

'They Will Not Police Us'

Fake Vaccine Rumours in Mombasa

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Abstract

Rumours about fake or harmful vaccines came sharply into view during the COVID-19 pandemic. Such rumours are widely dismissed as *misinformation*. Based on ethnographic research in Mombasa, Kenya, I argue vaccine rumours are better understood as sources of *information*, which emerge from and express discontent about discriminatory patterns of policing in the name of health. Through vaccine rumours that, in Mombasa, took the form of claims about fake vaccines, urban residents expressed contempt for the over-policing they are subjected to as Muslims and as Africans, and frustration with the under-policing of capital and corporations. Claims about fake vaccines mobilised a new, often fantastic, discursive mode that reveals the highly unequal nature of health policing and regulation.

Keywords: COVID-19, distrust, fakes, Islamophobia, policing, racism, vaccine hesitancy

'Bill Gates is using the vaccine to "solve" the African population problem—that's what people are saying'. It is November 2021 and Sumayya and I are talking about COVID-19 vaccine rumours while digging into *mishkaki* at Mubin's, a popular Mombasan eatery. The skewers of beef and chicken, marinated then barbecued, are as succulent as ever. Sumayya, a Swahili woman in her mid-twenties, is a primary-school teacher in town. We discuss a YouTube video, circulating in Mombasa (and around the world), claiming that Microsoft founder and global health billionaire Bill Gates funded COVID-19 vaccination drives to depopulate the world by putting chips in peoples' arms—starting in Africa, the most economically unproductive continent (International Tribunal for Natural Justice 2020).¹ 'Some say the chips will kill Africans within two years of being vaccinated', Sumayya tells me. 'Some believe they'll make you infertile. Others say the chips control you. Make you into a zombie'. I learn Sumayya's aunt quit her job at Kenya Airways because staff were required to be vaccinated, and her aunt was worried about the chip. The same aunt phoned the other day and was delighted that Sumayya had also chosen not to

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vaccinate—at least until she’s had children. ‘My aunt was so happy’, she explains. ‘She kept repeating, “They will not police us.”’

What happens if we take seriously such narratives: claims linking vaccines, zombies, chips and policing? In what follows, I do not pass judgement on the truth or falsity of vaccine rumours. Nor do I engage with questions of ethics—some rumours I discuss contain discriminatory and uncomfortable accusations. Drawing inspiration from scholars who have positioned rumours as expressive of injustice and anti-colonial critique (Arnold 2002; White 2009), I ask: what conditions allow vaccine rumours to emerge, and what do these claims *do*?

During the COVID-19 pandemic, people refusing or delaying vaccination were deemed evil or ignorant, lacking concern for the collective good (Salali 2020). Expressing hesitancy or outright opposition was seen to betray a lack of critical thinking. It brought forth accusations of being bound by tradition or religion, being gullible to conspiracy thinking, or, worse, being the malicious proponent of such (Brackley 2021; Mutua 2021). In contrast to this dismissal, I draw here on scholarship that takes rumours and claims about fakes as important sources of critical popular knowledge about power and inequality.

My ethnographic approach to vaccine rumours—a methodology that involved taking the seemingly fantastic and outlandish at face value—involved listening to rumours as they were told to me. Over six months between November 2021 and June 2022, I spoke to more than a hundred Mombasans about COVID-19 vaccines, collecting their views and the rumours they had heard. I spent time in and around Markiti (Mombasa’s central market), at cafés, hardware stores, and swimming pools, as well as in tuk-tuks and homes, mostly on Mombasa’s island centre and the wealthier mainland suburb of Nyali. Conscious of the polarisation around vaccines in Mombasa, my decision to focus on people I encountered in everyday settings was political. I conducted research outside of formal medical spaces, where I hoped people felt freer to share their views, and less likely to associate me with health authorities. I spoke to Mombasans of diverse class, age, religious, racialised, and ethnic backgrounds. Perspectives on vaccines varied as much within social categories as between them.

Listening to these voices, I came to realise that claims about fake COVID-19 vaccines in Mombasa *emerge from and express discontent about* discriminatory patterns of health policing. Health policing, in this article, includes an expansive array of practices and actors that encompass and exceed ‘the police’. These include:

- (1) the policing of mobility during COVID-19 through curfews and neighbourhood lockdowns enforced by the Kenyan Police Service, as well as international travel bans enforced by border and immigration authorities globally;
- (2) the policing of choice through vaccine mandates that threatened the withdrawal of employment and access to government services, and through COVID-19 vaccines themselves, which were perceived as restricting reproductive choices; and

- (3) the (under-)policing of capital and corporations, through regulatory regimes that permit dumping and substandard products entering African markets at the expense of consumer health.

