Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Misunderstanding poor adherence to COVID-19 vaccination in Africa

Authors' reply

We welcome Bernard Seytre's engagement with our Comment.[1] However, his response leaves us more perplexed than enlightened. It is not clear whether Seytre is questioning the sources or disputing the facts. In any event, a careful reader of the US study we cited,[2] for example, will find therein explicit treatment of racism, medical abuse, and public trust (page 2 of the study). This finding has direct bearing on vaccine hesitancy and the history of colonial medicine and medical abuse in Africa, as shown by several studies (see Lowes and colleagues for a sample).[3] We certainly hope Seytre does not dispute the facts about global vaccine apartheid.[4]

Comparing vaccine uptake for COVID-19 with that of diphtheria-tetanus-pertussis (DPT) is a false analogy. Vaccines for children have been widely accepted in Africa as a result of decades of investment in health workers and community engagement by governments and various partners, and the 80% coverage of DPT vaccines has been achieved by the WHO regional office over a long period of time. Additionally, and irrespective of knowledge, it is mandatory in most African countries for a child to be vaccinated to be enrolled in school.

It seems somewhat disingenuous that Seytre has referred to a dearth of knowledge in relation to his findings on risk perceptions, while castigating us for doing the same thing. This lapse, unwittingly, supports our conclusions. And if the whole point of Seytre's response is that vaccine hesitancy can be addressed by communicating on the fact that COVID-19 is present in Africa, how the virus is transmitted, and who is at risk for the disease, we do not know how one could do so effectively without understanding and combatting fake news and misinformation, which was one of our four recommendations.

Seytre seems to stage his own research as the ultimate truth. Yet our approach, unlike his, is holistic. Instead of a narrow focus on lack of knowledge and perceptions, we situate communication in the larger structural determinants of vaccine hesitancy and apartheid by analysing the causes of that risk perception. A detailed causal analysis of COVID-19 misinformation and vaccine hesitancy in Africa[5] confirms our argument.

It is unfortunate that Seytre's response generates more heat than light. Hair splitting and fault finding only distracts from attending to global vaccine apartheid and working towards global justice, which our Comment attempted to do.

We declare no competing interests.

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