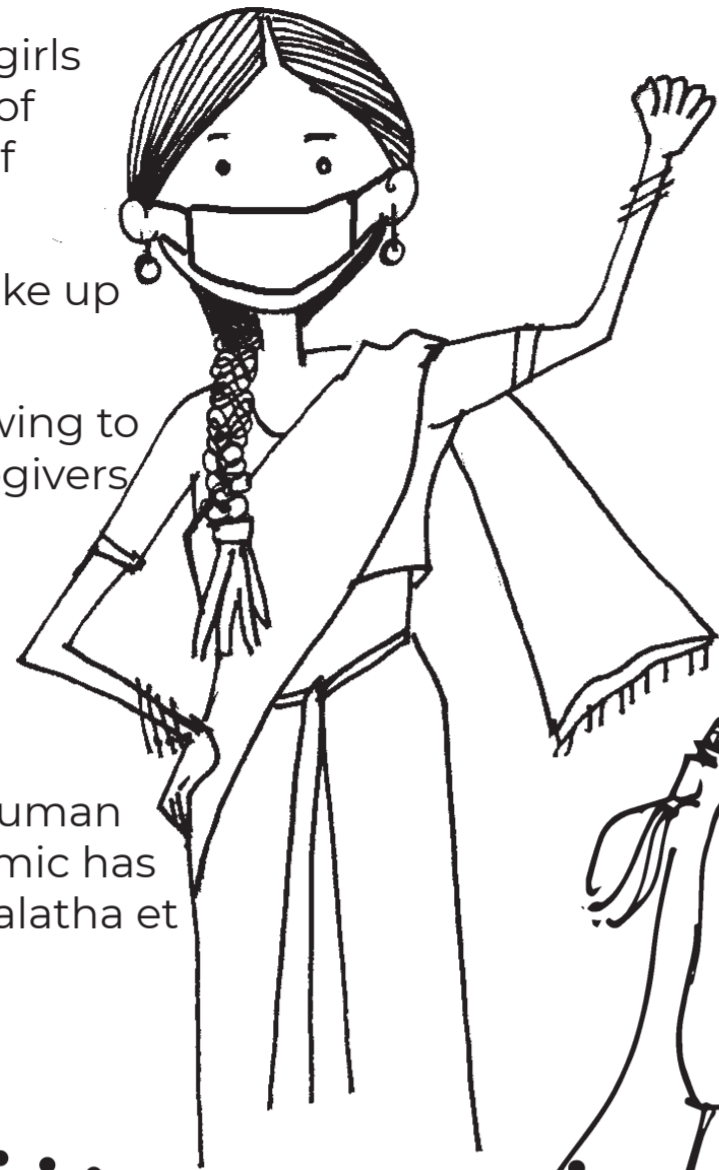




# Marginalised women

## Background and problem statement

- ⌘ Certain groups of women and girls may be at higher risk because of poverty, poor access and lack of information and resources,
- ⌘ Indian Nurses and midwives make up about 80 percent of HCW (UN)
- ⌘ More susceptible to exposure owing to their presence as front line caregivers and workers in the health and service sectors
- ⌘ "Being least organised and lacking institutional support, domestic workers are extremely vulnerable to exploitation and human rights violations, and the pandemic has aggravated the situation." (Sumalatha et al., 2021)



