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Bringing the Covid-19 Vaccine to Every Hamlet: The Story of Raigarh

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Abstract

India has achieved better Covid-19 vaccine coverage than most other countries in its income class, aided mainly by domestic production capacity and the government's decision to offer the vaccines to the adult population for free. There are stark sub-national differences, however, in the pace and coverage of the vaccine rollout. This special report tells the story of the district of Raigarh in Chhattisgarh—one of

the low-income, Empowered Action Group (EAG) States in India. Raigarh succeeded in quickly vaccinating a majority of its population as soon as the doses were made available, primarily through strategies such as cross-sectoral collaborations and socio-culturally sensitive communication.

Attribution: Ravi Mittal and Oommen C Kurian, "Bringing the Covid-19 Vaccine to Every Hamlet: The Story of Raigarh," *ORF Special Report No. 192*, June 2022, Observer Research Foundation.

Introduction

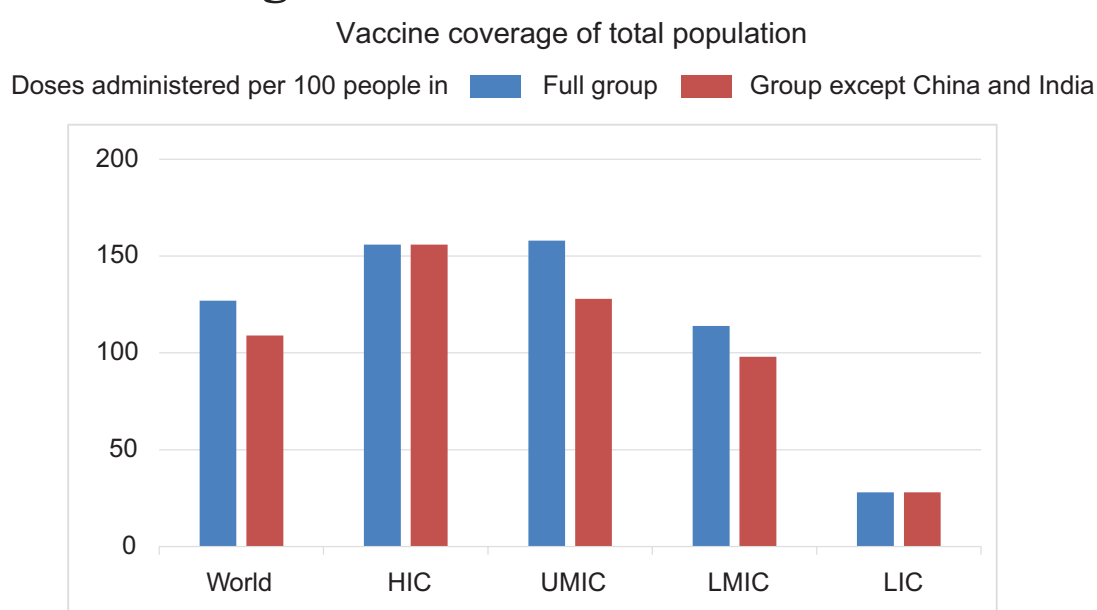
In May 2022, the World Health Organization (WHO) reported that about 81 percent of the population of Africa were yet to receive a single dose of Covid-19 vaccine.¹ The story is different for India: Proving many earlier predictions wrong, and remarkably leveraging its domestic manufacturing capacity, India was able to roll out its vaccination effort quicker than most countries in the developing world. It managed to fully vaccinate almost 70 percent of the total population,^a although there are variations in coverage across states.²

India launched its ambitious Covid-19 vaccination drive on 16 January 2021 with the aim of reaching 30 million healthcare and frontline workers. On 1 March 2021, the country initiated

the second phase for those above-45 with comorbidities and the cohort above 60. This was expanded on 1 April 2021 to cover everyone above 45 years, bringing the total target to over 300 million people. While this number accounted for only 22 percent of the population, they were also high-risk and most vulnerable, accounting for 80 percent of recorded Covid mortality in the country at the time. During the devastating wave in April 2021, the sudden rise in cases and deaths compelled the Indian government to announce the third phase of its vaccination campaign: Beginning 1 May 2021, those above 18 years were inoculated, adding another 600 million people to the list.

a More than one-fourth (26 percent) of Indians are under 15 years of age.

Graph 1: Global Vaccination Coverage and India's Impact on the LMIC Average



Source: <https://pandem-ic.com/covid-19-vaccine-doses-administered-per-100-people-by-world-bank-income-group-with-and-without-china-and-india/>

As of 6 June 2022, more than one billion Indians have received at least one dose, and 944 million are fully vaccinated. Full-vaccination coverage is higher in the 45+ population, at 95 percent. Indeed, among comparable lower- and middle-income countries (LMICs), India has one of the highest proportions of population vaccinated, as seen in Graph 1, which explores the huge impact of India's numbers on

