



The COVID-19 Vaccination Playbook



#COVID
ActionCollab

 **Swasti**
THE HEALTH CATALYST

With Support From



The
ROCKEFELLER
FOUNDATION

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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





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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.”

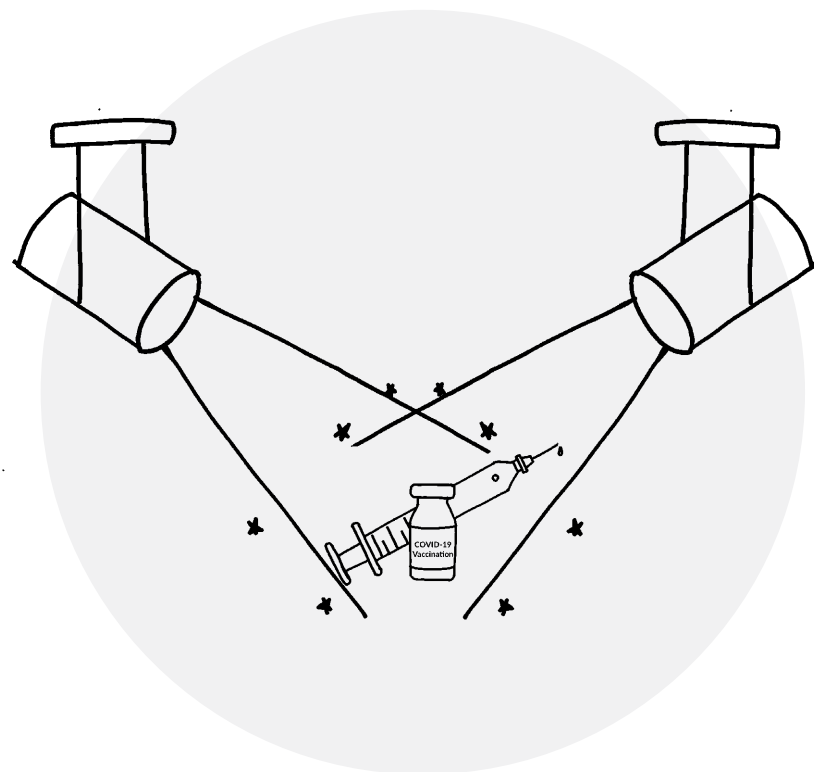
Character

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.



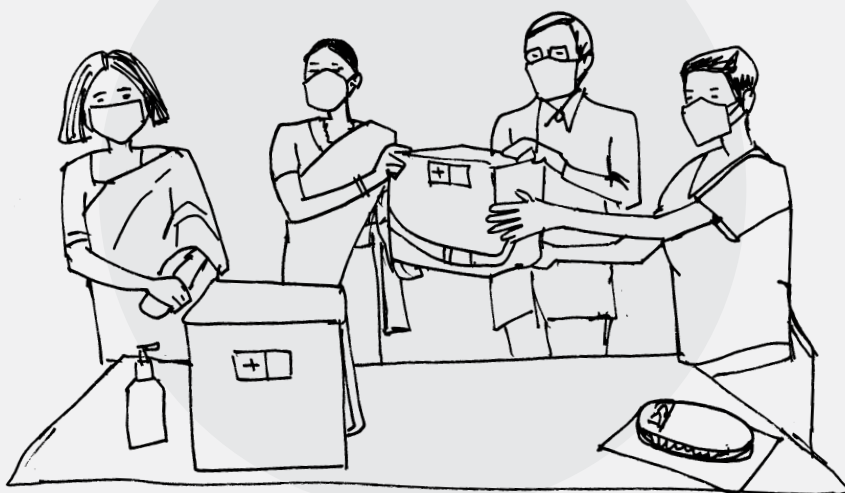
Covid-19 is a monumental event as for the very first time in the history of Indian healthcare there has been a need to prioritise vaccinations above all else on such a large scale.

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.