# COVID-19 Vaccination for Marginalised Women

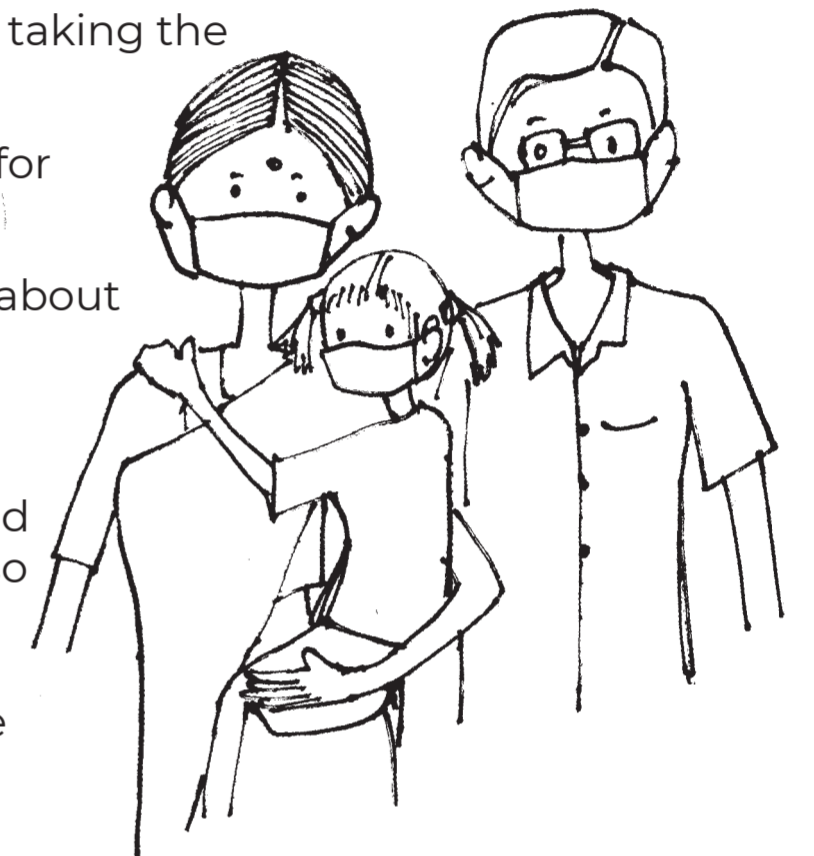
## How to help?

### How to gain trust

- ⌘ Vaccination camps should have a separate section for women with screens to make them feel more comfortable adjusting their attire whilst taking the vaccine.
- ⌘ Population specific vaccination camps (for trans, women, sex workers),
- ⌘ training of camp staff to sensitize them about gender issues

### How to advocate

- ⌘ Engage with Self Help groups (SHGs) and CBOs to spread more awareness and also tackle certain stigmas, apprehensions and fears about the vaccine. Proper education should be provided about the effects from the vaccination.



## Findings

### Delivery side gaps:

- ⌘ Poor operationalisation of Co-WIN
- ⌘ ID discrepancies for migrant women
- ⌘ reliance on their partners or male relatives for phones creating logistic difficulty
- ⌘ poor digital knowledge and access to devices
- ⌘ barriers in access to care due to gender gaps and lack of decision making

### Migrant women and factory workers face even more challenges such as :

- ⌘ lack of sanitation measures
- ⌘ lack of grievance mechanisms
- ⌘ poor facilities for women in the reproductive age
- ⌘ Inadequate investment in women's well-being-management is more reactive than responsive
- ⌘ Poor fabrication around women workers and well-being-no soap for hand wash

### How to increase uptake of vaccination?

- ⌘ Address their fears regarding the side effects of vaccination since most women (mothers) are afraid to fall sick which can impact childcare and in cases where they are employed and can lose daily wages/work.
- ⌘ Interact with leaders/head of religious and cultural groups and self-help groups as, they play a pivotal role in passing down the information to women members and can help convince them to get vaccinated.

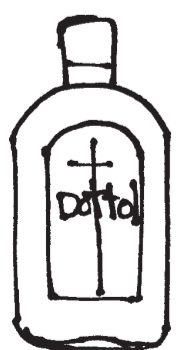
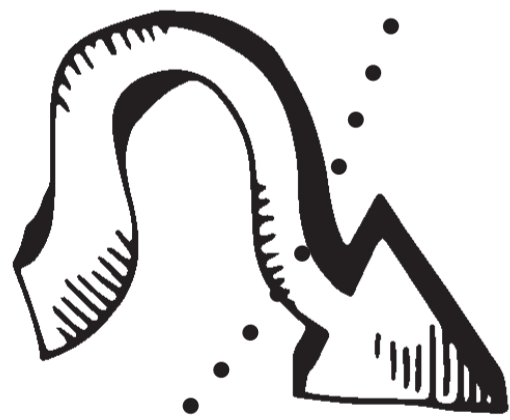
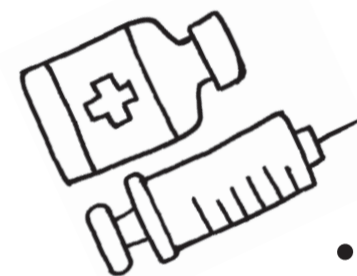
### How to mobilise

- ⌘ immunization sites or the mobile camps to be located closer from their homes
- ⌘ strategies of providing non-financial incentives such as ration for families (for days missed during vaccination)
- ⌘ Layering NCD screening and provision of ration kits, Provide-Home quarantine kits, provide post screening counseling about NCDs, etc, to improve access to ans experience of vaccination

