‘Only for African export’: understanding vaccine hesitancy in a Ugandan town

In the town of Arua, people refuse COVID vaccines for numerous reasons. ***Liz Storer (LSE)*** *and* ***Osuta Jimmy*** *explain how the colonial legacy in the region, worries about side-effects, conspiracy theories that feed into narratives of oppression by the West, and belief in prayer and herbal cures for COVID have made people reluctant to get the jab.*

In Arua, a border city located 420km from the Ugandan capital in the West Nile, self-reliance is paramount. The state cannot be relied upon for welfare or assistance, and most people are involved in agriculture or trade that depends on their own graft. Since the first lockdown exacerbated poverty and food insecurity, it is not surprising that many Aruans again evaded restrictions when a second national lockdown was imposed in June 2021, continuing to work and pursue a basic social life. Indeed, on 21 July, members of the Ugandan Parliamentary Technical Committee on COVID-19 declared Arua the worst district at sticking to lockdown restrictions. This was a particular concern since it sits in a ‘porous’ border region, where the virus could potentially spread across international borders.

The roots of resistance to government guidelines can also be found in the complex political-economic history of the West Nile sub-region. Successive waves of state-led exploitation and antagonism under colonial and post-colonial administrations have produced a distinct mistrust of state actors and militaries. Owing to the legacy of slave trading and the brutality of Belgian and British occupation, the sub-region was a backwater at the time of independence in 1962.

In the 1980s, armies belonging to the Obote II administration spread terror among West Nile’s civilians, who fled into international exile. Since Yoweri Museveni became president, there have been limited developmental gains. Across most sub-counties, people have continued to elect politicians from the opposition. In 2019, Arua was the site of anti-government protests – and military reprisals – following the assassination of Bobi Wine’s driver. Since crisis has so often been perpetuated by the state, it is unlikely that people entirely trust the state to contain crisis.

Yet mistrust of the state does not mean that people automatically resist government-led health programmes. In the 2000s, in the midst of the mortality crisis associated with HIV/AIDS, populations readily accepted antiretroviral drugs (ARVs) when taking pills stopped neighbours and family members dying. So strong was this memory that, in 2016, when Hepatitis B became a national health priority and testing was piloted in the region, many queued to learn their status, citing the earlier successes of HIV testing as their chief motivator. Subsequently, many who tested negative opted or paid for their own vaccination. In 2018-19, many campaigned for clinical protections as Ebola ravaged populations across the border in Eastern Congo.

When public health experts invoke ‘vaccine hesitancy’, individual behaviour is singled out as a barrier to vaccine uptake. Yet these decisions are conditioned by legacies of state mistrust and public health failures.

As part of Uganda’s National Deployment Vaccination Plan (NDVP), commitments have been made to vaccinate 21.9 million Ugandans, beginning with health workers, followed by high-risk groups including security personnel, teachers, frontline humanitarian workers and those with underlying conditions. Vaccine nationalism has promoted stark inequities in distribution. A recent report revealed that Uganda was being charged $7 per dose of AstraZeneca, more than three times more than the European Union. When transport was factored in, it was estimated to cost $17 to vaccinate each Ugandan.

To date, Uganda has largely relied on international donations. In March, the Ugandan Ministry of Health received 864,000 doses of the AstraZeneca vaccine via the UN’s Covax scheme, and more than 100,000 doses from the Indian government. This first shipment was enough to vaccinate just 1% of Uganda’s population. By mid-June, as Uganda faced a third wave spurred by the more infectious Delta variant, the country had reportedly run out of vaccine stocks. Public and private health facilities ceased distribution to the general populace.

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Playing football in Arua in 2007. Photo: Sanjoy Ghosh via a CC BY 2.0 licence

The Ministry of Health’s approach means that targeted groups must be vaccinated first, leaving the general population to wait. Even for eligible groups, vaccines have not always been available at health facilities. In Arua, many who received their first jab have not received their second. Reliance on alternatives is in part pragmatic, since in this context of scarcity, protection from a single (let alone a double) vaccination is simply not an option. Yet supply is not the only barrier. Many Aruans question whether the vaccine would work, and many health workers have been discouraging family members from getting vaccinated. When health workers and other Aruans rejected the vaccine, we found that advice was premised on three broad categories: worries about health outcomes, conspiracy theories, and reliance on alternatives.

Worries about health outcomes

On the one hand, Aruans worried that the timescales in which COVID vaccines were developed were insufficient to ensure safety. Usually, vaccine development took several years; COVID vaccines were licensed for approval in just a few months. This caused concern. Many also struggled to understand the different types of vaccine: though there was one virus, there were many different brands of vaccine whose efficacy was discussed in international media. Which one is the safest? The waters were further muddied when global reports spread about a link between the Oxford AstraZeneca vaccine and blood clots, following reported deaths in the UK and side effects in Europe. Since this was the vaccine donated through Covax, many Ugandan believed it was unsafe.