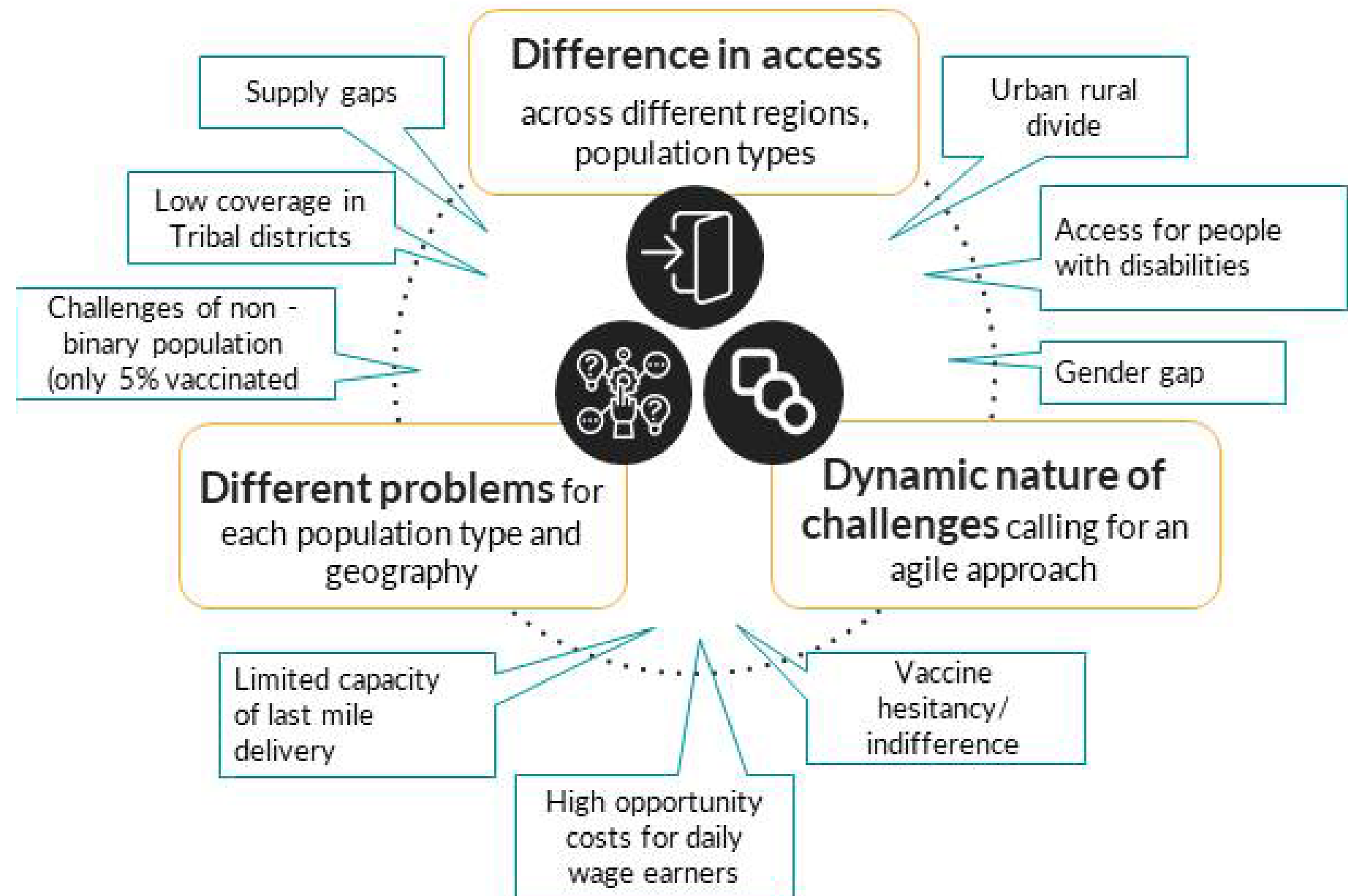
A large proportion of the population needs protection and access but also special considerations and an enabling environment for that access to be experienced.