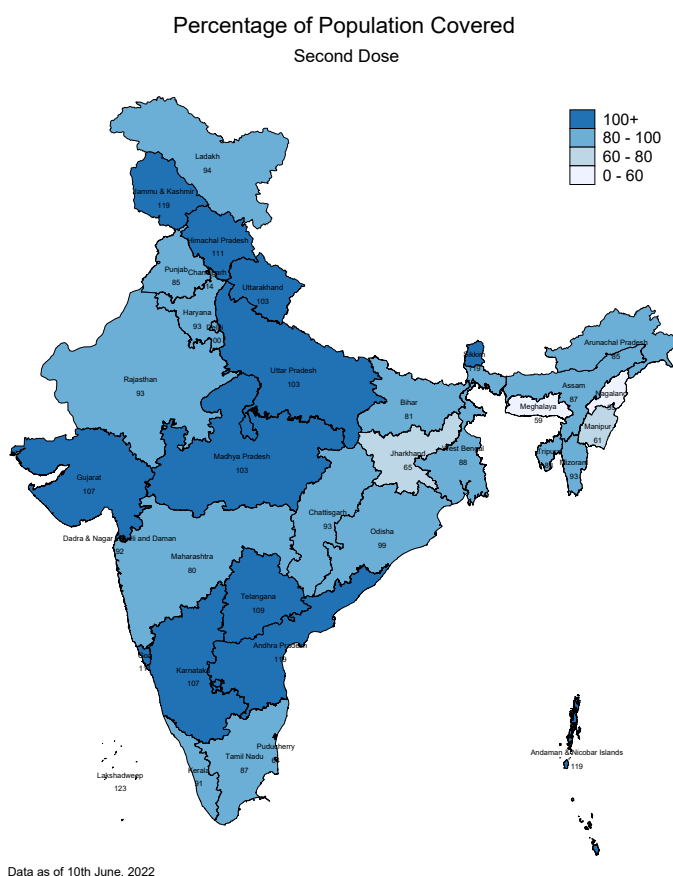
the LMIC average. To be sure, however, there are stark differences in the coverage across states. Earlier during the drive, a slowdown in the pace of vaccination amidst the relatively low case and death numbers and the overall public impression of low risk, prompted a meeting of chief ministers.

The ‘Har Ghar Dastak’ approach was launched, and the inoculation campaign managed to pick up pace again.

While some Indian states are still lagging in universal vaccination, there have been many notable achievements: the Covid-19 vaccination

drive has been conducted at an exceptionally fast pace in most Indian states, and near-universal coverage has been ensured, even within certain EAG States.

Map 1: Coverage of Second Doses Across Indian States

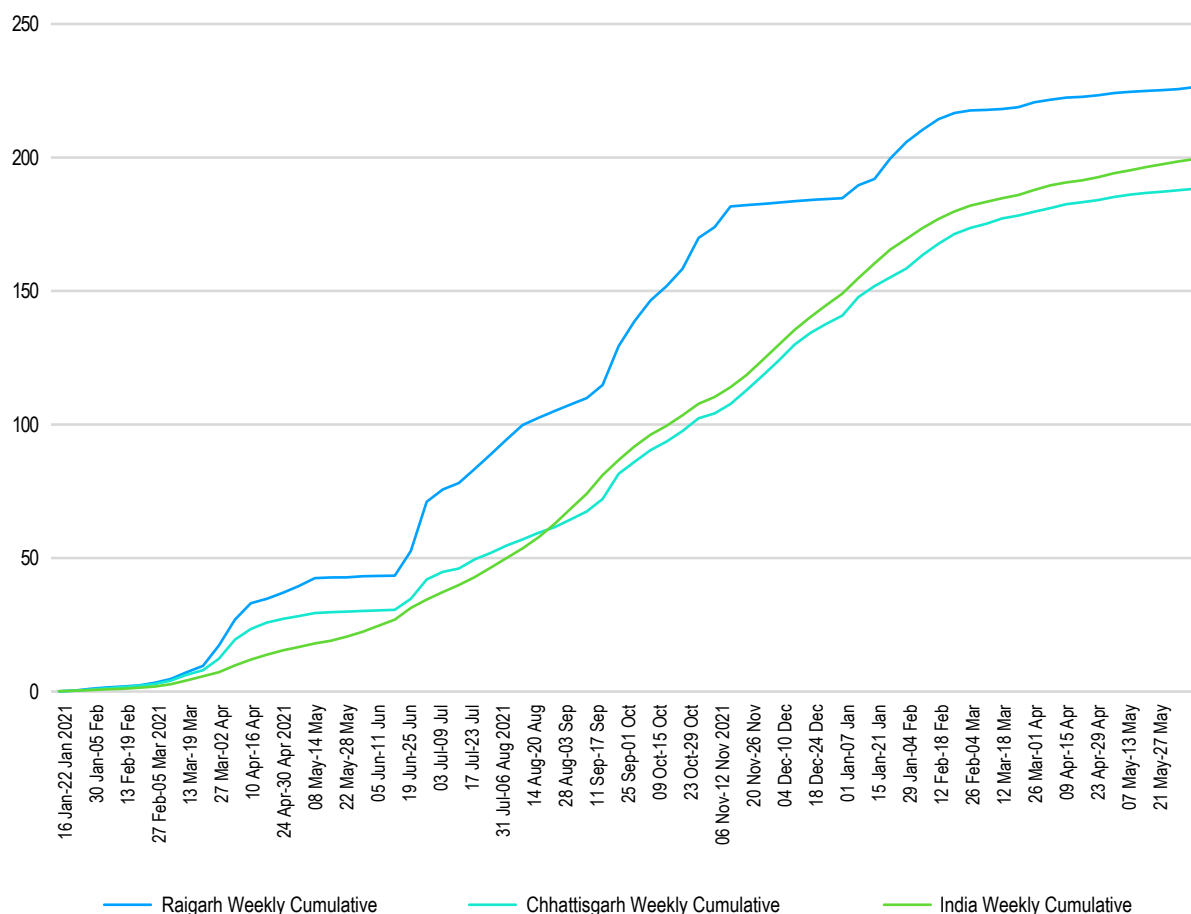


Source: ORF Vaccine Tracker (<https://www.orfonline.org/vaccine-trackers-india/>)

In the state of Chhattisgarh, for example, by 9 November 2021—i.e., just 298 days after the vaccination campaign started, the district of Raigarh had reached its target of vaccinating all adult citizens with the second dose. At that time, the national achievement was a far lower 35 percent of the target population fully vaccinated, and over 77 percent with a single dose. (Graph 2 tracks

the timelines for Raigarh, Chhattisgarh, and India overall.) While Chhattisgarh’s number of cumulative doses per 100 adult population has stayed close to the national average throughout the vaccination drive, Raigarh accelerated early on, and kept its pace.

