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Unilateralism and the Challenges of Covid-19 Vaccine Distribution in Africa: A theoretical Discourse

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Abstract

The study examines how the unilateral actions of States regarding purchase and distribution of Covid-19 vaccine undermined Africa's effort to effectively secure the vaccine for its citizens. The study hypothesised that due to unilateral decisions and actions of great powers, Covid-19 vaccine distribution in Africa has been grossly inequitable, viz a vis that of Asia, Europe and America. Unilateralism and Vaccine Nationalism on one hand; and Multilateralism and Cosmopolitanism on the other hand are two broad categories of theories used to unearth the philosophical foundations of States' actions regarding the acquisition and distribution of covid-19 vaccine. Documentary method of data collection from secondary sources was adopted to gather relevant data for the study; while qualitative descriptive method was used to analyse the data obtained. The study therefore concludes and recommends that Africa needs to rely on Africa to proffer solutions to its problems without relying so much on external powers. To do this, African Vaccine Acquisition Task Team (AVATT) must be strengthened financially and materially to deal with not just covid-19, but future viral pandemics that the continent might be entangled in.

Keywords: Unilateralism, Multilateralism, cosmopolitanism, Vaccine Nationalism, Covid-19

Introduction

It is no longer news that emergence of the new coronavirus disease has sent shock waves down the spines of billions of people around the world, causing the death of millions and infecting hundreds of millions more. On 30th January, 2020, the World Health Organisation (WHO) declared the disease a Public Health Emergency of International Concern (PHEIC), and on 11th March 2020, it declared it a global pandemic, as it reeled out guidelines and measures to be followed to mitigate the spread of the virus pending when a vaccine will be ready for inoculation (Masresha, et al, 2022).

It is imperative to note that as at May 6, 2022, about 6million deaths have been recorded thus far, and over 500million confirmed cases (WHO, 2022). But in a recent report made available by the WHO, it notes that there has been an excess death of over 15million people around the world. The reason advanced by the apex health body is that there were some deaths missed by national reporting systems due to lack of data or oversight in dozens of countries between 2020 and 2021 (Adam, 2022).

Interestingly, the rapid spread of the disease with its attendant death toll, led to an

unprecedent fast development, production and distribution of safe and effective vaccine. Before now, this usually takes between 10 – 15 years to produce (Rustschman, 2021a; Forman, et al, 2021). Today there are multiple vaccine candidates that have emerged in less than 2 years, receiving authorisations from world health authorities for emergency use (Forman, et al, 2021). Prior to authorisation, high income countries (who are just a fraction of the world's population) have already ordered more than half of the first batch of doses projected to be supplied. In fact, by mid-August 2020, the United States (US) through its infamous strategy of "Operation Warp Speed" have secured about 800million doses of 6 different vaccines that were in their developmental stages, for its 345million population (with about 2 per capita). United Kingdom (UK) had also purchased about 340million doses for its 68million population (about 5 per capita). The European Union on its part had also ordered for hundreds of millions of doses for its region (Callaway, 2020). This has been described as vaccine nationalism – the unilateral actions of States regarding the pandemic solely for the benefit of its citizens to the exclusion of others, especially low-income countries, globally (Gupta, 2021; Bhutto, 2021). Vaccine nationalist and unilateralist positions and sentiments are very strong, especially among States that manufacture vaccines or have the financial or economic wherewithal to purchase and stockpile for its citizens' use.

However, this raises important ethical issues for the multilateralist and cosmopolitans alike. The Global Vaccine Initiative (COVAX) framework and facility, largely supported by Vaccine Alliance (GAVI), Coalition for Epidemic Preparedness and Innovation (CEPI) and WHO is an example of a multilateral framework, with cosmopolitan ideology. According to them, while it is legal for some developed nations of the world to acquire about 2billion doses of different vaccines that are in their developmental stages, through Advanced Purchase Agreements (APAs), it undermines international cooperation and multilateral efforts advanced by both WHO and COVAX framework to equitably distribute vaccines in a fair, transparent and accountable manner to all nations of the world. APAs are bilateral arrangements that are legally binding between nations, where one nation gains access to a future vaccine through acquisition of specific number or percentage of the vaccine at a predetermined price (Jerker, Wightman and Diekema, 2021). Sometimes what is termed lawful might be unethical and what is termed ethical might be unlawful. Although, APAs are lawful. But with regard to vaccine management and distribution, they are unethical. This is so because such actions by developed countries through APAs only benefit a handful of nations, leaving the bulk of the world's population unvaccinated. Sometimes, ethical actions tend to benefit more people than lawful ones. This is the case with the administration of covid-19 vaccines. This is because leaving the bulk of the world's population unvaccinated only prolongs the pandemic period. This will in turn affect the global economy, which the developed nations are a part of, directly or indirectly. According to Oxfam (2020), more than 51% of the initial vaccines developed have been acquired and stockpiled by the developed nations of the world, who make up only 13% of world's population, thus making procurement and accessibility difficult for other nations.