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

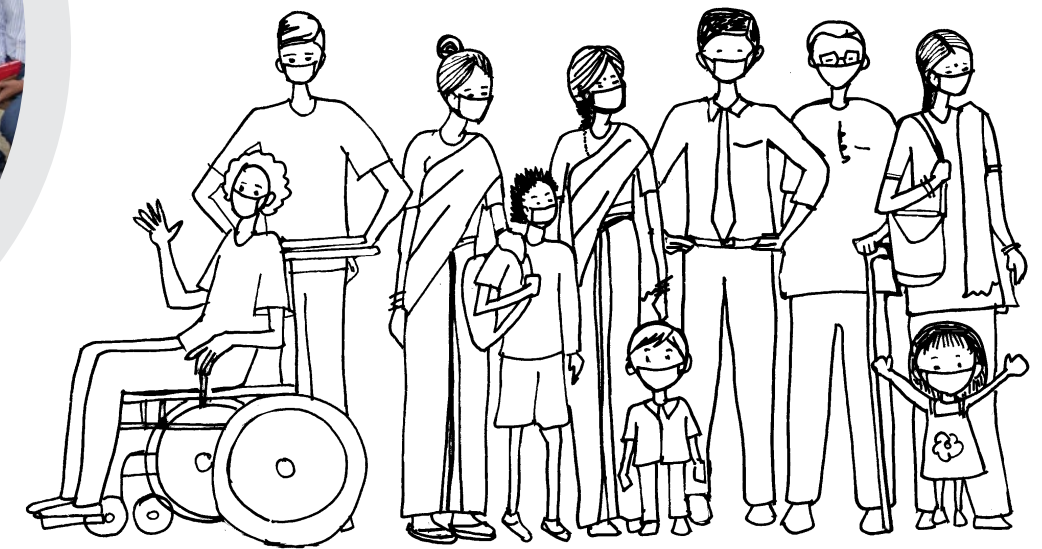
Definition of community representative

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).



Nothing for us without us



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



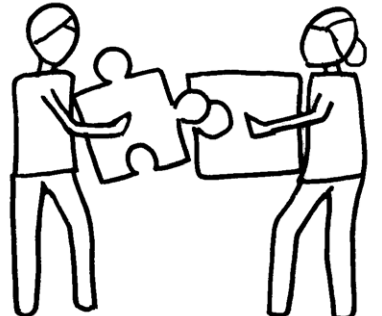
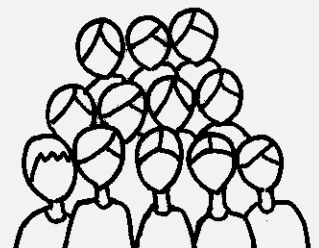

Situationally aware camp management:

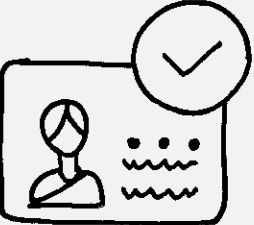

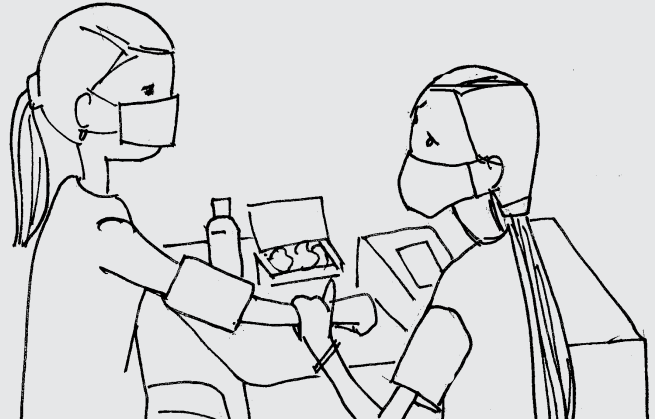
Anticipate interference and disturbances and have community leaders and senior managers at hand who can handle issues as they come up.


