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The challenges of our vaccination drive’s final stretch

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To quicken the pace of covid vaccination and its equitable distribution, we are working with over 500 Primary Healthcare Centres (PHCs) across 12 states. By end October, our effort will scale up to over 3,000 PHCs across some 20 states, helping serve about 100-120 million people in a wide range of geographies—from districts with predominantly Tribal populations to blue-tarpaulin slum settlements in metros. From these frontlines of India’s vaccination drive, here is a brief report of problems that hobble this all-important programme.

But first, a look at some that have misled some of us or been overemphasized.

The notion that public officials lack in dedication and hard work is flawed. From frontline nurses and medical officers to block, district and state level officers (and ministers), most are working as though this is a matter of life and death, as it is.

Vaccine hesitancy is less common and not as intransigent as often imagined. A common error is conflating unwillingness to get vaccinated for good reasons with hesitancy driven by unfounded fears and beliefs. The former needs to be addressed by resolving the relevant issues. The latter needs personal dialogue with a locally-credible individual who has been vaccinated.

Infrastructure to deliver vaccines is mostly adequate—cold chains, transportation systems and small tools like hub-cutters.

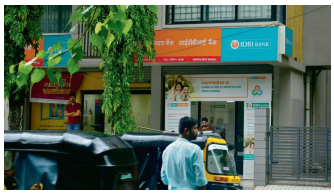
Now, let’s take up the problems that persist and are increasingly becoming bottlenecks as vaccine supply has improved.

The number of vaccinators is inadequate in remote rural areas, difficult terrains and slum settlements in large cities. Overall, our experience is that 20% places are facing shortages.

Over 90% places have multiple and substantial problems to do with data. First, with patchy net connectivity, entering each individual's data for vaccination into the computer system is a herculean task. Checking documents, creating or searching for registration, and then keying in information, with a snails' pace net, makes data handling the primary job, rather than vaccination. In a large number of places, data is noted down in a register because vaccination camp sites have no connectivity, and then uploaded into the system at a local PHC in the evening. Dedicated staff for handling data is scarce, and so vaccinators must willy-nilly handle this too, which reduces their capacity to vaccinate and adds to their stress.

Second, the data in the system does not have the addresses of individuals vaccinated. Picture this: A PHC is handling the vaccination of a population of 50,000 across 20 villages and a small town. The system tells them that 28,000 are vaccinated with a first dose. Their names, ages, identity document references and phone numbers are there, but where these 28,000 people live—across those habitations and beyond—is not available. How can any planning be done to cover the other 22,000? And how do you reach out with second doses for those 28,000?

PHC staff often make a few hundred calls a day to figure out locations, but usually to no avail. Phone numbers are inaccurate, people don't respond, and connections are poor. This example is an oversimplification. In most cases, our PHCs don't have accurate data on the overall population to be vaccinated. So, in reality, the PHC in the example does not know for sure whether it needs to cover 50,000 or much less or more, and where these people live.



Premium

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The underlying assumption of this entire system design is that people will, of their own accord, come and get vaccinated—and no effort will be required to reach out to people systematically. The first few months have made it clear that this is a faulty premise. Systematic, persistent and large-scale efforts have to be made to reach vaccines to people. So, the absence of the place-of-residence data and accurate population numbers is causing chaos as the country tries to achieve complete coverage.

One indicator of this is that second-dose coverage is running about 25% short of what it should be. With each passing week, granular planning is becoming more important. In that same example, four months ago none of the 50,000 was vaccinated. So, you could go pretty much anywhere and vaccinate people. But now you have to know the locations of those 22,000 who are still unvaccinated and of the other 28,000 for their second dose, to be able to plan the rest of the exercise.

The last big problem is the absence (or skeletal existence) of on-the-ground teams to mobilize local populations to get vaccinated. Such teams need to play many crucial roles, such as assessing the obstacles to vaccination, working out the convenience of people, addressing fears, disseminating reliable information, coordinating work at camps, and more. In essence this is the engine that must generate and match ‘demand’ to supply.

Exacerbating all these matters is a lack of capacity for planning and programme management at our PHCs. Achieving every additional 10 million first doses and timely second doses is becoming increasingly difficult in the absence of sufficient last-mile planning and management of delivery, which must be matched by demand-mobilization efforts.

We may soon be awash with vaccine supplies, but we will not know who these have to be delivered to, when and where, and how to make it happen. The last 25% of the country will be the hardest, and most of them would be the most vulnerable and disadvantaged. A few, but too few, states are acting systematically on all this. If we don’t rapidly improve our on-the-ground execution, it may well be a year before India is fully vaccinated.

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