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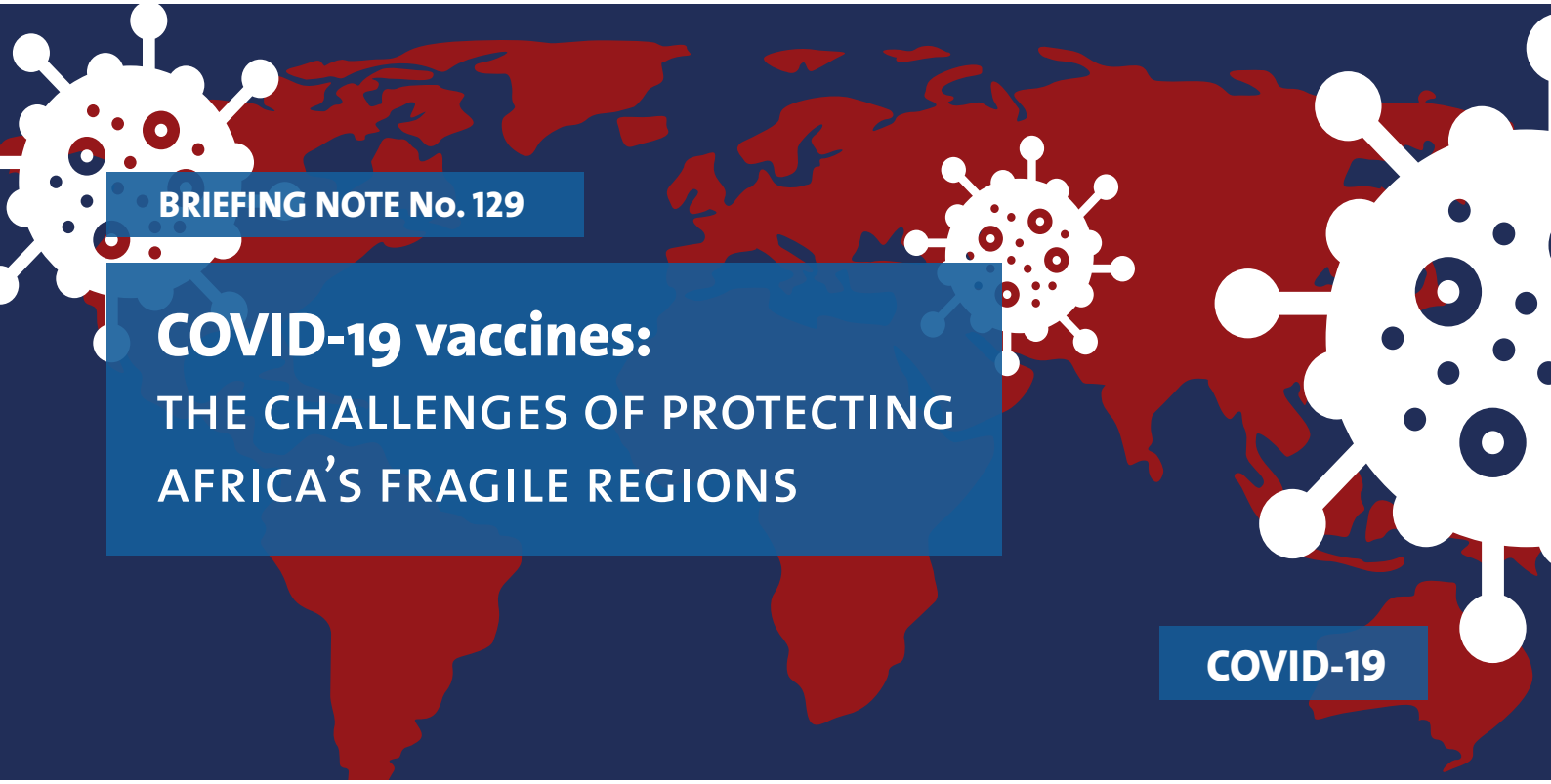

BRIEFING NOTE No. 129

COVID-19 vaccines: THE CHALLENGES OF PROTECTING AFRICA'S FRAGILE REGIONS

COVID-19

By Sophie Desmidt and Ashley Neat

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This briefing note looks at the challenges ahead for large-scale vaccination, as part of our series of looking at the longer term effects of COVID-19 on conflict and fragility in Africa. We ask some of the hard questions about the potential repercussions for highly fragile situations in Africa and what it might mean for the European Union's role in the global response to the pandemic.

As countries continue to deal with the socio-economic effects of the pandemic, they are now turning their attention to vaccination. Yet in a context of geopolitical competition surrounding vaccine procurement, Africa has been unable to secure sufficient doses of COVID-19 vaccines. The challenges are even greater for highly fragile and conflict-affected countries, where poor health infrastructure, limited access, security challenges and misinformation will make vaccination an arduous task. There is a real risk that the most vulnerable communities in Africa will be left behind. Without sufficient access to vaccines, the prolonged social, economic, health and political impacts of the pandemic are likely to exacerbate existing problems for the most fragile and conflict-affected regions.