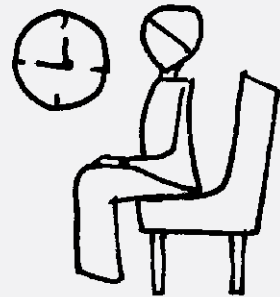



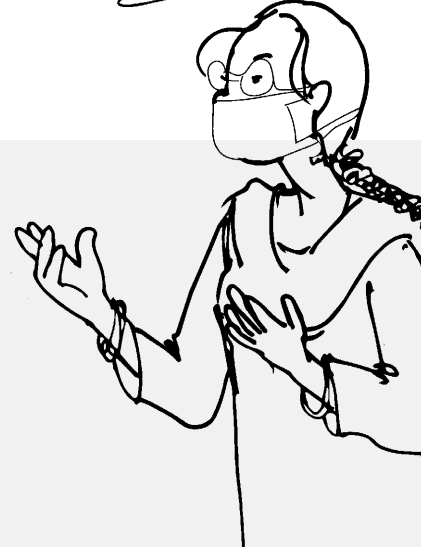
Security: Using or alerting local police or other security agencies during large camps is key to ensure safety of staff and beneficiaries.

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

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

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

Places

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

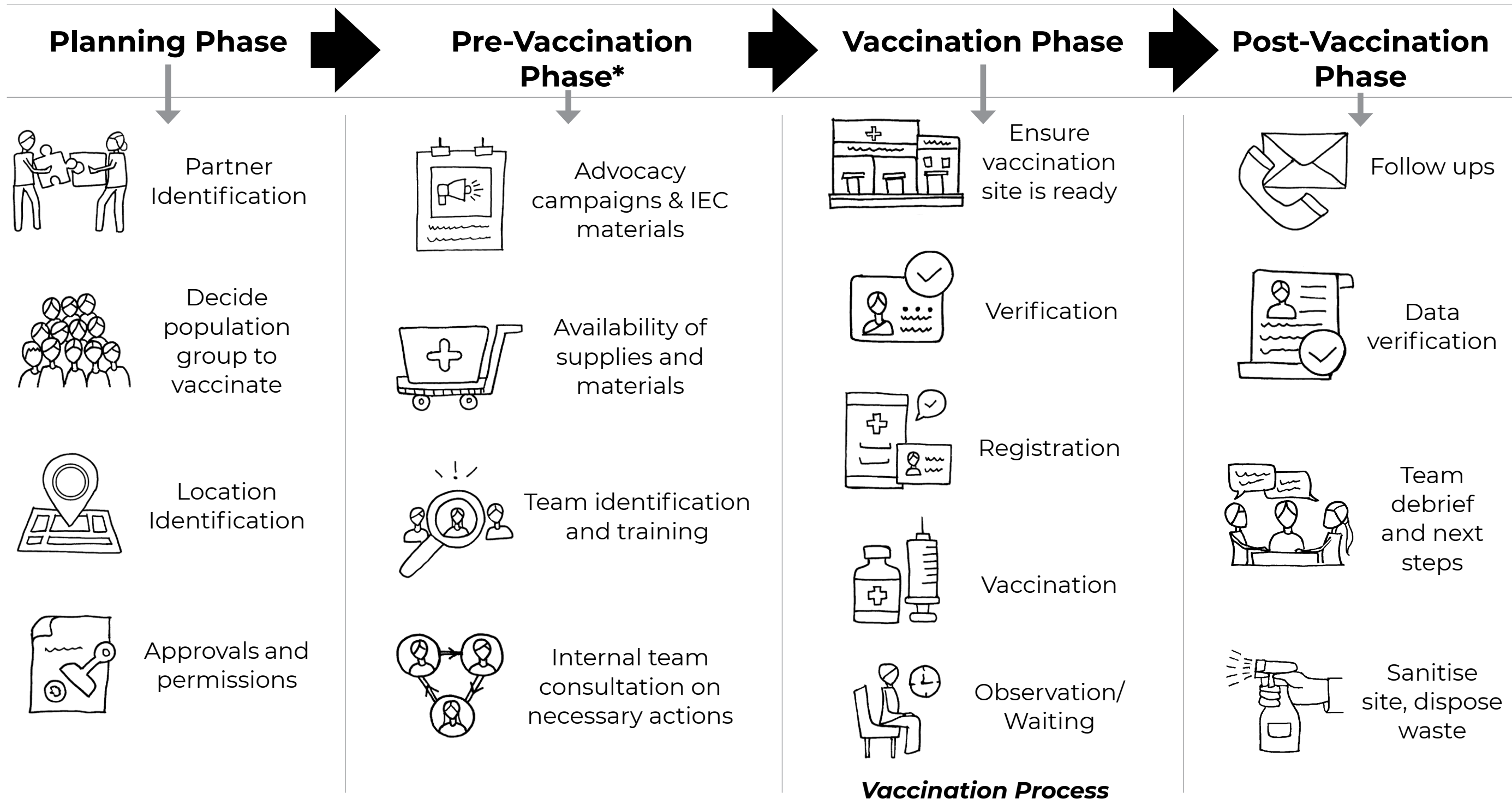
- ♦ In partnership with community representatives, choose the location of the vaccination centre that is most convenient and safe for them.
- ♦ The centre should also have an accessible drinking water facility, medical care, privacy curtains and washroom.
- ♦ If the centre is not within minimal walking 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