These varieties of health policing during COVID-19 were layered, in Mombasa, onto long histories of anger about the policing of Muslim and African life more broadly—including anti-Muslim counterterrorism policing, border policing that excludes people of colour, and forms of medical coercion (such as paternalistic family-planning programmes) seen to target poor Africans.

Here I show how vaccine rumours challenge the assumption that health policing protects the health of all. Vaccine distrust, I suggest, is symptomatic of the Islamophobic, racialised, and classed patterns of health policing by Western² governments, the Kenyan state, and global health actors. I argue this by exploring three genres of rumours or claims. The first set of claims casts COVID-19 vaccines as the latest vector of anti-Muslim harm, which I read in conjunction with Islamophobic counterterrorism policing in Kenya and beyond. A second set of rumours positions the vaccine as a racist, anti-African technology, which I consider against the backdrop of the Omicron travel bans, as well as longer histories of enforced immobility and medical coercion. A third set portrays vaccines as evidence of yet more 'fake shit' dumped in Africa, threatening health and life. Through these claims I suggest that Mombasans vocalise their contempt for the over-policing they experience as Muslims and as Africans, and frustration with the under-protection they face in relation to unregulated capital and corporate dumping. Taken together, claims about fake vaccines mobilised a new, often fantastic, lexicon of discontent that reflects the highly unequal nature of policing and regulation in the name of health. This is a powerful yet ambiguous mode of resistance: rumours express awareness and frustration with profound inequalities but offer little towards their undoing.

Context: Vaccine Distrust in Mombasa and in the Literature

The anti-vaccination movement is often noted for its global reach. However, racialised tropes about 'Africa'—as steeped in tradition and lacking adequate health and education infrastructures—have cemented the notion that vaccine distrust on the continent is particularly widespread (Hossain et al. 2021). When I arrived in Mombasa in late 2021, I was not surprised to find many opposed to COVID-19 vaccination—but suspected this was a product of politics more than tradition. Kenya's first COVID-19 case was confirmed on 12 March 2020, the day after the World Health Organization declared a pandemic (Kenyan Ministry of Health 2020a). Two elements of the Kenyan state's COVID-19 strategy offer insights into Mombasa's place within the national context and situate claims about fake vaccines within a long history of coastal marginalisation. First, Mombasa was especially heavily policed during COVID-19, particularly in relation to the night-time curfew,³ during which commuters were beaten and killed by police (Human Rights Watch 2020; NTV Kenya 2020; Otieno 2020). Second, for several weeks in 2020, there was

a temporary ban on movement into and out of the city's most prominent Muslim neighbourhood. While the government cited rising infection rates to justify lockdowns of Old Town in Mombasa and Eastleigh in Nairobi, most people saw the move as Islamophobic: these are the two most prominent Muslim neighbourhoods in Kenya, and very little testing was done to determine actual rates of transmission.

Scholars of Mombasa have long pointed out that the city occupies the geographic and political periphery of the Kenyan state (Kresse 2007; Mazrui 1993; Ndlovu 2014; Salim 1970). A graffiti tag seen around the city marks the sense of difference and distance between the coast and the rest of the country: '*Pwani si Kenya*' (The coast is not Kenya) articulates how many coastal residents view the nation-state. Likewise, many from 'upcountry' (inland Kenya) return the sentiment by imagining Mombasa as at best a kind of exotic 'internal orient' (Eisenberg 2012) and at worst a haven for narco-gangs (Omondi Gumba 2020), Muslim terrorists, and separatists (Botha 2014).

Mombasa has been Muslim and urban for over a thousand years, putting it at odds with a nation that conceives itself as a coalition of Christian tribes with rural roots (Gifford 2008). Throughout the postcolonial period, efforts by Mombasans to secure coastal and/or Muslim rights have been thwarted by the state.⁴ Police crackdowns became particularly egregious after the 1998 bombings of the US embassies in Nairobi and Dar es Salaam. Claimed by Al-Qaeda, these attacks precipitated the War on Terror in East Africa. Since then, the Kenyan government's anti-terrorism agenda, bankrolled by the United States and European Union, has focused on disappearing, killing, and imprisoning young Muslim men, particularly Mombasans of Swahili and Somali descent (Prestholt 2011).

Violence and counter-violence involving state and non-state actors has waxed and waned since the 1990s, often in line with events elsewhere in the country. Tensions in Mombasa reached a new low after the attack on Nairobi's Westgate Mall in 2013, claimed by militant group Al-Shabaab as a response to atrocities committed by the Kenyan Defence Forces in Somalia. For the next year and more, state violence rocked Mombasa, supposedly the locus of militant Islam and violent extremism in Kenya. The much-feared Anti-Terrorism Police Unit stormed mosques, and state security forces killed allegedly hard-line clerics (New Humanitarian 2014; Al Jazeera 2014). The title of a local NGO's report communicates the resulting resentment: 'We're Tired of Taking You to Court: Human Rights Abuses by Kenya's Anti-Terrorism Police Unit' (Muhuri 2013).