Graph 2: Vaccination Timeline: Raigarh, Chhattisgarh, and India



Source: Cowin Portal, Government of India

Upon reaching 100-percent full vaccination coverage in November 2021, Raigarh—with a population of 14.94 lakhs according to Census 2011—became one of the first districts in India to achieve vaccination for all. Scheduled Castes (Dalits) comprise 15 percent of its population, and Scheduled Tribes (Adivasis), 34 percent. There is a considerable population of Particularly Vulnerable Tribal Groups (PVTGs) in the northernmost hilly part of the district.

This report identifies the factors for the success of Raigarh's vaccination campaign. With full vaccination in regions like Africa still under 15 percent, this experience of success from a region known for its low income and weak health infrastructure could offer lessons for the rest of the world. These lessons can be particularly useful given the emerging vaccine fatigue with respect to booster shots.³

Indeed, during its early phases, Raigarh's vaccine rollout for the elderly moved slowly for reasons such as difficulty in reaching the sites due to immobility, and severe illness. Moreover, the projected target population estimated for the elderly—based on an extrapolation of the 2011 census—did not match the actual field survey conducted in the Gram Panchayats and the urban wards. Therefore, there was a gap in vaccination for the 60+ cohort between actual achievement and estimated targets. The inadequacy of age-specific population estimates for planning became evident, as the actual vaccination numbers for the 45-59 age category proved to be almost double the projected target. The absence of reliable age-disaggregated data on the population led to such differences.

**Table 1:
Vaccination Targets Vs. Achievements in Raigarh, by
Block (November 2021)**

COVID-19 Vaccination, by Age (1 st dose)								
Block	18-44 years		45- 59 years		60+ years		Total	
	Target	Achievement	Target	Achievement	Target	Achievement	Target	Achievement
Barmkela	74023	64764	11886	25904	17829	17425	103738	108093
Pussore	69268	65067	11122	22530	16684	15904	97074	103501
Sarangarh	118316	89117	18998	29357	28497	21793	165811	140267
Loing	84346	77934	13544	27451	20315	14803	118205	120188
Dharamjaigarh	104225	93109	16736	33588	25103	18883	146064	145580
Gharghoda	39601	38928	6359	13995	9538	6734	55498	59657
Kharsiya	75278	72612	12087	24153	18131	13166	105496	109931
Tamnar	50047	52985	8036	24724	12054	7881	70137	85590
Lailunga	65707	53903	10551	23751	15826	11278	92084	88932
Raigarh Urban	81595	88381	13102	25329	19653	12599	114350	126309
Total	762406	696800	122421	250782	183630	140466	1068457	1088048

COVID-19 Vaccination, by Age (2 nd dose)								
Block	18-44 Years		45- 59 Years		60+ years		Grand Total	
	Target	Achievement	Target	Achievement	Target	Achievement	Target	Achievement
Barmkela	74023	63226	11886	37658	17829	9003	103738	109887
Pussore	69268	63933	11122	24259	16684	14197	97074	102389
Sarangarh	118316	109620	18998	23331	28497	6426	165811	139377
Loing	84346	85747	13544	29255	20315	8901	118205	123903
Dharamjaigarh	104225	93006	16736	36198	25103	14919	146064	144123
Gharghoda	39601	37125	6359	19381	9538	3130	55498	59636
Kharsiya	75278	85366	12087	15355	18131	6692	105496	107413
Tamnar	50047	56940	8036	25768	12054	5127	70137	87835
Lailunga	65707	53876	10551	23161	15826	10281	92084	87318
Raigarh Urban	81595	83982	13102	24807	19653	11274	114350	120063
Total	762406	732821	122421	259173	183630	89950	1068457	1081944

Source: District Administration, Raigarh

Raigarh's Vaccination Drive: The Initial Phases

Other nationwide campaigns, such as elections for instance, are hardly able to achieve 100-percent coverage. The challenge was more formidable for the life-saving Covid-19 vaccination drive. To begin with, the timeline to accomplish the task was unprecedented in India. Furthermore, many sectors and government entities had then only started to recover from the devastating two waves when the vaccination gained momentum. The government machinery was required to clear the pre-pandemic backlogs, requiring extraordinary effort. Thus, the inoculation campaign could only expect limited support from other departments, such as those of Women and Child Development as well as Rural Development, which both play integral supportive roles in the activities of the health department.

In Raigarh, the vaccination campaign was not without challenges: some of these difficulties were foreseen, similar to those faced in other campaigns, and mere reflections of national and state-level challenges; however, many other obstacles were unexpected, were unique to the Covid-19 situation, and were peculiar to the district. These varied challenges can be broadly classified as *structural* and *functional*.