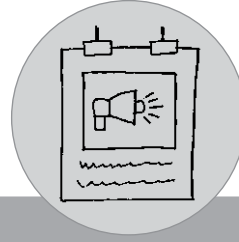


*Listed activities doesn't have to occur in same sequence and can even occur simultaneously



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

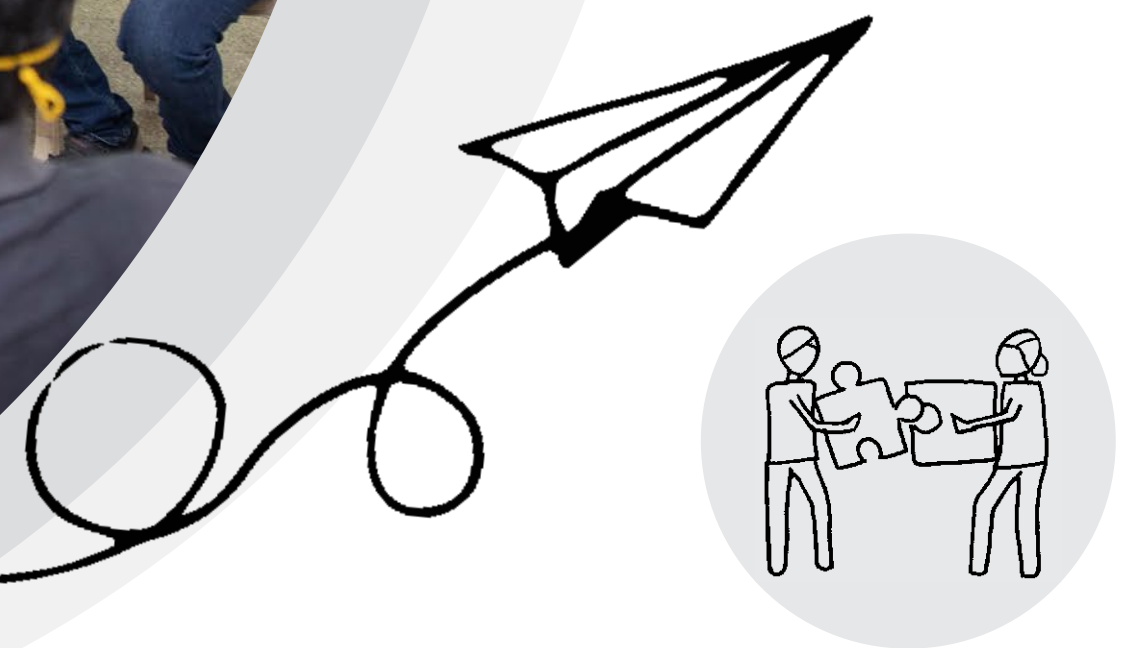


Post- Vaccination Phase