The EU's performance as a global health actor during this pandemic has been mixed. It has attempted to act as one bloc under 'Team Europe', supported global health initiatives such as COVAX, and financed research and innovation initiatives. However, it has also been criticised for over-ordering vaccines and for the relatively small amount of funding geared towards COVID-19 relief.

Taking all this into account, we put forth some recommendations on how the EU can support equitable access to vaccines in fragile and conflict-affected regions in Africa as part of its external action.

COVID-19 and vaccinations in Africa: the status quo

To provide Africa with the number of COVID-19 vaccines necessary for its populations, and to ensure that these are able to reach all parts of society, including the most vulnerable, a number of international initiatives have been set up to support vaccine supply in Africa (see Box 1 below).

The COVAX Facility aims to distribute 2 billion COVID-19 doses globally by the end of 2021 (McSweeney and Chingono 2021). For Africa, the COVAX Facility aims to provide 600 million doses to the continent by the end of 2021 (WHO 2021). **This, combined with doses ordered by the African Union, brings the total number of reserved doses for Africa so far to 1.27 billion.[2] Africa requires approximately 1.5 billion doses to immunise 60% of inhabitants, the threshold for herd immunity.**

Box 1: African and international initiatives in support of vaccine supply and development

African Union COVID-19 vaccination initiatives:

- **July 2020:** Africa Centres for Disease Control and Prevention (CDC) launches the **Consortium for COVID-19 Vaccine Clinical Trial (CONCVACT)**, in an effort to secure some 10 late stage vaccine clinical trials as early as possible on the continent (Africa CDC 2020a).
- **August 2020:** Africa CDC launches **COVID-19 Vaccine Development and Access Strategy**. This strategy has three major strategies for vaccination across Africa: 1. To accelerate African involvement in clinical development, 2. Ensure Africa's access to sufficient vaccine supply and 3. Remove barriers to wide-spread delivery and uptake of the vaccine across Africa (Africa CDC 2020b).
- **August 2020: African Vaccine Acquisition Task Team (AVATT) endorsed by the AU**, composed of a number of high-level African Union officials and special envoys.[3] At the time of writing, AVATT has **so far reserved 672 million COVID-19 vaccination doses for Africa (BBC News 2021a).**

International COVID-19 vaccination initiatives in Africa:

- **April 2020:** World Health Organisation (WHO) established the **Access to COVID-19 Tools (ACT) Accelerator**, a global collaboration to coordinate production of and boost access to treatments, vaccines and tests. The **COVID-19 Vaccines Global Access (COVAX) Facility**, coordinated by Gavi (the Vaccine Alliance), the Coalition for Epidemic Preparedness Innovations (CEPI), and the WHO, is the ACT Accelerator's vaccine branch.
- **June 2020:** Gavi launches the Gavi Advanced Market Commitment for COVID-19 Vaccines (Gavi COVAX AMC), as a financing instrument that represents the first building block of COVAX (Usdin 2020).
- **February 2021:** G7 leaders pledge to increase their contribution to the COVAX initiative, raising their overall commitment to $7.5bn (BBC News 2021b).
- **February 2021:** UN Security Council unanimously passed a resolution for the fair worldwide distribution of COVID-19 vaccines, intended to improve access to vaccines in fragile countries and encouraging wealthier nations to donate vaccine doses to countries (UN 2021).