Foremost among the structural challenges was vaccine shortages. Issues with the development, production, and distribution of the vaccines resulted in irregular supplies, and the frequent shortages resulted in uncertainty.

Moreover, regular changes in policy required a strategy that needed to keep all the stakeholders abreast with the latest developments. For instance, the phased rollout beginning with the healthcare workers to frontline workers, to the elderly with comorbidities, and so on, required innovative strategies for mobilising the targeted cohorts in a timely manner. Similarly, the shift of vaccine procurement responsibilities to the states and the subsequent reversal to central procurement, impacted the focus on beneficiary targeting.⁴ Third, resource limitations within the health system made it a daunting task to sustain the pace of the campaign while maintaining the essential health and routine immunisation services. Both human resources—i.e., vaccinators, operators, drivers—and the physical resources such as the venues for vaccination and vehicles for transport, were limited. As confidence towards the vaccine improved with new evidence, norms were gradually relaxed, aiding in the efficient deployment of resources.⁵

In parallel, many functional challenges were recognised early during the pilot vaccination of healthcare and frontline workers. The most prominent was vaccine hesitancy, varying degrees

of which were seen in different populations. For instance, blue-collar workers were concerned about potential loss of wage, not only for the particular day they would need to travel to the vaccination site but also in the event that they develop a fever following the jab. The hesitancy can also be explained as a result of fear-mongering rumours on social media, and safety concerns especially in areas where individuals have been reported to have experienced adverse side-effects from the inoculation.

Yet, there were pockets in the district that showed vaccine eagerness, leading to turn-outs higher than expected and, consequently, vaccine shortages. Raigarh, in the easternmost part of Chhattisgarh, is home to a considerable tribal population and access challenges proved to be daunting. Geographically, the district varies from thinly populated remote tribal hamlets in the forest-covered plateau in the north, to the densely populated treeless plains in the middle and south.

There were unique challenges, therefore, among them unexpected power outages, and poor road and internet connectivity in forested remote areas. Moreover, the district is mainly rural and agricultural, albeit with a rapidly growing industry sector. The large number of floating populations posed a unique challenge. Despite regular updates in the COWIN portal, technical issues were frequently encountered by the field staff.

Initiatives taken up at the national and state levels gave impetus to the district campaign in Raigarh. These include mandating mobile service providers to ensure vaccination caller tunes, and social media campaigns. The massive second Covid-19 wave could also have acted as a natural catalyst by showing examples of how the vaccinated healthcare and frontline workers were least affected by the Delta surge.

The time-bound vaccination rollout required detailed planning to ensure safety as well. The set of challenges were overcome with a coherent and meaningful strategy, which involved bottom-up planning. The District and Block Task Force committees, led by the District Collector and

SDMs, respectively, ensured preparedness even before the start of the campaign. Set up in late 2020, these committees provided a platform for cooperation and collaboration between stakeholders, and identification of bottlenecks and challenges at all levels. For instance, with the limited availability of vaccines during the initial phase, the planning and coordination for adequate security arrangements with the police department were carried out in these meetings. Subsequently, they provided closed monitoring and supervision of the campaign.⁶

The adversities were turned into opportunities. For instance, officials utilised the time during vaccine scarcity to update surveys on the vaccination coverage, formulate the vaccination plans for different areas, and carry out motivation strategies. Moreover, cues were taken from the experience of implementing other programmes and campaigns such as management of elections, as well as Information, Education and Communication (IEC) campaigns taken up under the Swachh Bharat Mission (SBM).

Raigarh's Strategies

In Raigarh, the challenges faced by the vaccination drive were overcome by systematic participatory strategies, underlined by building trust among various stakeholders. As Nobel Prize-winning economist Kenneth Arrow once said, “Trust is an important lubricant of a social system.”⁷ To nurture trust within the community, it is crucial to engage all stakeholders through collaboration.

Engaging all stakeholders. Local-level public representatives and government officials were amongst the first to be approached. Studies have found that in developing societies, households accord greater trust in government; this is especially true for poor and disadvantaged families.⁸ Moreover, by representing diverse communities, they can effectively influence and mobilise the people by acting as direct sources of information. For instance, Panchayati Raj Institutions (PRIs) played a remarkable role during the severe

months of the pandemic by providing essential leadership at the local level.⁹ The district administration leveraged this trust by engaging public representatives and officials from different departments. The public representatives at the grassroots, especially Sarpanch and Panches in the villages and ward members in the urban areas, were actively involved through physical and virtual meetings.

Furthermore, local-level officials from different departments acted as local influencers. These officials included ASHAs, Anganwadi workers, Gram Panchayat Secretaries, teachers, farmers' friends, and Kotwars & Patels.¹⁰ Such an engagement of public representatives and officials was a key to building confidence.

Leveraging various social networks. Research shows that it is crucial to capitalise on the creditworthiness of social networks to disseminate information.¹¹ In many Asian societies, individual preferences are shaped by those of specific others, especially people they trust and respect.¹² Therefore, local elements of social capital facilitate citizen participation.¹³ At all stages of the campaign, the Raigarh administration actively engaged networks such as self-help groups (SHGs), Mahila Arogya Samitis, religious institutions, volunteer organisations, youth networks such as NYK, NSS & NCC, NGOs, and village elders.

Aligning stakeholders' interests with the campaign objectives. The interests of other stakeholders were aligned for mutual benefit through creative strategies. For example, business establishments provided discounts, and in the urban areas, eco-clubs distributed free saplings upon presentation of vaccination certificates. Development partners such as UNICEF and Azim Premji Foundation also played a remarkable role at different stages of the campaign.