Against this backdrop of successive security efforts—with wars on drugs, terror, and now COVID-19—I wanted to understand how Mombasans responded to the state-led vaccine rollout. Many Mombasans happily received multiple COVID-19 vaccinations, but others were opposed. Given the politics of refusal through which much state intervention was already viewed at the coast, I was not surprised by the extent of vaccine distrust I encountered from the outset of fieldwork. But how was I to interpret the rumours themselves?

Through the literature on vaccine hesitancy, I learnt that many in global health see vaccine refusal and delay as a problem of information: people hesitate because

they are not informed enough or because they are inundated with misinformation (Ackah et al. 2022; WHO 2021). While ostensibly compelling, this emphasis on information reifies a narrative of victimhood. It positions people suspicious of vaccines as uneducated, easily manipulated, and irrational: victims of an unruly, omnipresent internet, rather than assertive and informed political agents.

More structural approaches to vaccine distrust exist in Northern scholarship. Toni Madorsky and colleagues (2021: S185) critique the notion of vaccine 'hesitancy', arguing it 'in effect faults the individual for their lack of confidence in a system that has historically failed and continues to fail them'. They offer the term 'vaccine distrust' to shift attention to the structural dynamics shaping vaccine practices: 'the public discourse, and too often the public health response, seems to frame vaccine distrust...*as the problem rather than a symptom of structural racism* and a flawed public health infrastructure' (Madorsky et al. 2021: S186, emphasis added). Their research with Black communities in Chicago suggests that vaccine distrust is a *predictable and reasonable* response to neglect by public health systems. This is echoed by research with communities of colour in the United Kingdom (Paul et al. 2022), Canada (Kur 2022), and Italy (Storer et al. 2022).

Vaccine distrust, then, may be better understood as a political response to discrimination and neglect (Gainty and Arnold-Forster 2020). As Heidi Larson (2020) writes, 'we don't have a misinformation problem, we have a relationship problem'. Melissa Leach and colleagues (2022) provide a rare, compelling application of this approach to vaccine distrust in Africa. In Sierra Leone and Uganda, they argue, political context shapes the bodily and social dimensions of 'vaccine anxieties' (see also Leach and Fairhead 2007). Under Uganda's autocracy, rumours abounded that the government's COVID-19 vaccine rollout was intended to poison political activists and ethnic groups known for their opposition to state policy (Leach et al. 2022: 6). In Sierra Leone, fears about Ebola vaccines as an exploitative 'white' technology translated into similar concerns that Americans or Chinese had bio-engineered COVID-19 vaccines to reduce African populations (ibid.: 7). These findings demonstrate how vaccine distrust is produced by experiences of coercion and distrust beyond healthcare settings. Aaron Rosenthal, Matt Motta and Christina Farhart (2021: 2) similarly argue US vaccine scepticism 'is not just about mistrust in medical professionals but also about state control readily represented by the police'.

Such work underscores the structural *causes* of vaccine distrust. But what accounts for the enduring popularity of claims about fake vaccines, and what do these articulate? Here I have found productive answers by putting vaccine rumours into conversation with the literature on fakes, seeing vaccine distrust as a form of 'fake-talk' (Hornberger and Hodges 2023). The concept of fake-talk distinguishes claims about fakes as a discursive genre. It moves us from debates about the veracity of such claims to questions about emergence and effect: under what conditions does fake-talk circulate, and what does it do?

Like scholarship on rumour as anti-colonial critique (Arnold 2002; White 2009), recent work on fakes offers answers to these questions. Constance Smith's

(2020) research into the collapse of residential tower blocks in Nairobi shows how residents denounce ‘fake’ concrete and steel to expose differences between the materials used in their homes versus those of wealthier consumers. Such claims reject entrenched housing inequalities and are powerful because they *expose the distance and difference* between social worlds. In contrast, Ackbar Abbas (2008) suggests fakes gain power by *collapsing difference*. A fake Gucci handbag challenges the status quo by erasing differences between haves and have-nots, even if only temporarily. The fake temporarily unites consumers divided by class and race—it democratises the Gucci handbag, exposing the constructed, fragile nature of social distinction. I am not suggesting fake vaccines are the same as fake buildings or handbags. What interests me is that Smith and Abbas reach opposite yet equally compelling conclusions about the effectivity of fakes—emphasising difference in one context, dissolving it in another.