More importantly, Africa, largely characterised as having low- and middle-income countries, will likely pay a high price before they can buy the vaccine. But they will find it difficult to purchase, given their restricted and limited purchasing power (Soumya, 2022). This is so because the bilateral APAs contracts lack pricing transparency and are sometimes shrouded in secrecy. For instance, there are different prices for different nations who are willing to purchase the vaccines. Notably, the Pfizer/BioNtech vaccine costs $19.50 in the US and $18.90 in the UK, all per dose. The Oxford/AstraZeneca costs $4 per dose, while the Moderna is pegged at $37 per dose. In light of this, it is quite astonishing that the Isreali government's rush to inoculate its population led it to pay a high amount of $30 per dose for the Pfizer/BioNtech vaccine that costs an average of $19 per dose (Guzman, Hafner, Maiga, and Giedion, 2021). In sum, agreement confidentiality undermines the bargaining power of low- and middle-income countries in Africa (Soumya, 2022).

In another light, cosmopolitans and multilateralist argue that vaccine global acquisition and distribution should be favoured to the unilateral actions of States engaging in vaccine nationalism. By way of illustration, as at 6th of May, 2022, about 11.6billion vaccines have been administered in the world. Of this amount, 7.5billion (more than half) have been administered to developed nations of the world. In Africa, only 488million vaccines have administered, which has only fully vaccinated 16% of its population, with only 23% receiving their first shot of the vaccine. This is the worst in the world when compared to Latin America's 75%, Asia's 70% and Europe's 76% and North America's 73% of populations that are fully vaccinated, having received all required number of doses (WHO, 2022; Statista, 2022a). With the foregoing, it is apparent that Africa is not likely to reach the 70% target vaccination of its population of mid-June, 2022, set by WHO for countries and regions in order to achieve herd immunity. Although, the African Union Vaccine Acquisition Task Team (AVATT) has set a 60% vaccination rate for the continent by 2022, it is still far from reaching this goal as at the time of writing, with just 16% of its population vaccinated so far.

Beyond vaccine nationalism and unilateralism, there are other factors responsible for Africa's slow vaccine uptake and demand. These include, lack of local capacity to manufacture vaccines, insufficient funding to procure vaccines, lack of operational and logistic funding within countries, safety issues and vaccine hesitancy, unavailability of covid-19 data of high-risk persons, disinformation, shortage of health care workers to administer vaccines, etc. With these factors in place, the continents will be exposed to more risks, especially now that new variants like Omicron is gaining traction. Other challenges responsible for shortages of vaccines in Africa is vaccine diplomacy (whose goal is only to further the foreign policy interest of wealthy, powerful nations in less powerful one), have been allowed to hamper COVAX dose sharing framework for the benefit of high-risk nations of the world (Puyvallee and Storeng, 2022; Bradshaw, Mamo and Akuagwuagwu, 2022; Almeida, 2020).

In order to remedy the above challenges, some policy options amongst others, need to be considered. First, to address the issue of effective distribution so low-income

countries with huge presence in Africa will not lag behind, is to develop a uniform strategy that saves the most lives and mitigate further spread. To do this, the COVAX framework, AVATT and WHO governance structure should be strengthened and financially empowered to source its vaccines from various countries and not just rely on some powerful nations who might manipulate vaccine distribution for nationalist and political interests. For Africa, especially AVATT, considerable efforts should be focused on local vaccine manufacturing so that the continent can be self-sufficient to inoculate its citizens, and not overly depend on foreign donations that are likely to disappoint at critical times of need.

Established in 2020, and endorsed by African Union Bureau of Heads of State and Government, AVATT is a 10-member team drawn from across the continent, with mandate of inoculating the continent's population to about 60%, in order to achieve herd immunity. With approved fund of $2billion from African Export and Import Bank, AVATT has been able to secure hundreds of millions of Johnson and Johnson Vaccines, and to negotiate for others (Ighobor, 2021).