Optimising resources. The vaccination campaign presented the twin challenges of vaccinating all the citizens at an unprecedented scale and speed, while ensuring essential health services. Therefore, resource mapping, planning and optimisation were crucial for effective and efficient allocation of resources. First, the state health department

mapped healthcare workers who can potentially support the vaccination effort with desired skillsets working both in the government and private sector, as well as those currently not employed or are retired. They included frontline personnel and back-room support staff, including vaccinators, verifiers or data entry operators, mobilisers, and crowd managers. The budgetary support for operational costs allowed their engagement, whenever required.

From the beginning, it was evident that the campaign would be a marathon, not a sprint.¹⁴ Therefore, it was critical to prevent burnout amongst the staff. An effective rotation policy was designed to ensure adequate rest and the continuity of routine health services as well as a scaled-up vaccination campaign even during weekends. Moreover, context-specific solutions were devised for the effective utilisation of human resources. For instance, centralised entry of records was done in some blocks to minimise the requirement of on-ground data entry operators. Along with human resources, a parallel mapping of physical health infrastructure was planned and carried out, with the aim of optimally placing Covid-19 vaccination centres. These included community halls, schools, Resident Welfare Association (RWA)-designated spaces, industrial premises, and other government and private sector spaces.

Devising the distribution plans. Due to frequent vaccine shortages, it was essential to have an objective allocation plan. Therefore, the blocks were allocated vaccines based on the principle of ‘Vaccinate more, Get more’. Apart from motivating better performance, it ensured the optimal distribution of scarce resource. Moreover, the plan utilised lessons from both the management of routine immunisation campaigns and elections in India. For instance, route charts were drawn to ensure that vaccines, first-aid kits, and other materials are delivered to multiple sites in the shortest possible time and using the least possible number of vehicles.

Regular engagement with the frontline personnel. This made sure that correct information and strategic priorities were passed on to the lower rungs of the healthcare ecosystem. Frequent national and state-level policy shifts necessitated the regular training of personnel at all levels. Innovative strategies were adopted to keep the stakeholders updated and resolve their concerns.¹⁵ Therefore, a team of “master trainers” was nurtured, who posted short video messages on social media groups and managed helplines to resolve issues in real-time. Such measures allowed swift dissemination of information and built confidence among the workers.

“Raigarh overcame the vaccination challenges by systematic participatory strategies, underlined by building trust among stakeholders.”

Targeted Plan for Mobilisation

There is an aphorism that describes India well: “The language spoken in India changes every few kilometres, just like the taste of the water.”¹⁶ Yet, the challenges in mobilisation are not only linguistic, but also ethnic, social, and religious. The wide range of density and geography— from thinly populated hamlets to dense cities and hilly terrains—compound the challenge. A targeted approach through bottom-up planning provided solutions.

The process started with **defining the baseline**. Vaccination targets for the districts are based on the population projected for 2021. Sixty-five percent of this projected population are adults. Since it is only an estimated target, the expected achievement will not precisely be 100 percent.¹⁷ Within Raigarh, there are blocks that showed more than 100-percent vaccination coverage for this reason. Therefore, targeted planning using the district-level projected

estimates will be imprecise and only approximate. It is thus critical to provide the actual workable figures for the blocks, urban bodies or villages and even rural and urban wards. To ensure this, the district utilised the electoral voter roll as baseline, the most popular and readily available database at the district level. The progress was regularly updated in this database by the field-level functionaries based on actual achievement.

Defining the electoral roll as the baseline provided the starting point for targeted planning by defining near-exact targets up to the grassroots level. Second, regular updates tracked the changes in demographics due to in and out-migration, marriages, and deaths. Third, it provided real-time data to identify the pockets with low coverage. It allowed focused review and interventions in such areas, for instance, extensive motivation campaigns in case of high vaccine hesitancy.

Formulating the Mobilisation Plans was the next step. Management of elections where polling booths are set up akin to the vaccination sites provided key lessons in devising the targeted strategy for vaccination. As a result, the district team formulated mobilisation plans through the bottom-up approach for targeted mobilisation. First, the blocks planned the number of vaccination sites and set the target for each. It was based on the availability of resources such as vaccinators and vaccines. Second, each site was linked with urban ward(s) or village(s) based

on the remaining population numbers to be vaccinated in the target area. Third, the site plans of all the blocks were aggregated to form the district-level mobilisation plan. Finally, the district plan was circulated among all the stakeholders a few days before the actual date. It allowed ample time for planning the logistics and implementing the motivation strategies.