Source: World Economic Forum

### What are the key tips to keep in mind while organizing the vaccination camps for marginalized women?

- ⌘ Ensure that the vaccinating area has privacy, make arrangements for screens and avoid conducting vaccination camps on open stages. Be respectful.
- ⌘ Guide the women who might not have the mobile phones or don't know how to use one to check for OTP messages.
- ⌘ Ensure the camp staff is trained and sensitized about gender issues
- ⌘ Ensure the camps are not too far from their homes and/or arrange for temporary creche



# COVID-19 Vaccination for People Living with Disabilities



## People living with disabilities

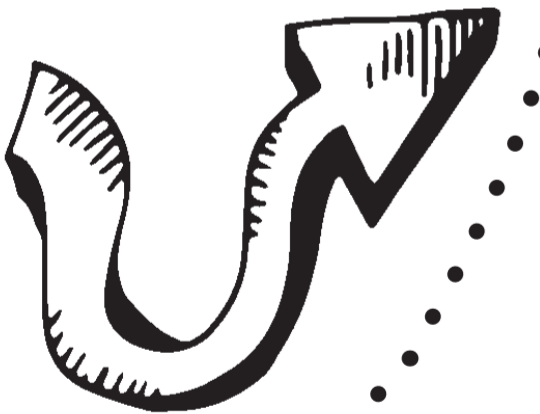
### Background and problem statement

- ⌘ In many communities, individuals with disabilities are at higher risk of infection, severe illness and even death from COVID-19 due to underlying medical conditions, mostly related to their primary disability.
- ⌘ Because disability is not listed as a priority risk group for vaccination, they are often left out from the eligible criteria causing a series of challenges:
  - ⌘ difficulty navigating systems to prove eligibility
  - ⌘ difficulty navigating systems due to limited mobility
  - ⌘ limited understanding of guidelines due to disrupted access
  - ⌘ inability to communicate challenges faced
- ⌘ For PwD, receiving inclusive and dignified care has always been a challenge and this difficulty to access healthcare has further exacerbated during this pandemic



## How to help?

- ⌘ Special provisions and mechanisms to vaccinate people living with disabilities
- ⌘ Track and create a list of PwDs in communities and conduct targeted vaccine drives.
- ⌘ Engage civil societies and organizations working for PwDs in awareness campaigns and mobilization efforts.
- ⌘ Conducting vaccine drives in locations accessible by the individuals from PwD community.
- ⌘ Targeted messaging to address specific concerns around vaccine hesitancy
- ⌘ Proper communication about vaccine drives to ensure communities get enough time to plan and attend the vaccination camps.
- ⌘ Specialised healthcare providers available at the centre/ campsite to cater to the specific needs of individuals with various types of disabilities.



## Findings



- ⌘ **Location of vaccination centers** have been the biggest challenge for PwD, especially for individuals with locomotor disabilities.
- ⌘ **Registration for vaccination** is a common problem for underprivileged PwDs who don't have a phone. **Unable to go and register physically**, makes the process more challenging for them.
- ⌘ **Inaccessibility of Co-win and Arogya Sethu** app is another challenge
- ⌘ **Families were sometimes reluctant** to take PwDs to vaccination centers, especially women members in rural locations
- ⌘ **Intersectionality among PwDs** - poverty, dalits, tribals, women etc. further amplifies the challenges in vaccinating these communities.
- ⌘ **Lack of knowledge** about the when and where of vaccination as well as whether they can attend the same camps as the general population
- ⌘ Myths and misconceptions leading to **vaccine hesitancy** among the PwD communities.





In our community, many members are not aware of COVID vaccines and it's benefits.

**VACCINES ARE FOR  
EVERYONE**

Scan the QR code to watch this video



When I received information about the vaccination camp for TGs, I was very happy and motivated two of my friends to come along. It was a well-organized camp with a humane approach. They gave correct and complete information about the vaccine and the post vaccine follow-up Clinic team was so empathetic that when I was unable to remove my long sleeve dress, they allowed me to go to a room nearby for privacy and the nurse gave the vaccine there only. Besides this, they provided a ration kit which sufficed my needs for the next twenty days. Post this, whenever I hear Swasti is organising a camp, I call all my contacts and ensure that maximum TGs are reached to the camp.