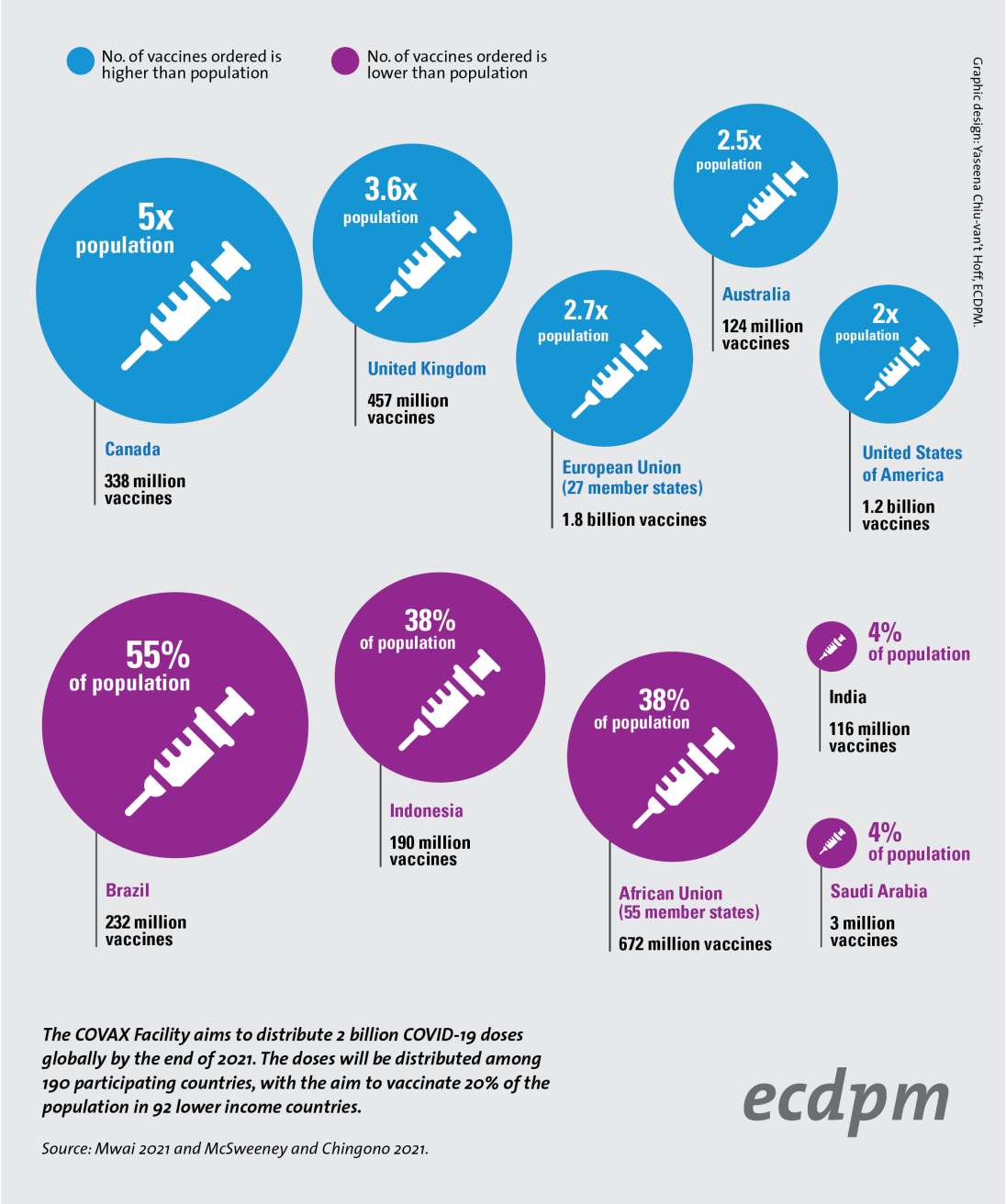
Testing and production of vaccines in Africa:

- **Human vaccine trials** were held in several African countries, including South Africa and Egypt. In South Africa, clinical trials were held for two vaccines, Novavax vaccine and the Oxford ChAdOx1-S vaccine (Makoni 2020 and Kagina 2020).
- Vaccines production capacity exists in Senegal, Egypt, Morocco, Tunisia, Ethiopia and South Africa (see Veron and Di Commo 2020).
- Three countries in Africa are planning to **manufacture international COVID-19 vaccines** so far – Morocco (the Chinese vaccine), Egypt (Russian vaccine), and South Africa (US Johnson & Johnson vaccine) (Development Reimagined 2021b).

These initiatives are a good starting point, but by **far nowhere near the necessary action required to effectively vaccinate Africa's populations.** The ACT Accelerator and its COVAX facility, for example, remain severely underfunded (Ravelo 2021). This has provoked the recent public outcry by Tedros Adhanom Ghebreyesus, Director-General for the World Health Organization, warning that "the world is on the brink of a catastrophic failure, and the price of this failure will be paid with the lives and livelihoods in the world's most poorest countries."[4]

COVID-19-related deaths in Africa have jumped by 40% in a month, the World Health Organization warned on 11 February 2021, as countries grapple with new variants of the virus and health systems become overstretched (The New Humanitarian 2021). New studies have raised fears, however, that the spread and occurrence of COVID-19 in Africa continued to be underreported in official figures.

Figure 1: Inequity in global COVID-19 vaccine orders (as of 1 March 2021)



Many countries, including fragile and conflict-affected regions, are unable to afford mass testing and lack capacity to collect reliable data on cases and deaths, especially in remote areas. This fuels the risk that the continent may not be seen as a priority for scarce global vaccine supplies despite the urgent need (The Guardian 2021). Eswatini, Malawi, and Mozambique for example are all struggling with a new COVID-19 strain, but are yet to receive a single vaccine dose (The New Humanitarian 2021).

At the time of writing, the AVATT has so far ordered **672 million COVID-19 vaccination doses for Africa** (BBC News 2021c). As demonstrated in Figure 1 on page 2, **this amounts to vaccination coverage of just 38% of the continent's population**. According to a press release from the AVATT though, **less than 20% of the initial 270 million doses first ordered by the AU will be available before June 2021** (Swalis and McSweeney 2021)**.** COVAX forecasts that it will also have supplied 640 million doses globally by that time, about 30% of which are for AU countries. This amounts to **approximately 246 million doses supplied to Africa by both the AVATT and COVAX combined before June 2021, a far cry from the 1.5 billion doses needed** for the continent. By comparison, the EU expects member states to vaccinate 70% of their adult populations by the summer (McSweeney and Chingono 2021).