- ♦ 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







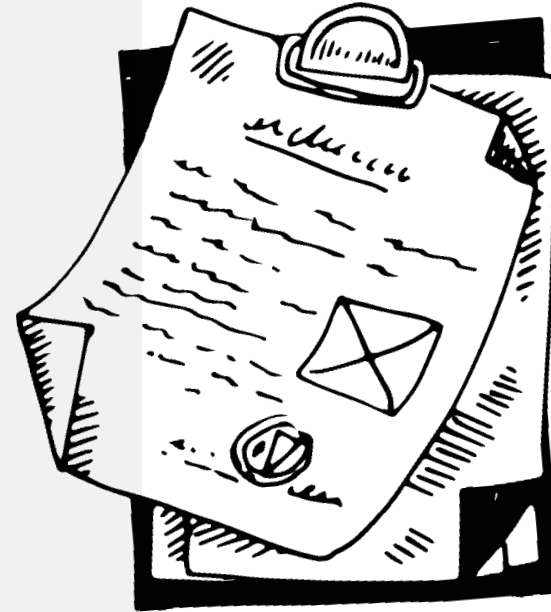
ACT 1 - SCENE 1

THE PLANNING PHASE

Planning Phase

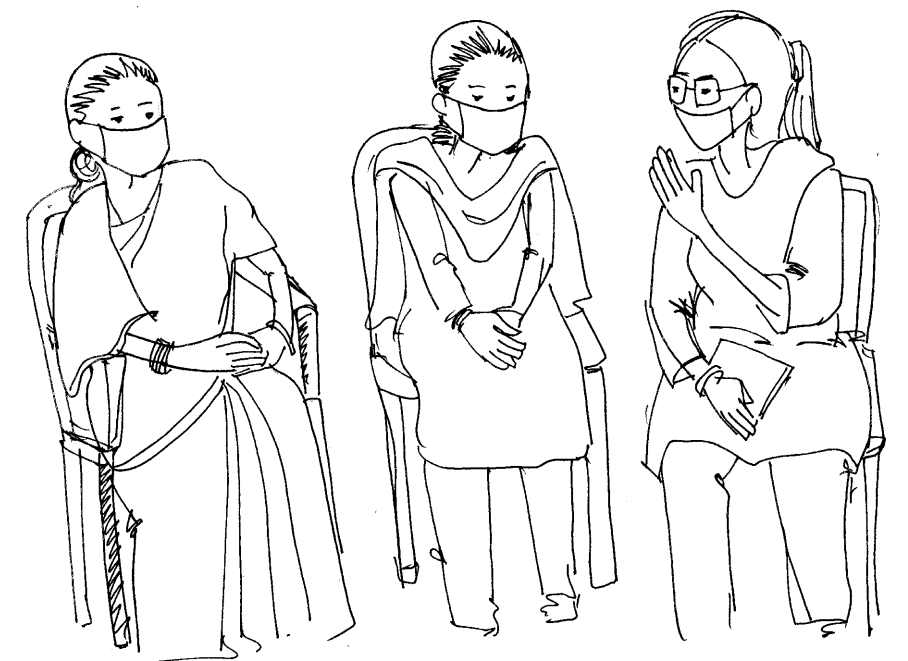
1. PARTNER IDENTIFICATION - Identify collaborating partners to conduct the drive