Figure 1: Decentralised Targets for Vaccination

कोविड -19 सत्र स्थल मोबेलाईजेशन (45 उम से अधिक हेतु)							
दिनांक 10.04.20251		समय प्रातः09 बजे से सायं 05 बजे तक					
क्र	विकासखंड	सत्र स्थल का नाम	मोबेलाईजेशन हेतु ग्राम वार्ड का नाम	ग्राम की जनसंख्या	लक्षित जनसंख्या (कुल जनसंख्या का 20 %)	न्यूनतम लक्ष्य	उपलब्धि (टीकाकृत)
1	Baramkela	CHC Baramkela	Baramkela	3709	742	150	
2	Baramkela	PHC Sariya	saria	7460	1492	150	
3	Baramkela	PHC Lendhra	Lendhara	2532	506	150	
4	Baramkela	PHC Bonda	Bonda	2032	406	150	
5	Baramkela	PHC Dongripali	Dongripali	753	151	150	
6	Baramkela	HWC Badenawpara	kotara	753	151	150	
7	Baramkela	HWC Dabhara	Lodhiya	1605	321	150	
8	Baramkela	HWC Risora	Amoda Mendra	887	177	150	
9	Baramkela	HWC Hattapali	Hattapali karapi pardhiyapali	1037	207	150	
10	Baramkela	HWC Gobarsigha	Marodraha bademkoni	839	168	150	
11	Baramkela	HWC Salheona	Katangapali Bilagarh	2024	405	150	
12	Baramkela	HWC Jognipali	Jhal Akabar	806	161	150	
13	Baramkela	HWC Devgoan	Ameri kosamdih Pewra Panchdhar	4143	829	150	
14	Baramkela	HWC Porath	Sankara Lukapara	4719	944	150	

Source: District Health Department, Raigarh.

The above planning paradigm was replicated every day. This targeted and astute planning with multi-stakeholder involvement engendered a festival-like spirit on the days of vaccination within the community.

At the outset, it was decided that a one-size-fits all approach would not be feasible for large diverse populations.¹⁸ The focus was on devising context-specific strategies. Locating vaccination sites close to the people's place of work or residence contributed to the higher vaccination rates. There were evening sessions for farmers who work in fields during the day, mobile sessions in urban places with high footfalls, and special camps for industrial workers within their work premises. Finally, community spaces within the villages were utilised for the door-to-door individual and community-focused vaccination campaigns. By providing convenience, the immunisation of the disadvantaged and reluctant communities was ensured.

In the course of the campaign, reaching and motivating populations in the far-flung areas and addressing vaccine hesitancy in pockets proved to be formidable challenges. On 23 July 2021, after two months of consistent efforts, the administration

finally convinced a reluctant community in the village Bhikampura in Baramkela block to get the jab. Similarly, Santosh Ghosh, a vaccinator posted in the remote tribal area of the district, trekked several kilometres to reach the Pahadi Korva community, stayed there through the night, and returned only after ensuring complete vaccination. There is no dearth in stories of turnarounds and extraordinary efforts of healthcare workers who went beyond their call of duty. To motivate the community and the workers, multiple indigenous strategies were adopted.

Crafting the narrative

The message, the medium and the messenger are crucial. The influential 'messengers' in the local 'medium' present a powerful 'message' to the community. Therefore, the campaign extensively used slogans, anecdotes, and jingles by famous artists and opinion-makers in the local languages. They were propagated through loudspeakers on bicycles, mobile marketing vehicles locally called 'Tikakaran Rath' playing jingles, wall writings, posters, and the local media. The regular dissemination of the clear message also dispelled myths about vaccination.

Furthermore, virtual conferences were held to provide a platform for the exchange of experiences and ideas. During such interactions, local representatives, healthcare and other local officials from the high-performing localities shared the motivation methods, which connect easily with the local population. Thus, it provided vital clues to the low performers on counselling and spreading the positive message. Focus was given to areas that suffered incidents of adverse side-effects.

In the beginning, they, along with their family members, were motivated to get vaccinated. It set an example for others. Subsequently, the videos of these influential people were circulated in local social media groups, creating a high positive impact within the community.

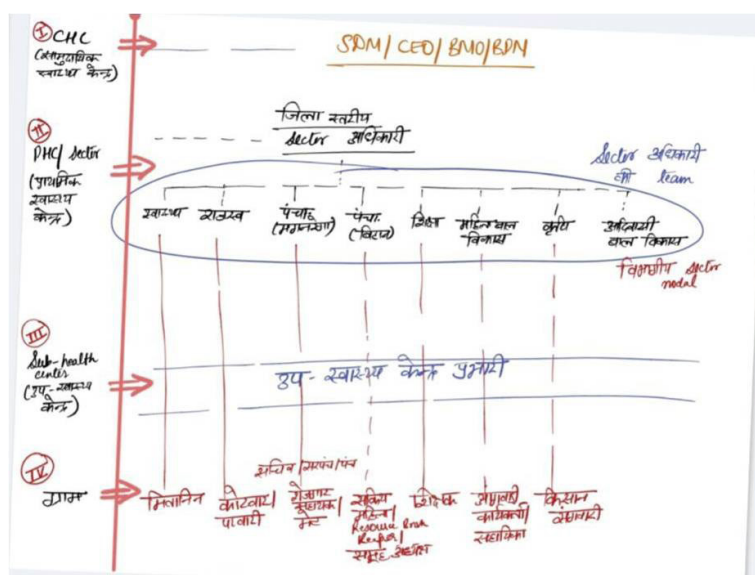
Setting examples

During uncertain situations, people look to their leaders for cues. The various stakeholders, particularly government representatives, officials and reputed members of local-level social networks, are seen as torchbearers within their community.

Generating the momentum

Once the narrative is crafted and examples are set, it is essential to break the public inertia. The district organised a massive vaccination campaign on 26 June 2021. Additional resources were mobilised during the huge drive, and each district officer was allotted a sector to supervise all the campaign-related activities on that day.

**Figure 2:
Plan to Deputise Grassroots Workers at the Mega-Vaccination Campaign**



Source: District Health Department, Raigarh

The campaign was a success both in the short and long term. Immediately, 14 percent of the target population were vaccinated in a day, against the target of 5 percent. The long-term impact was that it converted ‘fear of unknown’ into ‘fear of missing out’, and filled the citizens with enthusiasm and eased further mobilisation.