Poorer countries are also being encouraged to secure additional coverage through their own bilateral deals, **but the number of vaccine doses that have been secured are unevenly distributed across African countries**.[5] Twenty-five African countries do not have any COVID-19 vaccine orders (Development Reimagined 2021b).

This comes at a time of widespread "vaccine nationalism" in which wealthier nations have ordered vast quantities of vaccines from developers and manufacturers, causing global disparity in access to COVID-19 vaccines. As of mid-February, three-quarters of all global COVID-19 vaccine doses were in only 10 countries, and more than 94% of countries beginning vaccinations were high-income or upper-middle-income (The New Humanitarian 2021). According to Table 1, Canada, the UK, the EU, Australia, and the USA have all ordered enough vaccines to cover their respective populations at least two times over. In a recent report, the International Chamber of Commerce stressed the economic toll that unequal vaccine distribution could have, with the world economy potentially losing up to $9.2 trillion in 2021 if populations in developing countries are largely excluded from vaccination programmes, and with nearly half these costs borne by wealthy countries (Cakmakli et al 2021).

At the same time, Western powers have committed to support fair and affordable COVID-19 vaccination on a global scale, which needs to be seen against the backdrop of an international competition to win over the hearts and minds of decision-makers and populations in Africa and developing countries. So far, as highlighted in Box 2 on page 4, the EU has not played a particularly prominent role here, and the US has only recently announced its return to the WHO, leaving space for other global actors to step in as more reliable partners.

Box 2: Geopolitical implications of vaccine governance

The EU mobilised €38.5 billion for the immediate health emergency and socio-economic impacts of the pandemic (Bayer 2021). Yet, it has also ordered enough doses to vaccinate its populations 2.7 times over which has affected the supply for Africa in the short term, and has done damage to its reputation according to Save the Children Europe's director Anita Bay Bundegaard (Bayer 2021). The US, under the Biden administration, has recently announced its returned commitment to the WHO and its intention to join the COVAX programme (Mancini 2021). Damage done by the Trump administration to the reputation of the US as a reliable global health provider will not be forgotten quickly, however. Overall, in the eyes of many countries, Western states have selfishly hoarded vaccines at the expense of developing countries (Hinane El Kadi and Zinser 2021).

China, and to a lesser extent Russia, have presented themselves as alternative, more reliable, and more affordable vaccine suppliers to Africa (Campbell 2021), while having at the same time an immense need to cater for their own population which will also not go unnoticed in Africa. So far, China is emerging as a leading COVID-19 vaccine distributor in developing countries, asserting that its distribution networks in Africa are well established, and that its vaccine can be transported cheaply in off-grid refrigeration units. The Seychelles, Morocco, Egypt, and Zimbabwe have already started their vaccination campaigns with a number of doses supplied by SinoPharm (Mwai 2021). Morocco has also signed a convention to manufacture SinoPharm's vaccine and distribute it to other African countries on behalf of the Chinese pharmaceutical group (Hinane El Kadi and Zinser 2021).

However, Chinese pharmaceutical companies have not yet published all of their vaccine test results, and there are concerns about vaccine effectiveness (Fox 2021). If SinoPharm's vaccine restores a sense of normality to life across Africa, China will be praised and Sino-Africa relations could emerge much stronger from the crisis. But if the vaccine proves ineffective or creates unforeseen health effects, China's carefully crafted attempts to frame itself as the solution to - rather than the cause of - the pandemic, as well as a responsible power in the global South, could be undermined (Campbell 2021).

The challenges of carrying out COVID-19 vaccinations in fragile and conflict-affected countries

The prospect of large-scale COVID-19 vaccination campaigns sets unprecedented challenges globally. But this will be the case even more so in fragile and conflict-affected regions. Once enough doses of COVID-19 vaccines have been secured for Africa's populations, the continent will have to distribute vaccines alongside logistical challenges, limited health infrastructure, and restricted access to communities in regions affected by conflict. There, the situation is further compounded by the spread of misinformation and disinformation surrounding COVID-19 vaccines. Yet, previous vaccination campaigns have given African countries valuable experience to overcome challenges in the emergency delivery of vaccines in difficult and complex environments.

Logistical challenges

Only three countries in Africa are planning to manufacture international COVID-19 vaccines so far – Morocco (the Chinese vaccine), Egypt (Russian vaccine), and South Africa (US Johnson & Johnson vaccine) (Development Reimagined 2021b). But the question remains whether enough can be manufactured to meet demand (Development Reimagined 2021b), and given the existing low capacity for vaccine production in Africa, most vaccines will probably need to be imported. Several of the current vaccines such as Pfizer-BioNTech and Moderna require ultracold storage, making it

difficult to distribute them in several parts of Africa with considerable logistical, transport, and infrastructure challenges (Chatham House 2020). The Africa Centres for Disease Control and Prevention recently outlined an urban-centred strategy to allow African nations to roll out vaccines that require ultracold temperature storage.