Building on these approaches, I argue that claims about fakeness are powerful precisely because they can *both* reinscribe and unsettle difference. In Mombasa, claims about fake COVID-19 vaccines emphasise the unequal policing of Muslims and Africans. The same claims also assert solidarities across time and space, connecting Mombasans with other marginalised groups, such as Palestinians, African Americans, people of African descent, or Muslims globally. I was regularly shown social media videos of anti-vaxxers around the world—in Trinidad, Senegal, or the United Kingdom—as proof of the veracity of concerns. ‘Even in Trinidad, they’re saying that the vaccines are designed to kill Black people’, Saidi told me. Claims about fakes are powerful because they divide and unite, disconnect and connect. As I demonstrate in what follows, *claims about fake vaccines mark difference and distance as much as proximity and connection, reflecting global inequalities in policing while connecting the over-policed and under-protected across lines of difference*.

The second point I borrow from scholarship on fakes is the power of claims about fakes to comment on otherwise insurmountable social dynamics. As Julia Hornberger and Sarah Hodges observe:

Fake-talk enables new forms of expression of pre-existing discomforts and anxieties and offers a new way to name or frame existing tensions, tensions that had otherwise seemed unspeakable or insurmountable. Crucially, fake-talk thrives because it can provide a causal narrative—and thereby an easy solution—to an otherwise unresolvable problem. (2023: 11)

I extend this thinking on fake-talk by underscoring the centrality of the fantastic in such claims. The language of fakes is not just a new expression of older grievances. It is often literally fantastic. Why are claims about fakes, including fake vaccines, so often outlandish? What does the fantastic do? Ekow Eshun, curator of *In the Black Fantastic* at London’s Hayward Gallery in 2022, argues that the fantastic destabilises the binary between the real and unreal, making it ‘a sustaining force against the irrationality of ordinary life’ (2022: 55). This is a powerful framing for thinking through claims about fake vaccines: outlandish rumours speak back to a world where violent anti-African, anti-Muslim, and anti-poor policing is normal-

ised. The fantastic illuminates the unbearable. It also allows claims to catapult over the boundaries and constraints of the everyday, forging space for new connections and the imagination of new, more equitable realities. However, while claims about fakes express a frustrated awareness of inequalities, they do little to facilitate their transformation. Vaccine rumours endure as social commentary because they allow a fantastic rejection of how things are without actually rocking the boat.

'You Can See Why People Have These Views': Vaccines and Islamophobia

Let us turn to the first set of claims about COVID-19 vaccines I want to consider in detail. A number of Mombasan rumours suggest anti-Muslim actors crafted COVID-19 vaccines expressly to kill or harm Muslims. These assertions call into view the Islamophobic logic of COVID-19 policing in Kenya, seen as entrenching decades of anti-Muslim counterterrorism policing.

Globally, the pandemic saw unprecedented moves by police into public health. Police were charged with maintaining emergency mandates, such as social distancing, curfews, masking, and lockdowns. This only reinforced the role of police in 'maintain[ing] historically established...inequalities' (Martin 2018: 138). In the United States and United Kingdom, pandemic policing targeted young, working-class people of colour, especially young Black men who already bear the brunt of stop-and-search violence (Dunbar and Jones 2021; Harris et al. 2021). In Mombasa, pandemic policing entrenched *religious* discrimination. Male, Muslim Mombasans have long been the targets of Kenya's anti-terrorism policing and many Mombasans perceived the government's COVID-19 policing as similarly anti-Muslim.

This was evident in my conversation with Swaleh, a Swahili man and devout Sunni of the Shafi'i sect,⁵ who runs a health centre for young people. A keen observer of life and politics in Mombasa, Swaleh wears his erudition lightly and his devotion to the youth of the coast on his sleeve. His office is sparsely decorated. An expensive-looking standing fan blows a steady breeze between us, and pictures of youth health programmes hang on the wall. Swaleh sits opposite me, behind a capacious but simple desk. Matter-of-factly he recounts a set of popular claims linking vaccines to anti-Muslim agendas:

WhatsApp is full of stuff saying the vaccine was made to wipe out Muslims. Lots of people believe that Jews dominate Big Pharma, the same Big Pharma that created the vaccines. Jews are associated with the state of Israel; Israel wants Muslims dead. But it goes beyond Israel—the UK, the US, Russia. It's said they've [all] made the vaccine to wipe out Muslims.

He goes on:

It's often claimed that death won't be immediate—but that the vaccine will kill you in two years. I keep joking with my friends who haven't been vaccinated: 'Cool, well if the vaccinated are going to die in two years, then you'll be able to take over the UK, you'll get my car and my house' [because the vaccinated will be dead].

These claims mobilise uncomfortable, antisemitic tropes that Swaleh has no time for. However, he acknowledges, 'You can see why people have these views'. For him, and many others in Mombasa, anti-Muslim policing in the name of COVID-19 was layered onto decades of anti-Muslim policing in the name of security. Swaleh continued: 'At the beginning, when the government first imposed the curfew, the police were brutal. This infamous line was going around, that more people have died of police brutality than of Covid. It was shocking. And of course, the ferry was the first flash point'.