Celebrating milestones

The district administration widely recognised the public representatives of local self-governments, health workers, and other stakeholders of 100-percent vaccinated village(s)/ward(s) as champions.¹⁹ Their success was celebrated through press releases, certificates of appreciation, and recognition during virtual meetings. It helped to motivate others and sustain the momentum.

Robust monitoring and frequent feedback

This system ensured that the campaign did not lose steam midway. “What gets measured gets done” may be a cliché, but there is a reason it is. Regular monitoring was crucial to ensure effectiveness and correct the course whenever and wherever required.

Defining relevant outcome indicators

This laid the foundation for the monitoring system. The first step was to define the intermediate and final outcome indicators. For example, percentage population coverage with daily progress was monitored both by block and village. Similarly, the average vaccination per session site reflected the efficiency and relevance of each site.

Gamification

It is often seen that leveraging the elements of competitive play can unleash passion, potential, and personal commitment.²⁰ Therefore, gamification was introduced to the monitoring reports. The overall performance was sorted in a descending manner and arranged in the form of leaderboards. At the same time, the best daily performances were recognised with incentives like badges. The positions were colour-coded and the coded tables were posted in the official groups. It ensured the desired attention of the low performers to get out of the red zone.

**Table 2:
Block-Level Daily Performance Tracking**

Blockwise Target Vs Achievement			
Date : - 03.08.2021			
Block	Today's Target	Today's Vaccinated	Achievement
Raigarh Urban	1200	1258	105%
Pussore	100	103	103%
Gharghoda	900	811	90%
Sarangarh	580	494	85%
Kharsiya	1300	765	59%
Barmkela	470	272	58%
Loing	2000	1152	58%
Dharamjaigarh	2230	1183	53%
Lailunga	1700	732	43%
Tamnar	1600	444	28%
Total	12080	7214	60%

Source: District Health Department, Raigarh

Besides giving impetus to the efforts of all the stakeholders, regular monitoring provides an opportunity for course correction. For instance, the achievement of each session site was monitored four times during the day, i.e. 11 AM, 1 PM, 3 PM & 5 PM through the Google Sheet (Figure 4). The vaccination team at sites with below-par performance during early hours were individually

contacted. It helped solve many problems in real time. For example, making alternative arrangements in case of a team member's uninformed absence or sending additional doses in case of unexpected high turn-out.

Regular monitoring through outcome indicators allowed continuous improvement in overall planning, improving efficiency. For example, the sites where the performance was consistently poor as shown by the poor average vaccination per site were individually evaluated. In some cases, they

were found to be distant from the neighbourhood and thus, shifting the site to another building close to the community significantly improved the performance.

“What gets measured gets done’
may be a cliché but there is a reason
it is. Regular monitoring ensured
effectiveness and course-correction
whenever required.”

**Table 3:
Vaccination Sites with Poor Achievement at 1:00 PM
on 02-05-2021**

कोविड 19 वैक्सीनेशन सत्र स्थल (18 से 44 वर्ष)											
S.No.	Name Of Block	Name Of Facility	1st Dose Target	2nd Dose Target	Session Target for the day (HCW&FLW)	Achievement of 18 to 44 years Beneficiaries		Achievement Total			Achievement In %
						1st Dose	2nd Dose	1st Dose	2nd Dose	Total	
1	Barmkela	CHC Barmkela (18+)	130	0	130	31	0	31	0	31	24%
2	Barmkela	PHC Sariya (18+)	130	0	130	49	0	49	0	49	38%
3	Sarangarh	CHC Sarangarh (18+)	130	0	130	10	0	10	0	10	8%
4	Sarangarh	PHC Hirri (18+)	130	0	130	12	0	12	0	12	9%
5	Pussore	CHC Pussore (18+)	130	0	130	42	0	42	0	42	32%
6	Pussore	HWC Kodatarai	130	0	130	30	0	30	0	30	23%
7	Loing	CHC Loing (18+)	130	0	130	22	0	22	0	22	17%
8	Loing	PHC Nandeli (18+)	130	0	130	25	0	25	0	25	19%
9	Kharsiya	Samudayik Bhawan	130	0	130	9	0	9	0	9	7%
10	Kharsiya	PHC Turckela (18+)	130	0	130	9	0	9	0	9	7%
11	Tamnar	CHC Tamnar (18+)	130	0	130	9	0	9	0	9	7%
12	Tamnar	PHC Urba (18+)	130	0	130	9	0	9	0	9	7%
13	Gharghoda	CHC Gharghoda (18+)	130	0	130	9	0	9	0	9	7%
14	Gharghoda	PHC Bhairkela (18+)	130	0	130	12	0	12	0	12	9%
15	Lailunga	High School Lailunga	130	0	130	10	0	10	0	10	8%
16	Lailunga	High School Mukdega	130	0	130	7	0	7	0	7	5%
17	Dharamjaigarh	Mangal Bhavan	130	0	130	30	0	30	0	30	23%
18	Dharamjaigarh	PHC Chhal (18+)	130	0	130	4	0	4	0	4	3%
19	Raigarh Urban	Govt Girls H School	130	0	130	47	0	47	0	47	36%
		Total	2470	0	2470	376	0	376	0	376	15%


Source: District Health Department, Raigarh

Conclusion

Raigarh's success in taking the vaccination campaign to every hamlet is testimony to the multiple strengths of Indian democracy, including collaborative and cooperative federalism, the power of grassroots and civil society, and the value of unity in diversity. These lessons will go far beyond the Covid-19 vaccination campaign. The wisdom gained during the campaign will have a lasting impact on government institutions' ability to implement large-scale social welfare measures. The unprecedented challenge of scale, scope, and speed will leave a long-lasting institutional memory. Therefore, it is an opportune time to contextualise the lessons from this experience for other policy measures in a granular manner.

