World view

By Rabah Arezki

Cash payments in Africa could boost vaccine uptake

When doses finally arrive, use cash incentives to overcome hesitancy.

Any global-health researcher can tell you that solving one problem at a time is not enough. As the COVID-19 pandemic surges in Africa, securing access to vaccines is the dominant focus. But more must be done to ensure citizens will get them. The best option, in my view, is cash incentives.

There is a debate across the globe on how best to incentivize immunization. Regions of the United States have offered entry into prize lotteries, and even US$100 savings bonds. Uptake is particularly important in Africa.

Only about 1.4% of Africa's 1.3 billion people have been fully vaccinated. Since the start of the year, cases have more than doubled, with Botswana, Namibia, South Africa and Tunisia reporting their highest jumps in cases since the pandemic began. Right now, the problem is vaccine availability. Rich countries have more vaccine than they need, and African countries have been left with only 2% of the total supply.

Outrage at this disparity (plus the potential for more-dangerous viral variants to evolve where infection rates are high) has prompted promises of one billion doses to poorer countries alongside other initiatives and the ramping up of vaccine production.

Attention must now be paid to getting shots into arms. Already, vaccine hesitancy has cost Africa. Several African countries, including the Democratic Republic of the Congo, Malawi and South Sudan, have had to destroy or return vaccines because doses could not be used before their expiry date.

As chief economist at the African Development Bank in Abidjan, Côte d'Ivoire, and, before that, for the World Bank's Middle East and North Africa Region, I have evaluated many programmes and studies on cash transfers. I know the idea is controversial. Some critics argue that all efforts should be focused on securing vaccines. Others counter that the capacity to implement a cash-transfer programme on this scale does not exist. Still others say that offering cash incentives to people for behaviours that benefit them is ethically problematic, coercive or erosive of trust.

When I first heard of cash transfers, in a 2008 employment programme in Liberia, I was sceptical. But I have seen them used carefully and effectively. For instance, a programme targeting women of childbearing age in Nigeria significantly increased tetanus immunization. These programmes encourage vaccine uptake even as logistical challenges such as maintaining the vaccines in cold storage and distributing them are managed.

That means that a cash-transfer programme would complement other 'supply side' efforts, including logistics, communication and community engagement. (Of course, cash transfers must be combined with other mechanisms, such as mobile clinics, to ensure that people who want vaccines can get them.)

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In another example of their effectiveness, cash transfers to families in Indonesia for bringing children in for routine health care and enrolling them in school showed significant results, reducing stunted growth in children by up to 23%.

These programmes are so well established that they are being used to benchmark other interventions. Both development banks and non-governmental organizations (NGOs) have developed best practices for designing and implementing these programmes at scale, including targeting them to vulnerable communities.

I envisage a programme that would offer each individual eligible for vaccination in West African countries a payment for receiving the shot, say, 6,000 West African CFA francs (US$11). That amount is 10% of the monthly guaranteed minimum wage in Côte d'Ivoire.

In 2019, Africa received about $58 billion in foreign aid. I estimate that an effective cash payment would add some $9 billion to an estimated $15 billion for providing and administering COVID-19 vaccines across Africa. The bulk of the money would come after the second dose — or full payment be made at once in the case of one-shot vaccines. Funding would come from the world's richest countries, foundations and corporations, particularly those with business interests in the continent. This programme would reduce vaccine inequity, save lives and bolster hard-hit economies where the pandemic has plunged many into poverty.

The infrastructure to carry out such a payment programme is already in place: about half of Africans have mobile phones, and programmes designed around these have improved childhood vaccination rates in Bangladesh. By transferring money directly through mobile phones, authorities can better ensure that funds go to the intended recipient. For those without a phone, beneficiaries would receive a voucher with a unique identifier that could be redeemed for cash. Again, there is precedent. During the Ebola crisis, a vast cash-transfer programme used many delivery methods, including direct payments to people in the most remote areas without mobile phones.

The vaccine-incentive fund could be administered by development banks working with public-health bodies, NGOs and telecom operators. Blockchain technology could record doses and payments, to ensure traceability and limit corruption. The technology to record doses has been put in place by airline corporations and British hospitals.

This would be a huge benefit for Africa, and would be in donors' self-interest. Arresting the virus's spread in Africa would both revive a major global market and reduce the chances of the virus mutating into more-dangerous forms.

Rabah Arezki is the chief economist of the African Development Bank and a senior fellow at Harvard's Kennedy School of Government.
e-mail: rabah_arezki@hks.harvard.edu
Twitter: @rabah_arezki

NORA ARÉZKI