Here Swaleh references the chaos, beatings, and teargas of the first day of curfew in Mombasa. His lack of surprise at police brutality at the Likoni ferry terminus reflects the state's disregard for poor coastal residents, especially Muslims (Prestholdt 2011; Willis and Gona 2013). Likoni is one of Mombasa's poorest neighbourhoods and has large Muslim and Christian populations. Its residents have long been targets of state counterterrorism crackdowns (Muhuri 2013). As a human rights activist who attended the police press conference the day after the curfew violence explained, '[The police] hit with impunity, that means the order had to have come from the very top'. He implied the central government had given *carte blanche* to the General Services Unit, the elite paramilitary squad policing the curfew at Likoni ferry, to treat commuters as they wished. This egregious curfew policing was confined to select locations in the country (Human Rights Watch 2020).

Swaleh continues: 'And if the ferry violence wasn't enough, then they locked down Old Town and Eastleigh. This was too much. The only places in the whole country you couldn't move in and out of?' He looks at me incredulously. The ban on movement into and out of these areas applied *exclusively* to the Muslim neighbourhoods of Old Town in Mombasa and Eastleigh in Nairobi (Kenyan Ministry of Health 2020b). 'I went to the edge of Old Town to see what was going on. The police were there. Stopping anyone from coming in and out.' While these neighbourhoods have long been portrayed as havens for 'terrorists', they were now positioned as harbouring disease.

Many Muslim Mombasans viewed the lockdown as anti-Muslim. This was not only due to the Muslim majorities in the areas locked down and the lack of testing. The lockdown lasted a month, from 6 May to 7 June 2020, which coincided with several weeks of Ramadan, ending on 24 May that year. Swaleh and others did not see this as a coincidence: 'It was intended to break business, especially during Ramadan and Eid. After that how can you ask people to think that Covid policing wasn't anti-Muslim? The evidence was there'.

He goes on to tell me people he works with believe the policing of mask use was similarly politicised: 'Many staff and youth here have told me they only wear the mask to avoid trouble with the police, especially the young men. Not wearing a mask is only a problem in some places. In Mombasa you get stopped. In Eldoret nobody has a mask, and the police don't care'.⁶

Eldoret, a large, mostly Christian urban centre in the Rift Valley region, has longstanding ties to Kenya's political and economic elites, which for Swaleh confirms the motives behind such differential treatment. 'From here it's a small step

to seeing the vaccine as anti-Muslim', he spells out. 'It's all part of an Islamophobic continuum. Vaccines are just another prick in the story'.

Policing African Bodies in the Name of Health: Mobility, Mandates, and Microchips

Let us return to Sumayya's comment that Bill Gates used COVID-19 vaccines to accelerate his African depopulation agenda. While the previous section addressed rumours positioning Muslims as targets of malicious vaccines, the Gates rumour exemplifies a genre of claims-making that casts Africans as said targets. Mombasans variously asserted that the vaccines were intended to kill Africans within two years, to affect their ability to have children, or to turn them into microchipped zombies, controlled by external powers. Here I detail three claims about fake vaccines, examining their connections to racialised and classed patterns of policing undertaken in the name of health, whether by Western governments, the Kenyan state, or global health actors.

Within days of my chat with Sumayya, in late November 2021, the United Kingdom, United States, Canada, France, Germany, and others imposed travel restrictions on several Southern African countries. This policy was officially intended to stop the spread of the Omicron variant of SARS-CoV-2. However, commentators from the global health community as much as the streets of Mombasa decried what they saw as blatant racism. The travel bans drew on age-old accounts of Africa as the epicentre of contagion and unchecked mobility. These representations have long underpinned the global health security paradigm, focused on preventing disease transmission from the Global South and upholding an imagined cordon sanitaire around Europe and North America (Weir 2014: 27).

In response to the travel bans, Dr Ayoade Alakija of the Africa Vaccine Delivery Alliance spoke unequivocally during a BBC interview that went viral: 'Why are we locking away Africa when this [Omicron] virus is already on three continents? No one is locking away Belgium, locking away Israel. Why are we locking away Africa?' (Global Justice Now 2021). Alakija asserted that the Omicron variant arose from inequitable vaccine access, the solution for which was *not* travel bans on Africans. Speaking to CNN, Dr Githinji Githai of Nairobi-headquartered NGO Amref Health Africa concurred, 'This is how the world has treated Africa all along...the world locked vaccines from getting to Africa and now they are locking Africa from accessing the world' (Amref Health Africa 2021).