The Raigarh experience shows that a collaborative approach, sustained commitment, and contextualised planning can help achieve goals, despite challenges at different points. At the grassroots level, the cross-pollination of ideas between multi-stakeholders such as ANM, ASHA, Gram Panchayat Secretary defined the problem-solving approach. The lessons from one village/ward or block held wisdom for the other struggling village/ward. Although different situations require a context-specific approach to problem-solving, this basket of challenges has relevance to diverse conditions. Therefore, it provides vital lessons for other districts—and cities, states, and even nations—on the mission to vaccinate citizens, particularly as many regions have only started overcoming supply constraints of vaccine doses.

Streamlining weak health infrastructure, overcoming gaps of health workforce, convincing a skeptical population, ensuring motivation amongst the workforce till population coverage is achieved, will be the predominant concerns for many such countries and regions going forward. It is very

similar to where Raigarh was in early 2021 when the district flagged off its Covid-19 vaccination campaign. 

“Raigarh’s success is testimony to the strengths of Indian democracy, including cooperative federalism, the power of grassroots and civil society, and the value of unity in diversity.”

Endnotes

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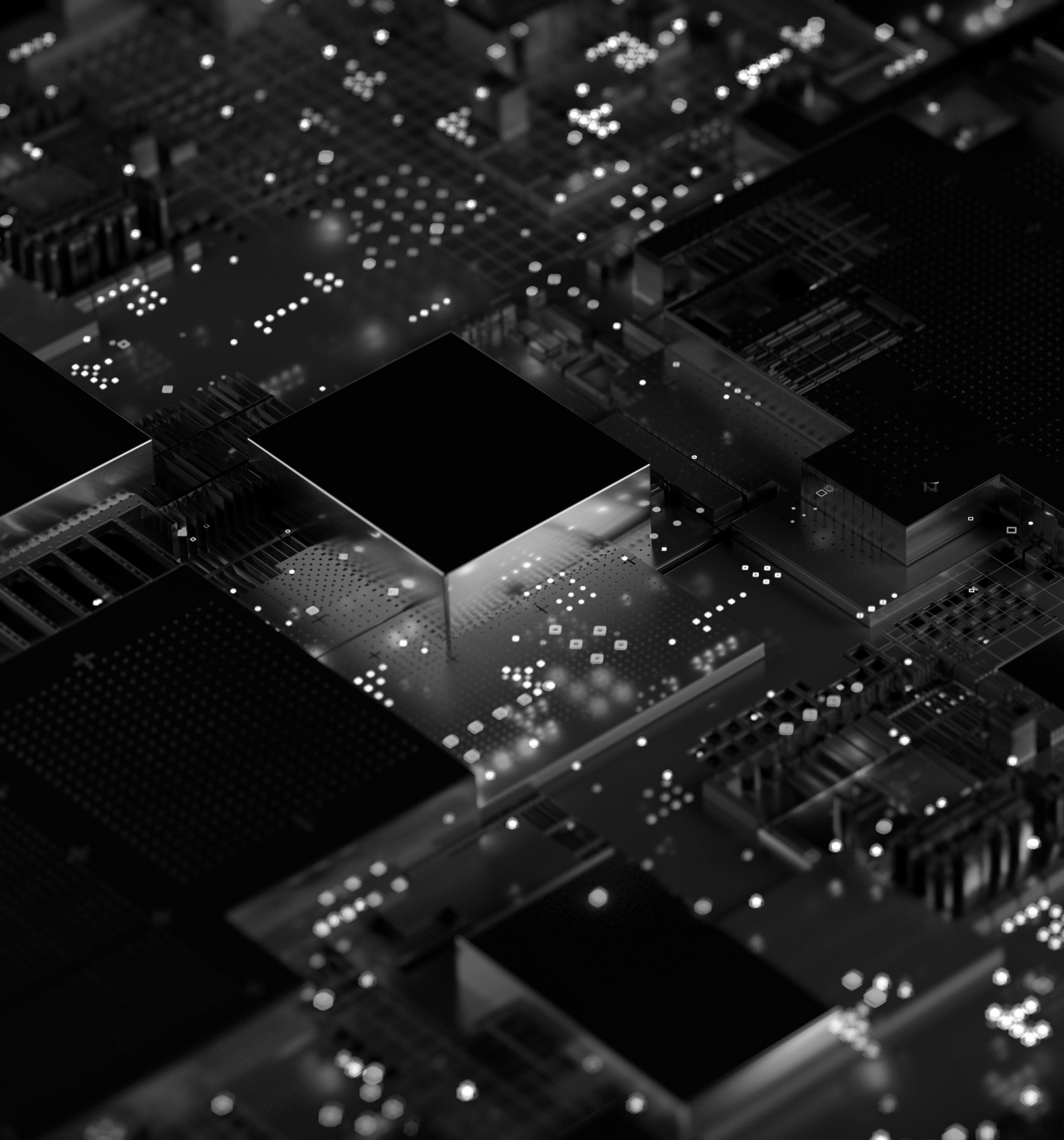
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