Despite having limited resources compared to other regions, African countries have demonstrated a wide range of innovation and strategies in previous vaccination campaigns to establish effective logistic channels, such as the use of solar-powered cold-chain fridges and mobile vaccine delivery points for sites with limited electricity (Edward-Ekpu 2021). Some companies plan to use alternative methods to distribute vaccines at their required temperatures and quantities, for example via drone delivery to hard-to-reach places in Rwanda, Ghana, and Nigeria (Cheney 2021). Notwithstanding technical and logistical innovations, highly fragile environments will face immense planning and monitoring challenges to control and manage the magnitude of the COVID-19 vaccination campaign.

Limited health infrastructure and institutional bottlenecks

In fragile and conflict settings, health facilities suffer from a lack of health personnel and are often under-capacitated due to the destruction, underfinancing and/or the overburdening of health services. Health infrastructures will undoubtedly struggle to provide the services necessary for successfully planning and administering such large COVID-19 vaccination campaigns next to their regular tasks. Due to limited connectivity infrastructure, being flexible with the administering of the second vaccine dose where required for certain vaccines will also be important in these settings. With more attention going to COVID-19 vaccination campaigns, the ability to respond to other health problems of the population and to give equal attention to other vaccinations, such as against polio, will suffer. Overall, the health infrastructure in these countries poses very big challenges. Further, legal challenges may arise given restrictions with regards to exchanges and contact with, and the provision of material support that is deemed as benefiting, non-state armed groups.

Restricted access to communities

In conflict-affected regions the central state has limited territorial control in certain areas. Access to vulnerable communities in these areas could be severely restricted. Other communities that are hard to reach include minorities, refugees and displaced people. In addition, there are communities that are de facto beyond the reach of the state and the international communities. How to deal with these communities will present a politically sensitive issue to take into in the design of vaccination campaigns.

Ceasefires have been proposed, including by the UN to ensure access to hard to reach communities. Without such local ceasefires, the need for travel permissions from non-state armed groups as well as ensuring the safety of health personnel could complicate and hamper vaccine distribution (ICRC 2020). But local vaccine ceasefires will need to be context-specific by design. In places where a peace process or dialogue is already underway, these will be easier to develop. A global ceasefire may spur discussions on a new (local) ceasefire, but this is no guarantee.

Gaining (temporary) access to these regions and carrying out immunisation activities will be problematic, although not impossible as previous experience shows.[6] In 2019, despite ongoing armed conflicts, healthcare workers were able to successfully introduce the Ebola vaccine to remote communities in North Kivu (Edward-Ekpu 2021). Some non-state armed groups have already announced their preparedness to cooperate with public authorities in the response to COVID-19, such as the Taliban in Afghanistan and Al-Shabaab in Somalia, in principle making the delivery of vaccinations easier and safer. Yet, fighting continues to undermine vaccine access in both countries (Felbab-Brown 2020).

Combating misinformation and disinformation

Misinformation and disinformation about COVID-19 could undermine vaccination campaigns and public health services in Africa, leading to less compliance with preventative measures and/or willingness to take a vaccine, and increased pandemic-related stigma fuelled by rumours (Search for Common

Ground 2021). African scientists and experts have expressed their worry about growing levels of resistance and misinformation around testing and vaccination on the continent (Anna 2020). For example, clinical trials in South Africa, one of the hardest-hit African countries, have faced opposition from protesters. For fragile and conflict-affected states, false information can spread quickly and take longer to be corrected as scientific information is even more limited (Chatham House 2020). The situation can be aggravated in areas with low (digital) literacy rates. Women across conflict-affected societies also face greater inequities in access to legitimate information and services (Search for Common Ground 2021).

A study on the Ebola crisis in West Africa showed that misinformation, especially shared via Twitter, led to serious consequences, including the victimisation of people and deaths (Oyeyemi et al. 2014). Misinformation also risks compounding a growing lack of trust between citizens and government authorities due to poor service provision and pandemic responses. This can deepen mistrust in public health services, thereby creating a dangerous operational environment for healthcare workers,[7] hindering access to vaccinate vulnerable communities, and undermining the COVID-19 vaccine acceptance needed to reach herd immunity (Search for Common Ground 2021). In conflict-affected or contested areas, trust is a central element in the dissemination of information. In these areas, communities may trust local and traditional community leaders more than the government, or the international community.

Despite the numerous challenges discussed in this section, organisations such as the WHO, UNICEF, the Red Cross, and many humanitarian organisations have a range of experiences and lessons learnt to rely on that can help to promote and implement vaccination campaigns in fragile and conflict-affected areas in Africa. In particular, as highlighted in Box 3 below, three key factors are considered high on the list of those which should be harnessed to make vaccination successful in complex environments.