The bans exemplify a 'long history of suspicion-based...policing in global health' (Hodges et al. 2021): policing reliant not on evidence but on ill-founded suspicions about the contagious potential of 'others', who almost always come from the Global South. When Sumayya and I discussed the bans later that week she said, 'It's hard not to think that my aunt was right about the vaccines...maybe Covid *is* all about policing Africans'. This sentiment was widely shared. 'They're always looking for new ways to keep us out. Omicron is just the latest excuse', proffered Mwanyolo, an Uber driver. Saidi, who works in a small printing shop, remarked wryly that

‘travel bans are the new *kipande*’, referencing colonial-era passes that Black Kenyans were compelled to carry wherever they moved. Whether by imposing travel bans or controlling movement through chips transforming people into zombies, these observations illustrate how Mombasans viewed COVID-19 policies through a long history of efforts by external powers to police African mobility.

Comments deriding travel bans registered Mombasans’ disdain for Northern attempts to police public health by controlling African bodies, mostly Black. However, health is policed by multiple actors—including the Kenyan state as much as its Northern counterparts—and has both racialised and classed dimensions. Rosemary, a Luo woman with roots in western Kenya, works as a cleaner for a white European couple in Mombasa. Rosemary suffered terrible side-effects after her first COVID-19 jab. When not incapacitated in bed, she spent time holding her mobile phone against the place on her arm where she had been vaccinated. Fearful she had been microchipped, Rosemary had heard that the phone would attach with magnetic force from the chip. She had seen WhatsApp videos of phones becoming inseparable from arms on contact, so she conducted the test several times—including with her boss’s phone, reasoning its superior quality probably included a stronger magnet. The phones never attached to her arm, but Rosemary vowed not to take the second vaccination.

At the time, in December 2021, Kenyan television channels and radio stations were full of official advertisements warning citizens: ‘No vaccine, no service’. Concerned about Rosemary’s welfare, I asked how she planned to access welfare services without a second jab. Rosemary looked at me with disdain: ‘I don’t use government services anyway’. Long neglectful of her, the state was suddenly rearing its head to ‘protect’ her through policing under the mantle of health. As Amnesty International Kenya’s timely statement pointed out, vaccine mandates affecting access to services disproportionately discriminated against the poor and ‘risk[ed] domesticating the global vaccine apartheid...creating those with rights and those without’ (Amnesty International Kenya 2021). Yet Rosemary made clear the withdrawal of services was an empty threat—she had nothing to lose in the first place. State policing of poor people’s vaccine choices was particularly farcical given that she saw the vaccine as an elite travel card for crossing international borders. Emphasising her own quite different preoccupations, Rosemary sighed, ‘We’re not going to the US, Europe, China—so leave us alone in Africa! That’s what people are saying’.

After a few weeks of ‘no vaccine, no service’ sloganeering, the Kenyan government ultimately did not enforce the mandate. Many employers, however, did compel staff to vaccinate. While Rosemary was not threatened with unemployment over her choice to remain partially vaccinated, she knew many who had. ‘This is how the rich control the poor’, she explained, ‘how can you survive in this world without a job?’ Rosemary’s account points to the association of vaccination with coercion, and her awareness of the anti-poor discrimination embedded in state and employer efforts to police health through vaccination.

This sense of being policed was also reflected in concerns the COVID-19 vaccine could affect reproductive choices and outcomes, bringing policing by global health

actors into view. Sumayya, who decided not to get vaccinated until after the birth of her future children, worried about the novelty of the vaccines and the lack of long-term studies. Others speculated Gates wanted to reduce the global population by making Africans infertile. This came up in my discussion with Mohammed, a Mombasan of Baluchi descent who owns a fruit-juice store on the edge of the city's Old Town. Over a glass of ice-cold tamarind juice he explained, 'You cannot tell an African man that the vaccine might affect his virility. He'd rather get Covid'. Mohammed gave me a knowing smile and my first thought was that this version of vaccine distrust was about fragile masculinity. But he continued: 'I will not be an African guinea pig. We have too many stories of Africans being experimented on, too many stories of forced sterilisation. [Bill] Gates cannot decide if me and my wife can have children. I don't know if the rumours are true, but I'd rather get Covid than let someone else decide my future'.

Mohammed's comments challenge the assumed benevolence of global health interventions and reject the experimental use of Africans. Such sentiments had global resonance during the pandemic, as seen through the hashtags #AfricaIsNotALaboratory and #AfricansNotLabRats that trended in April 2020 (Tilley 2020). For Helen Tilley (2020: 166–167), the substance of the Gates rumours during COVID-19 may have come from a controversial Gates Foundation report in 2018 about African 'overpopulation' and family-planning strategies—one instance in a long line of discriminatory efforts by global health institutions to police fertility in the Global South (Wilson 2017). Taken in sum, the claims discussed in this section associate vaccination with unequal policing in the name of health—and reflect how global health, immigration, and state welfare regimes fail most Africans.