Problem Statement

The United Nations mantra of "leave no one behind" appears not to be applied in the administration of covid-19 vaccination in low income countries of Africa and elsewhere. The evidence for this is ubiquitous, as the amount of vaccine and vaccination currently available and administered in the continent are largely insignificant when compared with other regions of the world. One of the reasons for this lies in the unilateral actions of developed countries who embark on vaccine nationalism by buying up and stockpiling different vaccines for its citizens, sometimes, much more than it needs. Another reason lies in the bilateral signing of Advanced Purchase Agreements (APAs) with vaccine manufacturing firm, which are sometimes shrouded in secrecy, especially with regard to pricing of vaccine per dosage. Similarly, bilateral vaccine diplomacy, where powerful States use the donations of vaccine to low income countries to advance their foreign policy objectives, presents another challenge. Next is the politicisation of the COVAX framework and facility, which undermines its effectiveness and promise of equitable distribution of vaccines based high risk priorities and targets. Other factors are inherent in the continent, caused by disinformation, lack of operational and logistical funds, safety issues and vaccine hesitancy, among others. Addressing some of these issues with their appropriate headings is important to make for better clarification and understanding.

Ethical and Legal challenges of APAs

Advanced Purchase Agreements (APAs) for vaccine procurement are bilateral arrangements made between a State and a manufacturing firm for the purchase of its future vaccines. While this is a lawful practice, it however raises some ethical questions, especially when wealthy nations procures more than what its domestic population needs. For instance, the US, although not needing the Oxford AstraZeneca Vaccine, still procured and stockpiled it (Williams and Stacey, 2021), leaving those who are in dire need of the vaccine in lack and want. This, according to some scholars undermine multilateral efforts put in place to equitably distribute

vaccines. Actions like this are however responsible for the theoretical debates between vaccine unilateralist and nationalist on one hand and cosmopolitanist and multilateralists on the other.

Theoretical Discourse

Unilateralism and Vaccine Nationalism

Unilateralism is theoretical construct which states that States in the international system will likely opt out of a multilateral framework when faced with national security emergencies, especially if the multilateral framework is not likely to enable it achieve its desired objective (Dupuy, 2000). According to Malone and Khong (2003), States often choose unilateral actions over multilateral ones because they do not wish to subject themselves to the generalised principles of conduct being negotiated or enforced, which are sometimes detrimental to their national interest. This is also in line with *Realism*, an international relations theory that emphasises power (military, economic, diplomatic, soft, or hard) as the main tool of engagement with States in the international system. In this light, the decision of some powerful States to pre-purchase more than half of different vaccine candidates by the third quarter of 2020, through APAs, specifically for its population, is termed as vaccine nationalism (Rutschman, 2021b). From early 2021, most have purchased even beyond what their domestic population needs. For instance, by mid-August 2020, the United States (US) have secured about 800million doses of 6 different vaccines in developmental stages, for its 345million population (with about 2 per capita). United Kingdom (UK) had also purchased about 340million doses of its 68million population (about 5 per capita) (Callaway, 2020). Also, even though the US regulatory agencies did not approve AstraZeneca vaccine for domestic use, it nevertheless purchased and stockpiled it (Williams and Stacey, 2021). The security threat posed by pandemic on States accounted for the corresponding behaviour of unilateral acts, leading to vaccine nationalism. Although, unethical, but not unlawful.

Fundamentally, vaccine unilateralist and nationalist reject cosmopolitan view of vaccine distribution as they see it as an attempt by poor and weak to States to prey on the resources of the rich and powerful during this pandemic to achieve their own national interest (Gantsho and Wareham, 2020). This view, as we shall see later, is however, strongly opposed by the multilateralist and cosmopolitans.

Cosmopolitanism and Multilateralism

The word Cosmopolitanism is derived from the Greek word *kosmos*, which loosely translates as "a universe of order and harmony." In one of the earliest English translations, *kosmos*, means "a beautiful world order" (Walker, 2000, p. 52). This thought dates back at least to the stoics, who referred to themselves as cosmopolitan "human beings living in a world of human beings, and incidentally, members of polities" (Barry, 1999, p. 35). Cosmopolitanism can also be traced to the works of Paine: *Common Sense* (1776); *Rights of Man* (1791) and his famous *Letter to Abbe Raynal* (1782). Other scholars on cosmopolitanism are Pogge (1994, 2013); Beitz (1994); Kor-Chor (2004).