**Mx. Madhu**

*Member of the Transgender community, Bangalore*

I went to 3 different hospitals five times in the last two months. Every time they say either stockout or it is for 45 plus years. One time, I stood in queue and when I reached almost to the counter, they closed it saying that there was no more stock. I was dejected and decided that I will not waste my day's work for vaccination hunt and requested Janani madam in SMS (Swathi Mahila Sangha , a Community Organisation of Women in Sex Work) to support.

**Ms. Sindhu** (name changed), Sex worker



# Marginalised women

## Background and problem statement

- ⌘ Certain groups of women and girls may be at higher risk because of poverty, poor access and lack of information and resources,
- ⌘ Indian Nurses and midwives make up about 80 percent of HCW (UN)
- ⌘ More susceptible to exposure owing to their presence as front line caregivers and workers in the health and service sectors
- ⌘ "Being least organised and lacking institutional support, domestic workers are extremely vulnerable to exploitation and human rights violations, and the pandemic has aggravated the situation." (Sumalatha et al., 2021)



# COVID-19 Vaccination for Marginalised Women

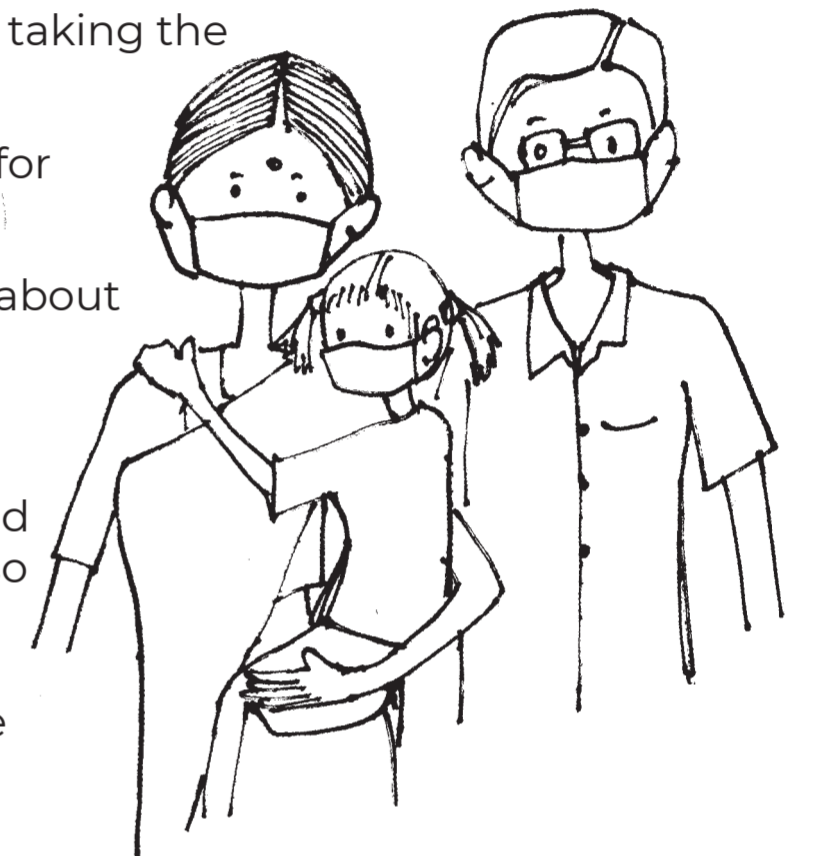
## How to help?

### How to gain trust

- ⌘ Vaccination camps should have a separate section for women with screens to make them feel more comfortable adjusting their attire whilst taking the vaccine.
- ⌘ Population specific vaccination camps (for trans, women, sex workers),
- ⌘ training of camp staff to sensitize them about gender issues

### How to advocate

- ⌘ Engage with Self Help groups (SHGs) and CBOs to spread more awareness and also tackle certain stigmas, apprehensions and fears about the vaccine. Proper education should be provided about the effects from the vaccination.