'In Africa, We Get All the Fake Shit': Vaccines, Unfettered Capital and the Disposability of Black Life

I have shown how claims about fake vaccines express Mombasans' discontent with their *over-policing* as Africans, poor Kenyans, and Muslims. A further set of rumours about fake vaccines evoke an interrelated sense of *under-policing*. Earlier I analysed how vaccine rumours are indicative of racialised, classed, and Islamophobic policing. Here I want to add what vaccine narratives say about the policing of capital, referring broadly to the policing and regulation of commerce, capital, and corporations. I explore how Mombasan vaccine rumours illuminate a *lack* of such policing, resulting in threats to health and wellbeing.

The bifurcated nature of policing is well documented: police protect the propertied while penalising poor and racialised communities (Martin 2018: 156). While bifurcation usually points to differentiated policing between communities (wealthy Kenyans are far less likely to experience police violence than their working-class compatriots), we can also see bifurcation as occurring between communities and commercial entities. Mombasan vaccine rumours reflect this.

Let me give an example. The women-only swimming pool in Kizingo is its usual 2:00 p.m. self, serene and empty in the lull between morning and afternoon

swimmers, as most people are home digesting lunch. In the break after completing my first laps, Mariam glides into the pool next to me. Like many women who frequent the pool, Mariam is Mombasan of Somali origin. Her family arrived in the early 1990s, soon after the beginning of the civil war in Somalia and a few years before Mariam was born. (Other swimmers claim Hadhrami, Swahili, or Gujarati roots, as well as long histories on the Kenyan coast.) Mariam was happy to be vaccinated but her parents refused. ‘They’re conservative’, she surmises. Her father was inoculated, but only because he needed to travel for business. Mariam is not angry with her parents. She has accepted their decision and positions their distrust within a history of ‘fake shit’: ‘You know, all the products that don’t really work, that aren’t good quality...well, where are they sent?’ She raises her left eyebrow with rhetorical flourish:

In Africa, we get all the fake shit. The crappy electronics, the cement, the rice. It doesn’t matter what it is. There are so many stories of substandard stuff ending up here. So of course, people are worried that it’s the same with the vaccine. Everyone says the vaccine that’s going to the West is *not* the same as the vaccine coming here. This is what my parents think.... I can’t blame them. We’ve seen that too many times—companies sending crap to Africa. And then the governments here have no quality control. So how can we know if the vaccines are quality or not? This is what people are saying.

Mariam continues: ‘And even if quality vaccines arrive here, then what? Would you trust the Kenyan government to monitor the cold chain? [Amongst] my friends who are getting vaccinated, no one wants Pfizer’. Here she references how the Pfizer vaccine must be kept at –70 degrees Celsius, which she does not trust the government to achieve.

Mariam’s words demonstrate her awareness of who is, and is not, protected by supply chains. She voices a lack of trust in global commodity flows and the risks that regulatory failures pose to African consumers. I read her words as an example of widespread frustration about how capital is regulated on the continent and the racism implicit in that. The accusation that ‘fake shit’ is dumped on Africa reflects decades of economic liberalisation and WTO hegemony, leaving governments subservient to international trade regimes that offer little protection against poor quality goods. In Mariam’s account, the policing of capital is marked by two kinds of lack: insufficient policing of corporations, and insufficient protection for consumers.

The co-opting of the police to protect Big Pharma over the health of poor consumers has been demonstrated in a variety of contexts (Hornberger 2018; Quet 2017), including when anti-counterfeit police squads criminalise fakes (Hornberger, this issue). In cases of dumping and quality regulation, however, policing produces profits by its absence. Profits accrue because corporations are not adequately policed when sending goods to jurisdictions such as Kenya.

Mariam’s account portrays African life as perennially subject to ‘fake shit’: substandard products that threaten health and wellbeing. Her narrative emphasises

both the under-policing of corporations and what Sirleaf calls the 'disposability' of Black life: 'the presumption of the disposability of people of colour implicitly persists in disparate areas of law and policy' (2021: 94). Mariam's fear that vaccines sent to Africa are likely to be as substandard as other products sent to the continent affirms this: 'people are viscerally aware that their lives and their futures matter less in any global balance sheet' (Tilley 2020: 166).

Conclusion

During the COVID-19 pandemic, vaccine distrust was often dismissed by people working in global health, policy, and the media, as well as in public discourses more widely-taken as reflecting ignorance, miseducation, or conspiracy thinking. In the case of Mombasa, I argue vaccine distrust is better understood as reflecting discriminatory patterns of health policing. In Mombasa, seemingly outlandish claims about COVID-19 vaccines position the vaccine rollout within a genealogy of policies and patterns of control that continue to harm Africans and Muslims. Claims about fake vaccines express Mombasans' frustrations with their over-policing by the Kenyan state, its Western counterparts, and global health actors, all of whom simultaneously fail to protect Africans against corporate profiteering. Mobilising the fantastic, claims about fake vaccines shine a light on everyday violence.