Aruans also understood that since the vaccine contained live virus, it was likely to have many side-effects, including site pain, fatigue, headache, muscle pain, chills, joint pain and fever. On occasion, the fever might be so severe that people could die, as with malaria. Fears were particularly acute for those with allergies or chronic conditions like asthma. For those who had already caught COVID and had acquired immunity, the vaccine was deemed unnecessary. Ultimately, many questioned why they should voluntarily take a jab which carried the chance of death.

Conspiracy theories

During the early months of the pandemic, when no cases were registered in Arua, many asked whether the virus was a hoax. Given the unfortunate coincidence in the timing of the onset of the virus in 2020 and a national election (which Museveni won, again), many commented that either COVID did not exist, or that its prevalence and severity was being manipulated for political ends.

A rumour spread around Arua that a public broadcast of the health minister Dr Ruth Aceng getting the jab on national TV was a fraud. In fact, the vaccination was re-enacted so that photographers could get a better shot.

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Some young people in Arua believe that the vaccine would inject them with 5G microchips, and subsequently put them under government surveillance. Other rumours relate the vaccine to biowarfare between black and white people. According to one Aruan young man: "Africans didn't die like the whites from the first wave of the pandemic, so the vaccine from the West imported to Africa is to kill them." Others claimed the vaccine caused infertility, altering a persons' DNA so that they will not be able to produce children. Pictures on social media of vaccine labels inscribed with 'Only for African export' or 'Not for UK' fuelled fears about the vaccines Uganda would be receiving. For many Aruans, the vaccine was a sinister tool to control an ever-growing African population.

On the one hand, these conspiracies offer an exciting narrative in which current suffering is entangled with dynamics of global inequities and histories of exploitation. Parallels can be found in talk about novel wealth-promoting witchcraft, called *mazi,* which is acquired from foreign specialists to convert the blood of relatives into immense riches. Literally embodying colonial extractions, those who acquire witchcraft are often seen accompanied by spirits of white people. Talking about 'Western' or Chinese conspiracy theories rescripts relationships which explain suffering in Arua, even as Europeans are perceived to choose between different vaccines.

On the other hand, conspiracy theories also feed off charlatans who seek to profit from the pandemic. In July, the Ugandan police arrested two nurses and were hunting for a man who had persuaded several companies to receive vaccines at between 100,000- 200,000 Ugandan shillings ($28-$56) per shot. Later, these vaccines turned out to be water. This was not an isolated case.

Homegrown alternatives

As a recent study shows, herbal pathways of care have become established in Uganda, and have even been promoted by health workers since the onset of the pandemic. It is perhaps unsurprising that many see no need for a vaccine when herbal medicines and prayer are trusted alternatives.

This is perhaps not surprising given the fear that clinical approaches to managing the virus have provoked in people. Aruans say that confirmed COVID cases mix with other suspected cases in hospital, and that health workers attend to infected and uninfected patients side by side (apparently using the same gloves). This means many fear to approach the facility. In a public radio broadcast, the Anglican Arua Archdeacon narrated the trauma of his ordeal in the COVID ward: "In that room there are three people – that is, you the patient, the devil, and Jesus. That the devil will be asking for your life and Jesus is there to save it."

People trust alternatives because they are socially embedded. Aruans often seek help from herbalists for critical illness like poisoning, epileptic seizures or critical wounds. When a patient recovers, their faith is strengthened, whereas the results of vaccination are not visible.

Scepticism and survival

In a classic account exploring how Bunyole people in Eastern Uganda act upon affliction, Susan Whyte explains that therapy seekers adopt a subjunctive mood, of questioning and interrogating possible causes. Uncertainty itself is productive of new ways of pragmatically acting upon illness. In a similar way, throughout the uncertainty which has accompanied the pandemic, Aruans question and ask about the virus and potential cures.

Public messaging around COVID vaccines has fed into the wider context of uncertainty accompanying a new virus with 'no cure'. Many Aruans recognise that opting for a vaccine could potentially limit their risk of dying from COVID. It is precisely because so much is at stake that people seek to iron out uncertainties. In this exercise, multiple scripts are circulated by different social actors and public authorities. Through very different linguistic registers, people debate the causes of suffering and the prospects of being well, side by side. When young men share seemingly implausible conspiracy theories from WhatsApp, or when families assess which type of *aro* (medicine) is the most appropriate way of managing a potential COVID infection, people participate in conversations as to how to endure and survive an uncertain viral threat. These rumours and treatment pathways have become entrenched, giving them a legitimacy which has fed into debates about the efficacy of a new vaccine, the outcome of which it has not been possible to observe.

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