Box 3: Determinants of success for effective vaccination campaigns in Africa

Locally embedded information campaigns: In particular with regards to polio, the work of UNICEF and the WHO to overcome misinformation has been cited as an example of lessons learned about conducting vaccination campaigns in challenging settings in Africa (Chatham House 2020). The recent experience with Ebola can also help inform the design of locally embedded information campaigns that promote efforts to spread clear and evidence-based information to overcome vaccine hesitancy (Edward-Ekpu 2021).

Community engagement: Related to this, community engagement has been noted as a key factor for success, not just for the vaccination itself but also for information sharing. Many examples of successful community-led efforts to fight the spread of the disease exist, which could be harnessed for the vaccination campaign. This was also a clear recommendation by a recent study conducted by a consortium of African health organisations, who recommended building on local needs and engaging trusted local leaders whenever possible (PERC 2020).

Context-sensitive strategies: Lastly, given the uniqueness of each conflict situation, context-specific strategies will be needed, taking into account the actors and factors that mark a specific conflict. Challenges to vaccination/immunisation in conflict situations can range from active conflict situations where health responses have to navigate around intense fighting, to situations where specific bans (access) are imposed (f.e. by non-state armed groups), to situations of general insecurity, or contexts where health workers are deliberately targeted.

Some hard questions ahead

Despite existing experience for vaccinations in Africa, there are a number of difficult questions and many unknowns related to the production, supply and use of COVID-19 vaccinations in fragile and conflict-affected states in Africa.

How much harm could be caused if COVID-19 vaccines do not become available for African societies in the near-future?
Severely limited supplies of COVID-19 vaccines to Africa will certainly cause a slow roll out of vaccination campaigns across the continent but this will be compounded in fragile and conflict-affected areas by a range of additional problems as highlighted above. Until entire populations can be vaccinated against COVID-19, African economies will continue to be negatively impacted by constraints and restrictions. Consequently, as our previous briefing note explained, poverty and food insecurity levels in Africa are likely to rise substantially, creating a climate with high potential for instability and conflict in Africa further down the line (Neat and Desmidt 2021).

Why do we need vaccination strategies that target the most vulnerable communities?
The most vulnerable communities already living in fragile and conflict-affected areas are at risk of being left behind in the COVID-19 vaccine race, due to lack of priority, logistical issues, or simply not being included in national vaccine distribution frameworks at all (ICRC 2020). Working in informal sectors and lacking social safety nets, they are particularly exposed to the negative socio-economic impacts of COVID-19 on poverty and food security, as prolonged COVID-19 restrictions will hinder them from carrying out essential livelihood activities. In addition, and as mentioned above, decision-makers will have to face the fact that not all communities can be reached by state and international aid. The implications of this, and how to scale support mechanisms to the needs of these communities, will need to be considered in vaccination strategies.

Why should we focus on both rural and urban zones?
So far, most vaccination centres are **urban-focused** in particular for vaccines that pose high logistical (cooling) challenges. But experts have warned that if urban populations are vaccinated against COVID-19 before rural populations, we are likely to witness a widening of the rural-urban divide in terms of socio-economic development (Schulten 2020). A return to relative normalcy in socio-economic conditions for urban settings risks giving rise to potential new tensions between rural and urban communities, and a deepening of mistrust between rural communities and state authorities deemed ineffective and discriminatory in their vaccine response.

What is the impact of COVID-19 on ongoing immunisation and vaccination campaigns?
While the global community focuses on the distribution of COVID-19 vaccines, there is a risk that these efforts will be made at the expense of continued investment in basic routine immunisations and their roll outs. According to Saferworld, COVID-19 has caused the suspension of immunisation programs in more than 60 countries for numerous diseases, for which safe and effective vaccines exist (Reliefweb 2020 and Save the Children 2020). Interruption of only one or two years of systematic vaccinations for diseases like measles or diphtheria could cause them to skyrocket amongst vulnerable populations, pushing them further into fragility and undoing hard-won gains on vaccination coverage of other diseases.

What is the threat posed by criminal and/or extremist groups in fragile regions?
In regions affected by conflict, notably border regions, and where the vaccine is likely to be scarce initially and insecurity high, distribution trucks and storage facilities may be raided or stolen by transnational criminal and/or extremist groups involved in criminal activities. The medication, possibly damaged through poor storage, might be resold online to health facilities or to increasingly desperate people (Felbab-Brown 2020). Criminal networks may illegally advertise fake vaccines and medicines for sale both physically and

online. These illicit medicines are a direct risk to the health of the most vulnerable, and can severely undermine national vaccination strategies and health efforts.

How could a failed vaccination lead to new grievances?

Unable to get access to safe vaccination, and struggling to mitigate the continued economic hardships of the pandemic, the most vulnerable communities may feel neglected by their governments and resent their lack of support. This notably includes neglected groups, such as migrants, refugees, and unregistered people, which risk ending up at the very bottom of the priority list for COVID-19 vaccination, and in some cases may not be included in the national vaccine programmes at all (ICRC 2020). Displaced people, often living in overcrowded and unsafe conditions, are particularly vulnerable to the socio-economic and health impacts of COVID-19. Neglecting these groups in the vaccine race could spark new grievances and heighten the risk for conflict and instability.