- 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



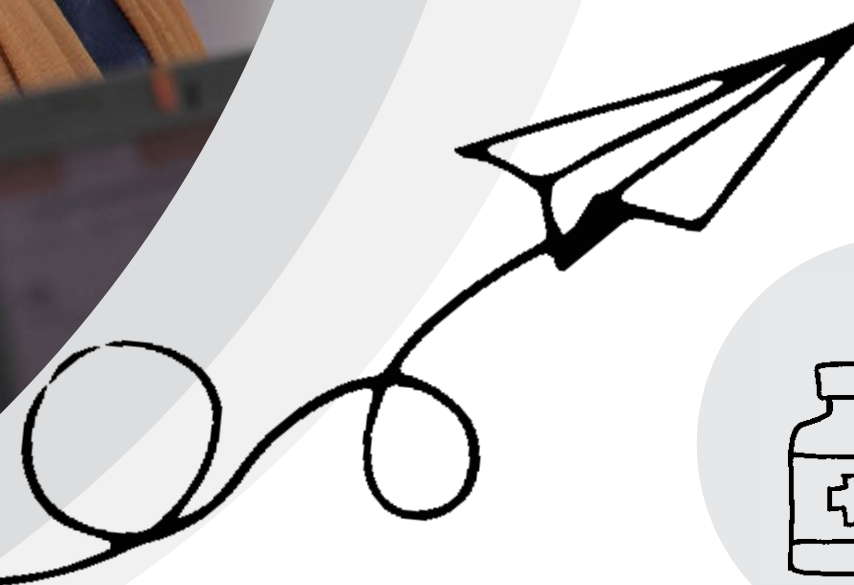


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We identified and targeted the willing members first. We addressed accessibility issues by making the vaccination process more mobile and shifting them to their locations to ensure that they get vaccinated. These community champions are our partners! 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.

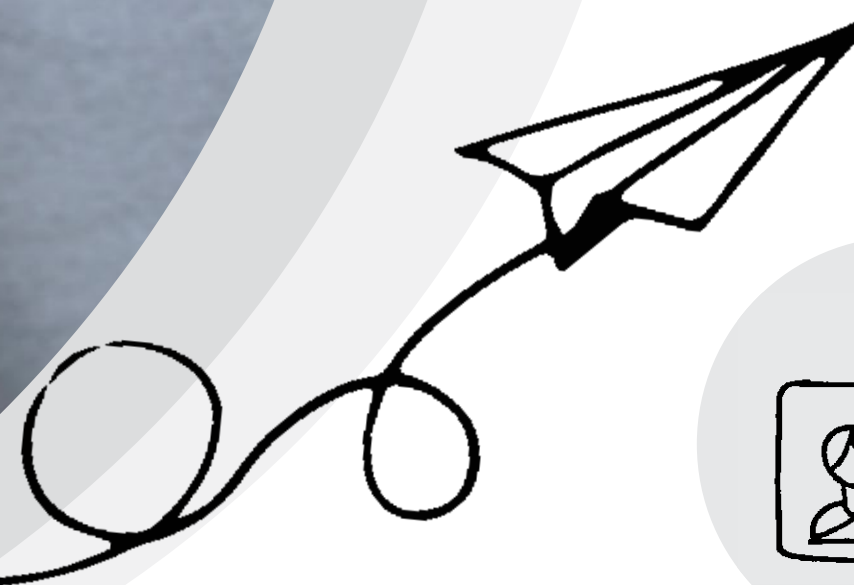
2. ENSURE THE SITE IS READY - Prepare the facility to ensure the following things:

- 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 colocating 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.

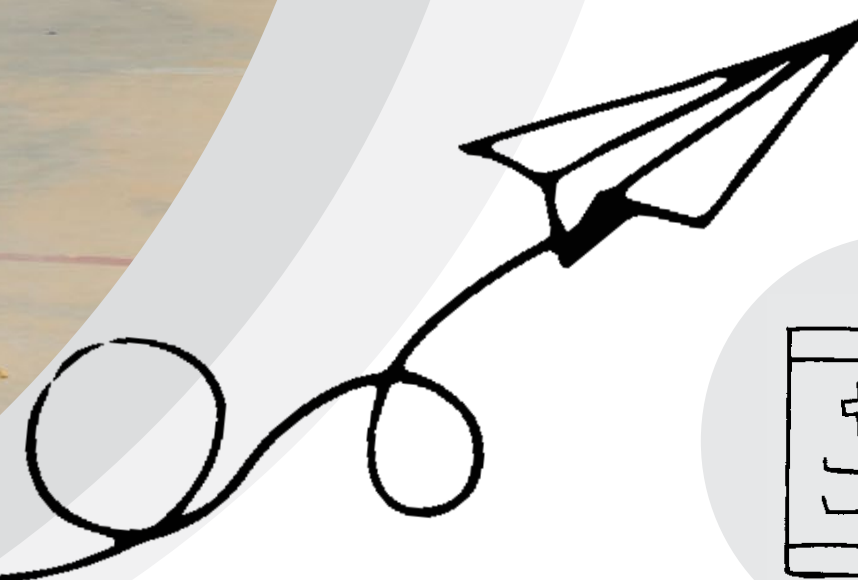
A Cooperative on the other hand is a legal entity - it is an autonomous / self governed association of persons who come together voluntarily to meet their common economic, social,

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.

