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NEVA MAKGETLA: We need to understand why vaccination got bogged down

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File picture: REUTERS/DADO RUVIC.

The recent slowdown in vaccinations illustrates the national — and global — approach to the pandemic, which appears to consist largely of putting our fingers in our ears and wishing really, really hard that everything would go back to 2019. This strategy has led to disasters in much of the world. Now, the Omicron variant looms over Christmas.

Weekly vaccinations peaked at 1-million a month ago, but have since fallen by nearly half. Currently, 35% of adults are fully vaccinated, though the figure ranges from 40% in the Western Cape, Eastern Cape, Free State and Limpopo, to about 30% in Gauteng and KwaZulu-Natal, which together account for almost half the population. Even for people aged over 60, the vaccination rate is below 60%, and for those 18-35, it is just 20%.

At this rate it will be mid-2022 before SA has fully protected 70% of the population, leaving lots of time for new surges and more new variants — each a blow to our lives and to the economy. In the past week, SA's vaccination rate ranked 42nd among the 65 upper middle-income economies included in the Oxford project Our World In Data. The share of the entire population (including children) vaccinated in other Brics members ranged from 75% in China to 31% in India. In SA, the figure was just 24%.

To accelerate vaccinations we need a consistent diagnosis of why the rollout has bogged down. The mechanisms behind the failure fall into two categories:

unnecessary obstacles to getting a jab, and the general tendency for individuals to overestimate the risks of action compared to inaction.

SA's vaccination system appears to have been designed by and for the richest 15% of the population. It works well if you have a smartphone, a car, easy access to advice, information on availability, and ideally a medical scheme. For everyone else — the vast majority of South Africans — the system is unnecessarily hard to understand and access.

To succeed, the vaccination system has to reach people where they are in terms of both information and physical sites. That means, for instance, spreading information through community leaders and health workers, schools, churches and sports clubs, as well as relevant digital formats such as SMSs. We need mobile vaccination sites in communities, malls and workplaces, rather than expecting people to find the money, time and initiative to travel to a clinic.

Provinces have made an effort in all of these areas. But scaling them up means making vaccinations a priority across the state. The government (and the media) should allocate far more time and capacity to providing information about the jabs and making them easily accessible. And we need to draw far more consistently on the knowledge and experience of community practitioners and organisers.

The vaccination campaign must also deal with built-in shortcomings in the way people assess risk. A variety of studies show that individuals tend to worry more about regretting conscious actions than inaction, even when doing nothing would be far more harmful. For vaccinations, the result is a tendency to overstate the dangers of (actively) obtaining a jab compared to (passively) getting severe Covid-19.

Vaccine mandates provide a critical collective correction to this individual tendency to misjudge risks. That said, mandates in SA cannot simply copy the global north. Most people here cannot afford to spend much time in restaurants or clubs. But it would help to require proof of vaccination for work, school, worship or bars, and for public transport and sports venues. Again, that means it has to be easier to get the certificate without internet access.

Like other individuals, political and business leaders find it easier to avoid innovative and contested decisions, including the big steps needed to scale up the vaccination campaign. The costs of inaction are, however, becoming intolerably high for both public health and the economy.

• Makgetla is a senior researcher with Trade & Industrial Policy Strategies.