Where **armed groups** actively recruit amongst neglected groups, this risks providing an additional push factor for the population to support or join non-state armed actors, especially if these groups provide health, social and vaccination services themselves. This contributes to heightened levels of instability and conflict, as non-state armed groups are able to establish a stronger foothold in territories where vulnerable communities reside.

Implications for Europe for ensuring EU vaccination support to fragile countries

On balance, a mixed account on EU vaccination support

In response to the COVID-19 pandemic, "Team Europe" emerged in Spring 2020, in an attempt to align the initiatives of EU players. Team Europe mobilised some €38.5 billion from EU institutions, member states, the European Investment Bank (EIB), the European Bank for Reconstruction and Development (EBRD) and European development agencies (Jones and Teevan 2021).

EU delegations played a prominent role in the immediate response. The delegations coordinated the EU country response packages, with the active participation of member states' embassies and their agencies and development finance institutions. This coordination included the exchange of information, mapping and repackaging of activities and joint communication campaigns (Jones and Teevan 2021). According to Jones and Teevan (2021), this "Team Europe" approach played a role in increasing the coordination of EU member states with regards to the immediate humanitarian and health response. However, they note, the extent to which this approach increased coordination and coherence was determined to a large extent by the country context and "the preexisting relationship between the EU Delegations and the member states present in the field" (Jones and Teevan 2021).

Despite efforts to launch a more visible, joined up, and effective response to the COVID-19 pandemic, the EU's reputation as an effective and reliable partner in the realm of global health provides a mixed account. On the one hand, the reaction to its efforts to support COVID-19 related international aid has been lukewarm because of its limited financial scale. According to Jones et al (2020), it consisted mainly of the reallocation of resources and the repackaging of existing programmes. Bilal and Di Ciommo (2020) also noted the difficulty of tracking the EU's actions amongst a flurry of international initiatives, falling short of "providing good quality data on Europe's international response to COVID-19". So far the EU has not put in place a dedicated strategy or guidelines on how Team Europe aims to support a conflict and gender-sensitive recovery (including vaccinations) beyond their financial support package (Desmidt & Neat, 2020)

On the other hand, the EU's political messages in favour of solidarity and collective action (Team Europe) have been welcomed, as well as its role as a global convener and funder of global health initiatives (such as COVAX). In addition, the EU has been appreciated for its contributions to research and innovation (R&I) – in particular its collaborative work

with African countries and its efforts to promote open science. But overall, the EU has a limited legal mandate on health in its external action, as EU member states maintain most autonomy in health policy, regulation and implementation. Despite the pandemic, health remains so far relatively low on the list of top priorities for the EU's external action (Veron and Di Ciommo 2020).

The question of equitable access to vaccines is now becoming the focus in the global fight against COVID-19. As vaccination campaigns continue to roll out over the course of 2021, the EU will be involved in those where it is active in fragile and conflict-affected regions. As such, the EU's actions in this area will have important repercussions for its credibility in the years to come.

Courses of action for enhanced EU support

According to the People's Vaccine alliance, an estimated 9 out of 10 people in low-income countries are unlikely to receive a COVID-19 vaccine this year. Notwithstanding, humanitarian and health organisations are already preparing for the practical considerations of such a large undertaking (Lieberman 2021). In a recent op-ed, European, African and international leaders noted that "our health safety chain is only as strong as the weakest health system. COVID-19 anywhere is a threat to people and economies everywhere."[8]

If Team Europe aims to address the weakest health links in highly fragile contexts, much remains to be done. The current programming for the new EU budget 2021-2027 could be an important opportunity, not only to strengthen the EU's action on global health, but also to strengthen the intersection between health, development and peace in the EU's external action. The following courses of action for the EU to support COVID-19 vaccination campaigns in highly fragile and conflict-affected regions in Africa should be considered:

- **Continued and increased support to COVAX:** The EU should uphold or increase funding to COVAX and the Access to Covid-19 (ACT) Partnership to ensure that enough vaccines can be manufactured and delivered to Africa, considering to earmark a certain percentage for highly fragile countries. The EU recently announced that it will double its financial commitment to COVAX as part of a wider-G7 commitment to increase its contributions (BBC News 2021b). Beyond that, the EU should provide support to regional health organisations (such as the African Center for Disease Control, CDC) for the effective and safe delivery of vaccines to conflict-affected regions. It should also capitalise on its convening power to stimulate funding and investments in collaborative research and innovation with African research centres and universities to develop vaccines that are logistically easier to handle, requiring less cooling in particular.