## Findings

### Delivery side gaps:

- ⌘ Poor operationalisation of Co-WIN
- ⌘ ID discrepancies for migrant women
- ⌘ reliance on their partners or male relatives for phones creating logistic difficulty
- ⌘ poor digital knowledge and access to devices
- ⌘ barriers in access to care due to gender gaps and lack of decision making

### Migrant women and factory workers face even more challenges such as :

- ⌘ lack of sanitation measures
- ⌘ lack of grievance mechanisms
- ⌘ poor facilities for women in the reproductive age
- ⌘ Inadequate investment in women's well-being-management is more reactive than responsive
- ⌘ Poor fabrication around women workers and well-being-no soap for hand wash

### How to increase uptake of vaccination?

- ⌘ Address their fears regarding the side effects of vaccination since most women (mothers) are afraid to fall sick which can impact childcare and in cases where they are employed and can lose daily wages/work.
- ⌘ Interact with leaders/head of religious and cultural groups and self-help groups as, they play a pivotal role in passing down the information to women members and can help convince them to get vaccinated.

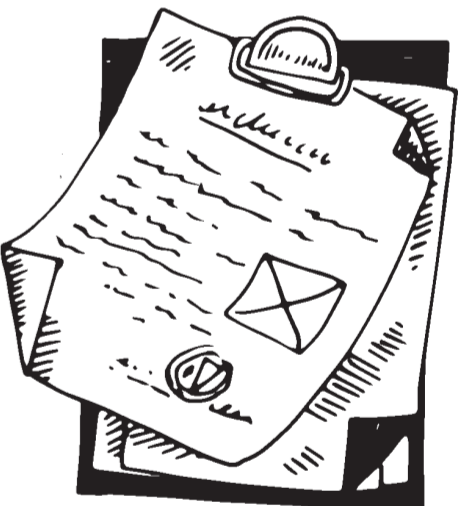
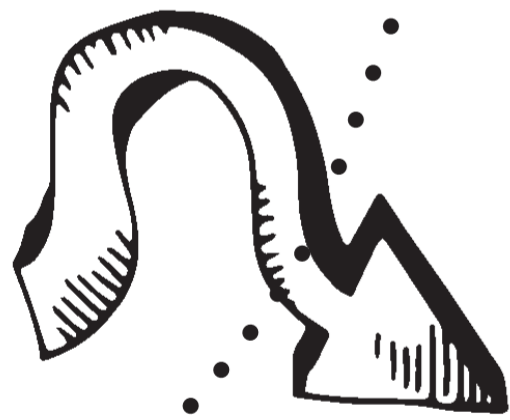
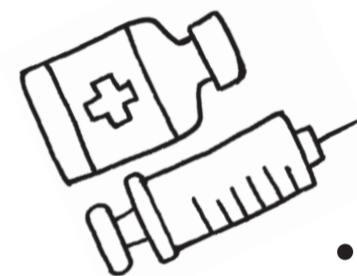
### How to mobilise

- ⌘ immunization sites or the mobile camps to be located closer from their homes
- ⌘ strategies of providing non-financial incentives such as ration for families (for days missed during vaccination)
- ⌘ Layering NCD screening and provision of ration kits, Provide-Home quarantine kits, provide post screening counseling about NCDs, etc, to improve access to ans experience of vaccination

Source: World Economic Forum

### What are the key tips to keep in mind while organizing the vaccination camps for marginalized women?

- ⌘ Ensure that the vaccinating area has privacy, make arrangements for screens and avoid conducting vaccination camps on open stages. Be respectful.
- ⌘ Guide the women who might not have the mobile phones or don't know how to use one to check for OTP messages.
- ⌘ Ensure the camp staff is trained and sensitized about gender issues
- ⌘ Ensure the camps are not too far from their homes and/or arrange for temporary creche



# COVID-19 Vaccination for People Living with Disabilities



## People living with disabilities

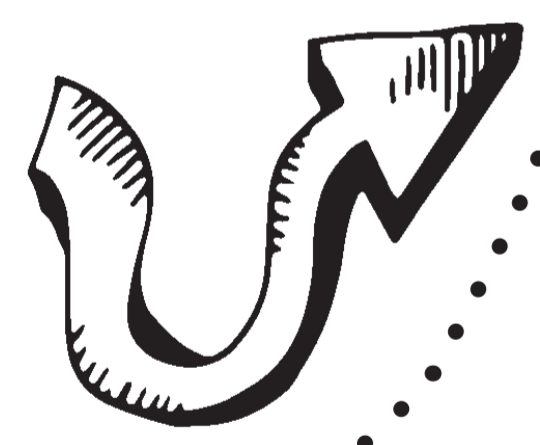
### Background and problem statement

- ⌘ In many communities, individuals with disabilities are at higher risk of infection, severe illness and even death from COVID-19 due to underlying medical conditions, mostly related to their primary disability.
- ⌘ Because disability is not listed as a priority risk group for vaccination, they are often left out from the eligible criteria causing a series of challenges:
  - ⌘ difficulty navigating systems to prove eligibility
  - ⌘ difficulty navigating systems due to limited mobility
  - ⌘ limited understanding of guidelines due to disrupted access
  - ⌘ inability to communicate challenges faced
- ⌘ For PwD, receiving inclusive and dignified care has always been a challenge and this difficulty to access healthcare has further exacerbated during this pandemic