The policing of COVID-19 restrictions—including curfews, lockdowns, and masking—entrenched histories of heavy-handed, often brutal policing targeting Muslims and coastal residents. Many Mombasans perceived the Kenyan state's COVID-19 policing as characteristically Islamophobic, fuelling claims that vaccines were vectors of anti-Muslim harm. Similarly, the racism of Omicron travel bans and the classism underpinning the Kenyan government's punitive vaccine mandates added weight to historical fears about health interventions as anti-Black, anti-African, and anti-poor. Claims about fake vaccines express the enduring over-policing Mombasans experience as Muslims, Africans, and working-class people. Vaccine rumours also reflect Mombasans' contempt for the policing of capital, seen as insufficiently regulated and under-policed at the expense of African consumers. Against this background of inequality, Mombasans asked why COVID-19 vaccines would be different from other fake and substandard products in African markets.

This article adds to calls to take vaccine rumours seriously, as discourse that highlights the expansive policing and regulatory violence which fosters suspicion in global health. In some instances, such as with concerns around COVID-19 vaccines and fertility, enduring reproductive scandals perpetuated by global health institutions offer clues as to why such fears arise. However, vaccine concerns frequently extend beyond the medical establishment, and the bounds of the city. Claims about fake vaccines are wide-ranging diagnostic tools, offering insights into local and global injustices, as well as how these scales are experienced as connected.

By centring Mombasan rumours, this article adds ethnographic and East African perspectives to the largely Euro-American and survey-heavy scholarship

on vaccine distrust. Moreover, positioning vaccine distrust as fake-talk helps clarify both the power and limitations of this speech act. Fake-talk is exceptionally able to encompass contradictions. Claims about fake vaccines reinscribe disjuncture and difference while simultaneously forging connections. This also accounts for the limits of such claims: fake-talk both subverts and sustains the status quo. While expressing discontent about inequitable health policing, claims about fake vaccines are not transformational. Vaccine rumours do not provide a programme for justice or change.

The evidence from Mombasa confirms that rumours about vaccines reflect deep-rooted distrust between citizenry and state, and between consumers and the providers of healthcare, whether the latter be the state, civil society, or global health actors. Yet claims about fake vaccines are as much about proximity as about distance. Claims *forge* relations, as much as underscore their fragility. Relaying vaccine rumours as a collective position—‘that’s what people are saying’—allows the speaker to articulate rumours while avoiding responsibility for accuracy. Predicating a community of rumourmongers underscores the sociality fundamental to claims about fakes, while retaining strategic ambiguity about the speaker’s relation to that community and those claims.

As with other articles in this issue, mine challenges widespread assumptions about the relationship between policing and fakes—there are no stories here of police rooting out fake vaccines and the fraudsters who make them. Fake vaccines in Mombasa are certainly entangled with policing. However, rather than fake vaccines being what police find, it is policing itself, and specifically inequitable policing, that produces vaccine fake-talk. *Policing does not stamp out fake vaccines. It fuels claims about them.*

Finally, I have shown that vaccine distrust often has little to do with vaccines or health per se. This necessitates engaging with the wider concerns that underpin local suspicions, including the behaviour of national police, and the unequal policing of both human mobility and global supply chains. These conclusions call for a fundamental reframing of what constitutes a problem in global health. Rather than anti-vaxxers or vaccine rumours, the evidence from Mombasa suggests that it is discriminatory health policing that requires attention.

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Notes

1. This YouTube video is widely discredited for peddling false claims (see e.g., Swenson 2021). Nonetheless it has spawned much speculation in Mombasa and beyond.
2. Terms like 'Western' can be obfuscating (Hall 2019 [1992]); I retain them here to reflect local usage in Mombasa, referring to Europe and North America.
3. A national night curfew—originally from 7:00 p.m. to 5:00 a.m., later shortened from 9:00 p.m. to 5:00 a.m.—ran for over a year and a half, from 27 March 2020 to 20 October 2021.
4. This includes the quashing of the Mwambao Movement to secure coastal autonomy at independence (Salim 1970), violent crackdowns on the Mombasa-based Islamic Party of Kenya in the 1990s (Ndzovu 2014), and the disappearance of leaders of the separatist Mombasa Republican Council in the 2000s (Willis and Gona 2013).
5. Mombasan Muslims often define themselves both by sectarian affiliation and by genealogy. Shafi'i Sunnis are most numerous, and include Swahilis, Somalis, and people from Mijikenda communities. There are also Muslim communities of Gujarati origin, including Hanafi Sunnis and Shias. There is a growing number of Shias of Swahili and Mijikenda descent, as well as adherents to the eighteenth-century theologian Muhammad ibn Abd al-Wahhab.
6. A Mombasan man expresses similar views in a video on YouTube by Kenyan advocacy NGO InformAction Kenya (2021).

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