- **Waiving intellectual property rights over COVID-19 vaccine technology:** Related to the above, the EU should encourage pharmaceutical companies and research institutions to waive intellectual property rights for COVID-19 vaccines so that additional manufacturing could be mobilised to help address vaccine disparities. This could be done by supporting global mechanisms that facilitate this sharing such as the World Health Organization COVID-19 Technology Access Pool (C-TAP). Linked to this should be efforts to boost the local development and production of vaccines. If this is not possible in (highly) fragile countries, efforts should be made to increase such production capacity on the African continent. As mentioned above, there is already some vaccine manufacturing capacity in several African countries, but more will be needed to supply the African population.

- **Upscale investments in early warning, local health systems, and social safety nets:** The EU should increase its support to early warning and mediation capacities, and stimulate the integration of health considerations in early warning systems. Part of these preventative measures should be to ensure that social safety nets are established in order to mitigate the worst of COVID-19-induced socio-economic

challenges for the most vulnerable and neglected members of society. To support the effective roll out of vaccination, this should also include targeted and long-term financial and capacity support to local public health systems in Africa, particularly in hard-to-reach, fragile, conflict-affected, and rural contexts.

- **Incorporate health more strongly as part of the EU's external and diplomatic action**: Health has been a central component in the EU's humanitarian actions as well the EU's international cooperation efforts. In fragile settings, the EU's humanitarian actions will be faced with health challenges as a result of COVID-19, and possibly future pandemics, for some time to come. The just published Communication on the EU's Humanitarian Aid (expected early March 2021) provides an opportunity for the EU to identify and implement new ways of working to address health at the intersection of peace, humanitarian aid and development in the post-COVID-19 world. But attention to (public) health, in particular vaccination and immunisation, could be further strengthened as part of the EU's external action from a longer-term perspective, and in support of the EUs role as a global health actor. This will require enhanced coordination between the EU bodies and EU member states because the competencies between the EU and its member states are shared.

- **Supporting vaccine access in conflict settings:** The EU should carefully consider how to calibrate its support to vaccines ceasefires in conflict-affected and fragile areas. This will include a thoughtful consideration about the balance between visibility and behind the scenes support. Ultimately, this will require the EU in exchange with its local and international partners to find out how they can support (i.e. financially, politically and/or legally) actors that have the credibility, the experience, skill and capacity to negotiate access and supply vaccines in hard to reach areas and situations of conflict. The EU, for example through its delegations, can also support the development and implementation of context-specific and conflict/gender-sensitive vaccination programmes by assisting international and local organisations with prior experience in this field, to capitalise on existing know-how, access and trusted relations. Finally, where politically sensible, the EU could play a part in backing the UN Security Council's recently renewed call for local ceasefires to enable humanitarian access and vaccination campaigns in conflict-affected areas (UN 2021), either by promoting its inclusion in exiting peace process or by supporting (local and/or international) actors that have the leverage to negotiate such access.

- **Curbing the spread of counterfeit vaccines and misinformation:** The EU can step up its efforts to support regulatory mechanisms to manage the distribution of vaccines that come from legitimate sources. It should invest in supporting national and local governments and civil society organisations to engage and build trust with local communities (including community leaders), and help to develop information campaigns that can raise awareness of the general public to counterfeit medicines and false information, especially those living in fragile contexts. The EU could support efforts by international health organisations, local health authorities, and local communities to design and implement context-specific and community-led vaccine campaigns, which should include the sharing of information in local languages in order to achieve maximum uptake of vaccines.

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References

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[2] As of 1 March 2021.

[3] Members of the AVATT include: Chairperson of the AU Commission Moussa Faki Mahamat; Strive Masiyiwa, AU Special Envoy; Dr Donald Kaberuka, AU Special Economy Envoy; Professor Benedict Oramah, President of the AFREXIMBANK; Amira Elfadi Mohammed, Commissioner of Social Affairs; and Dr. John Nkengasong, Director of the Africa Centres for Disease Control and Prevention (Africa CDC).

[4] Tedros Adhanom Ghebreyesus, director-general, World Health Organization (in Furlong 2021).

[5] The Seychelles for example aims to obtain enough vaccines to cover 178% of its population, versus others such as Algeria, Rwanda, and South Africa covering only 1% or less of their populations (in Development Reimagined 2021a).

[6] For humanitarian aid agencies to gain temporary access in Somalia, senior aid agency managers communicated with the Al-Shabaab senior leadership through intermediaries to gain access (in Jackson 2014).

[7] Earlier health emergencies have proven this point, as eruptions of violence against healthcare workers and treatment centres during the Ebola pandemic were especially frequent in highly fragile and conflict-affected regions.

[8] Project Syndicate.

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HEAD OFFICE
SIÈGE
Onze Lieve Vrouweplein 21
6211 HE Maastricht
The Netherlands *Pays Bas*
Tel +31 (0)43 350 29 00
Fax +31 (0)43 350 29 02

BRUSSELS OFFICE
BUREAU DE BRUXELLES
Rue Archimède 5
1000 Brussels *Bruxelles*
Belgium *Belgique*
Tel +32 (0)2 237 43 10
Fax +32 (0)2 237 43 19

info@ecdpm.org
www.ecdpm.org
KvK 41077447