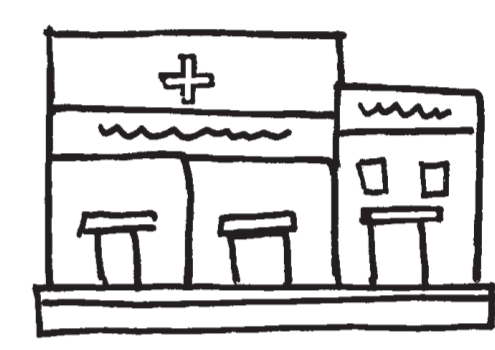


## How to help?

- ⌘ Special provisions and mechanisms to vaccinate people living with disabilities
- ⌘ Track and create a list of PwDs in communities and conduct targeted vaccine drives.
- ⌘ Engage civil societies and organizations working for PwDs in awareness campaigns and mobilization efforts.
- ⌘ Conducting vaccine drives in locations accessible by the individuals from PwD community.
- ⌘ Targeted messaging to address specific concerns around vaccine hesitancy
- ⌘ Proper communication about vaccine drives to ensure communities get enough time to plan and attend the vaccination camps.
- ⌘ Specialised healthcare providers available at the centre/ campsite to cater to the specific needs of individuals with various types of disabilities.



## Findings



- ⌘ **Location of vaccination centers** have been the biggest challenge for PwD, especially for individuals with locomotor disabilities.
- ⌘ **Registration for vaccination** is a common problem for underprivileged PwDs who don't have a phone. **Unable to go and register physically**, makes the process more challenging for them.
- ⌘ **Inaccessibility of Co-win and Arogya Sethu** app is another challenge
- ⌘ **Families were sometimes reluctant** to take PwDs to vaccination centers, especially women members in rural locations
- ⌘ **Intersectionality among PwDs** - poverty, dalits, tribals, women etc. further amplifies the challenges in vaccinating these communities.
- ⌘ **Lack of knowledge** about the when and where of vaccination as well as whether they can attend the same camps as the general population
- ⌘ Myths and misconceptions leading to **vaccine hesitancy** among the PwD communities.



# Closing Note

Dear Colleagues and Well-wishers,

Despite deep personal challenges and profound losses this year, the leaders and teams in community institutions across the country have risen up to the challenge, not only survived but many have thrived. In course of all the work done collaboratively in partnership across diverse sectors towards last mile COVID-19 vaccination, we learnt critical lessons. We made several mistakes, made amends in tight loops together with the communities, where our teams consciously and deliberately went above and beyond their call of duty.

Communities taught us what they needed, and together we found ways to respond in their hours of need. We adapted, we adopted, we “made-do” with resources we had.

From addressing vaccine access and hesitancy, to scaling primary health to the last mile using digital technologies, to ensuring food rations and life saving medicines and oxygen concentrators - we innovated, demonstrated, scaled and influenced all the while showcasing evidence.

I cannot begin to describe the gratitude I feel for our communities and existing partners who backed us up and new partners who stepped up to the challenge. This Playbook is a LIVE document and a testament to all that was made possible in the hour of need - only because everyone - including you, dear colleague, came together in partnership with communities and frontline workers to take COVID-19 vaccination to everyone.

Because #VaccinesR4Every1.

For all that is to come, this Playbook is a prototype on the What, Why and How To. And for any other question that you may find unanswered, we are just an email or a tweet away.

**Dr. Angela Chaudhuri**

*Partner*

*Swasti, The Health Catalyst*



@angelachaudhuri



# References

[SOP for COVID-19 Vaccination of Persons without Identity Card](#)

[COVID19VaccineOG111Chapter16](#)

[Standard Operating Procedure - template](#)

[Report template - NHSI website](#)









*Conceptualised and designed by:* **The Pen & Mouse, Bangalore**  
*Illustrations by:* **Shilpa B Hali**  
*Photos by:* **Satish VM (Kamerakirriks)**  
*Printed at:* **GP Solutions**