Central to the thoughts of cosmopolitans is the great attention for the individual human beings, as primary concern of global

justice, and not States, or other forms of human association (Soumya, 2022; Pogge, 2013; Beitz, 1994). In fact, Paine in his *Letter to Abbe Raynal*, asserts that humans must work to develop "universal society, whose mind rises above the atmosphere of local thoughts and considers mankind, of whatever nation or profession they may be, as the work of one creator." (Paine 1782, cited in Walker, 2000, p. 60). The concept of global justice, equity or fairness are an offshoot of cosmopolitanism. In cosmopolitan philosophy, the need to share resources with fellow humans does not stop at State borders. Thus, the principle of shared responsibility is paramount in all human relations (Pogge, 1994; Held, 2003; Kataria and Qu, 2021). Multilateralism on the other hand, refers to the cooperation of States in the international system with regard to solving an identified global issue or challenge through a generalised principle of conduct (Malone and Khong, 2003).

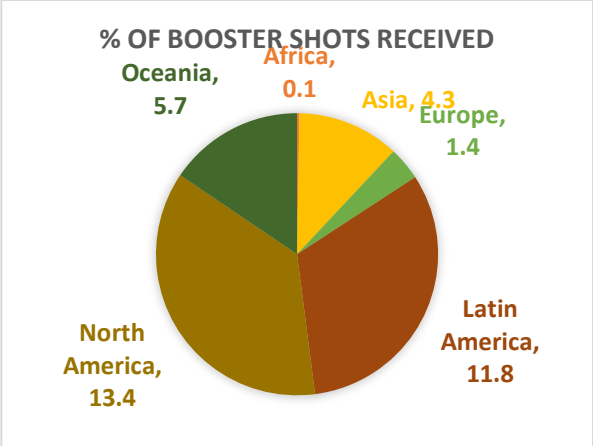
Table 1: Regions and percentage of vaccinated population

Regions	Region's population	% of population vaccinated
Africa	1.4billion	16%
Asia	4.7billion	70%
Latin America	437million	75%
Europe	749million	76%
North America	601million	73%

Source: Researcher's compilation from based on data obtained from WHO (2022) and Statista (2022a, b, c)

While vaccine nationalist and unilateralist have a strong case of moral responsibility to protect its citizens and compatriots whom they are directly responsible for, before any other, cosmopolitans and multilateralists reject such particularistic duty in favour of a shared responsibility to all humans, irrespective of their nationality or place or origin (Kleingeld and Brown, 2019; Kor-Chor, 2004). The case of Africa in all this is particularly pathetic, as table 1 above and fig 1 below show the disproportionate distribution of vaccine and booster shots taken in various regions of the world. As evidently shown above in table 1, African countries, having the second largest population in the world, have only fully vaccinated 16% of its population, with only 0.1% of its population receiving the booster shots. See fig 1.

Figure 1: showing booster shots distribution for various regions of the world



Source: Researcher's compilation from based on data obtained from Ordu and Golubski (2022)

Again, while nationalist and unilateralist view of vaccine distribution accuses poor and weak States of using cosmopolitanism and multilateralists views of vaccine distribution to manipulate wealthy States in helping them achieve their national interest, the cosmopolitans disagree, as its major concern is to cater for those who are at high risk irrespective of borders, nationality or place of origin. According to them, if these individuals are within the borders of

developed and wealthy States, then the main focus of care and vaccine distribution must also be concentrated there and not anywhere else where such care is of no immediate importance (Gantsho and Wareham, 2020). Table 2 below for instance, reveal that the most vulnerable individuals at risk in Africa are yet to be inoculated. This ultimately show where the vaccine allocation should be channelled to.