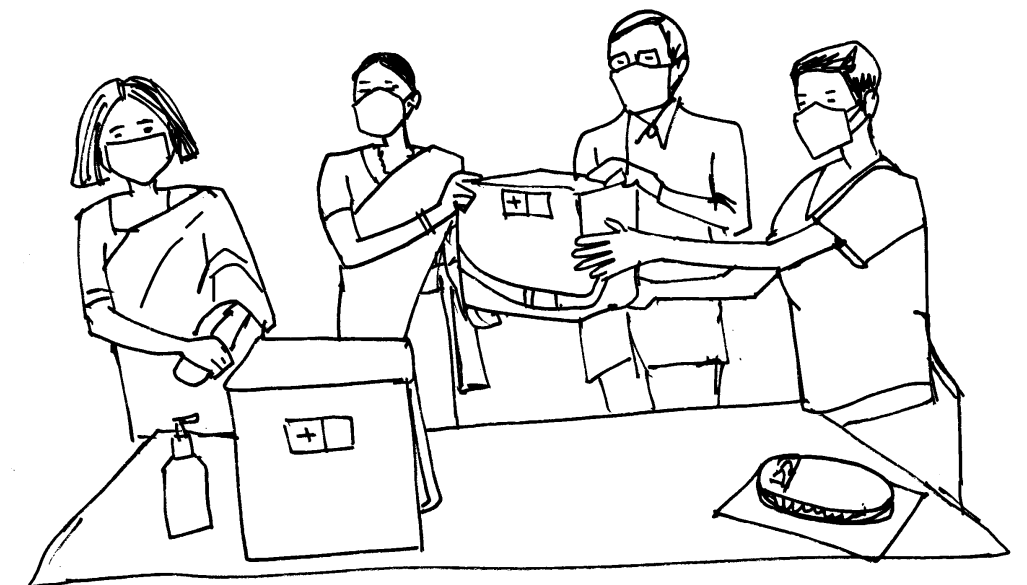
07

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.

Pull Out Pages

Working Around Stigma



COVID-19 Vaccination for People Living With HIV



COVID-19 Vaccination for Transgender and Non Binary People





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



**COVID-19 Vaccination for
Marginalised Women**

**COVID-19 Vaccination for
People Living With Disabilities**

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

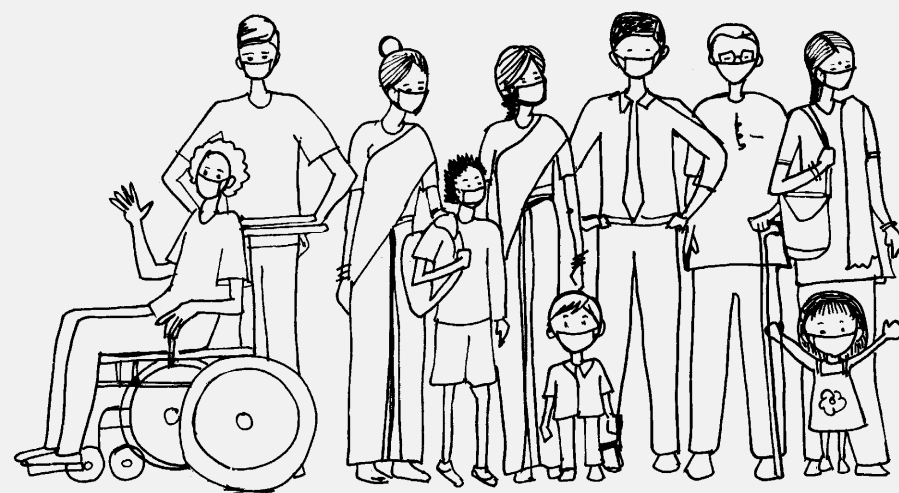
SOP for COVID-19 Vaccination of Persons without Identity Card

COVID19VaccineOG111Chapter16

Standard Operating Procedure - template

Report template - NHSI website







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