Table 2: Showing vaccination of high-risk populations in Africa

African countries	Vaccinated patients with comorbidities		Vaccination of older adults		Vaccination of health workers	
	Num. of pop.	%	Num. of pop.	%	Num. of pop.	%
Algeria	-	-	-		-	
Angola	-	-	-		-	
Benin	-	-	-		-	
Botswana	-	-	200,000	15%	20,000	0.3%
Burkina Faso	40,000	5%	1,200,000	85%	30,000	0.4%
Burundi	10,000	1%	-		10,000	0.1%
Cabo Verde	20,000	2%	80,000	2%	10,000	0.1%
Cameroon	220,000	27%	300,000	25%	50,000	0.8%
CAR	-	-	-		-	
Chad	10,000	1%	20,000	0.3%	10,000	0.1%
Comoros	20,000	2%	10,000	0.1%	10,000	0.1%
Ivory Coast	90,000	15%	-		30,000	0.4%
Congo DR	190,000	24%	-		-	
Djibouti	-	-	-		-	
Egypt	-	-	-		-	
Equatorial Guinea	10,000	1%	-		10,000	0.1%
Eritrea	-	-	-		-	
Eswatini	35,000	4.5%	100,000	4%	15,000	0.15%
Ethiopia	-	-	-		230,000	15%
Gabon	20,000	2%	-		10,000	0.1%
Gambia	30,000	4%	70,000	1%	10,000	0.1%
Ghana	-	-	120,000	5%	250,000	18%
Guinea	10,000	1%	-		10,000	0.1%
Guinea Bissau	300,000	30%	-		-	
Kenya	-	-	1,300,000	90%	240,000	14%
Lesotho	-	-	600,000	40%	30,000	0.4%
Liberia	300,000	30%	-		-	
Libya	-	-	-		-	
Madagascar	180,000	23%	150,000	6%	20,000	0.3%
Malawi	40,000	4%	155,000	6.5%	20,000	0.3%
Mali	20,000	2%	280,000	16%	-	
Mauritania	-	-	-		-	
Mauritius	-	-	-		-	
Morocco	-	-	-		-	
Mozambique	60,000	7%	70,000	1%	40,000	0.7%
Namibia	-	-	-		10,000	0.1%
Niger	-	-	-		10,000	0.1%
Nigeria	-	-	-		350,000	26%
Rep. South Africa	-	-	-		-	
Rwanda	170,000	22%	700,000	55%	50,000	0.8%
Sao Tome & Principe	13,000	1.2%	20,000	0.3%	10,000	0.1%
Senegal	785,000	85%	650,000	45%	390,000	29%
Seychelles	-	-	-		-	
Sierra Leone	-	-	-		1,400,000	85%
Somalia	-	-	-		-	

Source: Researcher's compilation based on data from World Health Organisation (2022)

Politicisation of COVAX Framework and Facility

Partly governed by the Vaccine Alliance (GAVI), Coalition for Epidemic Preparedness and Innovation (CEPI) and WHO, the Global Vaccine Alliance (COVAX) was established in June, 2020. Its major remit is to see to the equitable distribution of vaccine to the world's poorest populations with approximately 2 billion doses (Zhou, 2022), especially to the 177-participating low- and middle-income countries, of which African countries are a part of. But this initiative has failed to meet up with its target, partly so, because of a number of reasons. Chief of which is vaccine nationalism, vaccine diplomacy, shortage of funding, and other internal contradictions within the COVAX

framework and facility. All these are as a result of the politicisation of the framework and facility by powerful COVAX partners, for the pursuit of their national interests (Moon, et al, 2021; Gavi, 2020).

Vaccine nationalism and vaccine diplomacy were the two major ways in which COVAX partners undermined the effectiveness and transparency of the facility and to make them not reach their target in 2020. One reason that accounts for the inability of COVAX to get vaccines on time for the world's most vulnerable populations in 2020, was because its wealthy partners have gone ahead to buy up the vaccines from manufacturers ahead of time through APAs, strictly for the benefit of its domestic populations. Its partners also used vaccine diplomacy to frustrate COVAX's meeting of its target as they failed to donate the required number of vaccines on time because they were busy using the vaccine to further their foreign policy objectives in weak States. For instance, countries like China, India, Russia, donated doses bilaterally to allies before donating to COVAX. Netherlands donation to COVAX came in late November, 2021, after it had donated to former colonies like Suriname and Indonesia. For Portugal, it donated first to former colonies as well, like Guinea Bissau, Sao Tome and Principe, Angola, Guinea Bissau, Cabo Verde, and Mozambique (Puyvallee and Storeng, 2022).

Intra African Challenges Undermining Vaccine Distribution and Delivery within the Continent.

Aside from the aforementioned and discussed global challenges undermining speedy vaccine delivery to low- and middle-income countries of the world, and in particular, Africa, there are other domestic or continental challenges to vaccine delivery and vaccination in general. These include but not limited to, inadequate cold chain facility, earmarking of vaccines, violent conflicts and civil wars in countries like Somalia, Mali, and in North Eastern part of Nigeria presents a challenge to vaccination of the population, poor coordination of stakeholders and budget, lack of local capacity to manufacture vaccines, insufficient funding to procure vaccines, lack of operational and logistic funding within countries, safety issues and vaccine hesitancy, low mortality rate in Africa compared to other regions of the world, unavailability of covid-19 data of high-risk persons, disinformation, shortage of health care workers to administer vaccines, etc (Puyvallee and Storeng, 2022; Bradshaw, Mamo and Akuagwuagwu, 2022; Almeida, 2020).

Poor funding of health systems in Africa is one of the biggest challenges confronting vaccination programmes in the continent. For instance, Africa was only responsible for the manufacturing of less than 1% of vaccines administered within the continent. This means that Africa imported over 99% of vaccines administered on the continent and consuming over 25% of vaccines produced globally (Sidibe, 2022)

Conclusion

The study discussed the challenges faced by African States in the equitable distribution of covid-19 vaccine. This challenge was attributed to unilateral decisions and acts of some powerful States in the international system. Various theories were discussed to fully grasp and understand the reason for States' actions regarding the vaccine. Africa, on its part, established AVATT as a means to help the continent acquire and distribute vaccine to its population. But

their efforts were seriously undermined the great powers' unilateral actions.

Recommendations

In view of the foregoing challenges, problem discussion, theoretical debates and analysis, Africa, through its AVATT establishment, must endeavour to implement the following policy recommendation if it hopes to meet up with its vaccine mandate of vaccinating 60% of Africa's population by the end of 2022, and to also be readily prepared to deal with future viral pandemics.

- Although it has collaborations with other multilateral and cosmopolitan institutional frameworks, like COVAX, World Bank, UNICEF, WHO among others, AVATT must however, lend its voice in no uncertain terms to dissuading wealthy and powerful partners of these frameworks, especially COVAX, from unilateral acts of vaccine nationalism, in favour of a more efficient and resilient global, cosmopolitan and multilateral approaches to vaccine distribution and delivery to the most vulnerable populations of the world.

- AVATT should ensure that there is adequate and scaling up of financing in Africa's health sector. In the realm of vaccine production, development, management and delivery, financing is key in all its value chains. From research and development, to importation or procurement of materials or vaccines, acquisition of syringes, refrigerators and freezers, remuneration of frontline workers, etc., proper funding is key. In light of this, AVATT and its leadership must stress this at the African Union level and domestically, for the State governments to meet up with the 2001 Abuja Declaration of allocating 15% of their national budgets to domestic health care systems. This will be of immense benefit to African health systems, as it will also contribute to making it resilient and efficient. They should also recommend appropriate sanctions to member States who fail to meet up with this obligation. This is because the health of a nation is the foundation of any meaningful development that a State hopes to achieve.

- AVATT should endeavour to persuade foreign donors to also fund recurrent expenditures that have largely undermined the vaccines distribution and delivery domestically and finally, into the arms of the populations. These recurrent expenditures include: remuneration of frontline workers, provision and maintenance of cold chain facilities, transportation, and other logistic support provisions.

- AVATT should endeavour to enlist the services of paramedics and sometimes, non-health workers to assist in vaccination campaigns and outright jab administration across the continent. Focusing on medical practitioners and professionals alone will not be adequate for the vaccination campaign, and thus will further keep the continent and AVATT from reaching its target. However, when other paramedics are enlisted, it will help to create needed awareness and to meet up with vaccination target by the year end of 2022.

- To deal with vaccine apathy, hesitancy and safety issues,

AVATT should prioritise the vaccination of frontline health workers. In as much as this is a standard health practice, it will also help to boost general confidence of vaccine uptake and intake among the population. Also, mobilisation campaign through all media outlets must be properly planned, well-funded and adopted. From social media, to print, radio and television jingles, and more importantly, religious and community leaders must be educated and persuaded to encourage their followership to accept the vaccine and also to help dispel myths surrounding vaccine intake and safety.

- AVATT can also advice its parent body, the African Union and its members to set aside one day in a month, called maybe, *Adult Vaccination Day*. This might be similar to the monthly sanitation that goes on in most African countries, where citizens do not leave their homes until 10:00am, every last Saturday of the month. The difference here is that this will take the whole in order to give health care workers ample time to carry out their vaccination programme for the day. This, will not only create more awareness, but also increase vaccination rate within the continent.

- Local capacity must be developed to manufacture vaccines domestically. This will help curb over reliance on foreign donations and imports. To this end, AVATT must ensure that the proposed/ongoing transfer of technology to Africa, between French government and South Africa, to localise vaccine manufacturing of the mRNA model, is pursued vigorously and realised (Africa Renewal, 2022). This will not only be useful for vaccine production for covid-19, but also, for other viral diseases (e.g. HIV/AIDS) that has been plaguing the continent for decades.

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