# Vaccinating the Body, Immunizing Dissent

## Persuasion and Control in Ethiopian Immunization Policies

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**Abstract**
This article examines how vaccination practices in northern Ethiopia (Tigray) are shaped by the interplay between persuasion, community pressure, and institutional control. Drawing on long-term ethnographic fieldwork conducted in Mekelle and surrounding rural areas (2015-2019), it analyzes how Health Extension Workers (HEWs), the Women Development Army (WDA), and their *one-to-five* system structure everyday encounters around immunization. Through interviews, observations, and case studies, the article shows how mothers' decisions to vaccinate emerge less from individual autonomy than from community expectations, emotional persuasion, and forms of grassroots surveillance. Local explanatory models of illness, religious interpretations, and fears of social stigma intersect with state-driven public health agendas. The analysis highlights how biomedical rationales, moral obligations, and political narratives of modernity combine to construct vaccination as a civic duty, while non-adherence is framed as a threat to collective well-being.

**Keywords**
Vaccination Policies, Community Mobilization, Health Extension Program, Women Development Army, Tigray.

### 1. Introduction

This article draws on a long-term ethnographic fieldwork conducted in Mekelle and the Tigray region of northern Ethiopia between 2015 and 2019, through several extended stays. The research was carried out among local communities and institutions responsible for organizing and monitoring vaccination practices. It focused primarily on the urban context of Mekelle – headquarters of the main regional health and governmental institutions – while extending to nearby rural areas through fieldwork alongside *Health Extension Workers* (HEWs), whose main task is to promote vaccination awareness in collaboration with other local actors.

The investigation, based on qualitative interviews, focus groups, and informal conversations held in health centers, hospitals, and schools, explored how vaccination policies are interpreted, negotiated, and enacted in everyday life. Special attention was paid to mothers, the main targets

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of public health campaigns, and to how persuasion, social pressure, and institutional surveillance converge in shaping adherence to immunization.

The research was conducted immediately before the Tigray war (2020-2022), a conflict that devastated the region and further undermined access to basic health services. Although the structural model of Ethiopia's vaccination system – centered on Health Extension Workers (HEWs) and, as discussed below, on the Women Development Army (WDA) – has remained largely intact, its effectiveness has been severely affected by insecurity, famine, and disrupted health infrastructure.

This paper examines the practical implementation of vaccination strategies in Ethiopia, showing how the "decision" to vaccinate oneself or one's children emerges from the interaction of persuasive and supervisory mechanisms carried out by territorial actors. It argues that compliance is socially constructed through community-based health strategies that operate beyond formal control, embedding persuasion within informal networks of community relations. In this sense, surveillance and persuasion work together to establish vaccination as a social norm, while non-adherence becomes framed as a moral and public health threat to collective well-being.

## 2. Vaccination Policies and Strategies in the Ethiopian Context

Starting from the early smallpox eradication campaigns, international programs and prevention plans were developed through collaboration among agencies such as the World Health Organization (WHO), GAVI (the Global Alliance for Vaccines and Immunization), and UNICEF (the United Nations Children's Fund). These initiatives sought to harmonize vaccination strategies across countries and reduce inequalities in access to immunization services.

*Smallpox* was the first disease for which active immunization was widely practiced, beginning in 1796, the year Edward Jenner discovered the smallpox vaccine. In 1967, the WHO launched a global vaccination campaign to eradicate the disease, which was officially declared eliminated in 1979 [1].

Among the strategies promoted by these international bodies, the Expanded Program on Immunization (EPI) occupies a central position. Established in 1974, the EPI was a large-scale vaccination initiative aimed primarily at children in developing countries. Ten years later, it was standardized to include six antigens – diphtheria, tetanus, pertussis, poliomyelitis, tuberculosis, and measles – and was introduced in Ethiopia in 1980, with the ambitious goal of achieving 100% vaccination coverage of all children under two years of age within the following decade [2].

In 2004, to strengthen the performance of the EPI and ensure continuous improvement, the Ethiopian Ministry of Health and the Ministry of Education launched the Health Extension Program (HEP). Entirely funded by the state, the HEP represents a strategy of healthcare decentralization based on redistributing institutional functions across both rural and urban areas. It introduced a new model of community-centered healthcare focused on preventive education and local participation. The program also expanded the health workforce nationwide by training and deploying 30,000 Health Extension Workers (HEWs) throughout the country.

HEWs were assigned to Health Centers and Health Posts, the two main infrastructures of Ethiopia's primary healthcare system. *Health Posts* are community-level first-aid facilities designed for populations living in rural areas more than five kilometers from major treatment centers. *Health Centers*, by contrast, provide basic preventive and maternal care services, including pre- and postnatal assistance, and typically serve between 15,000 and 25,000 people.

HEWs operate through community-based and household-based strategies whose effectiveness lies primarily in door-to-door interaction and mass communication initiatives aimed at promoting vaccination, hygiene, and family health education. The HEP has become the most important institutional framework for achieving the Millennium Development Goals (MDGs), particularly those related to reducing maternal and child mortality. The MDGs, launched by the United Nations in 2000 and concluded in 2015, have since been replaced by the Sustainable Development Goals (SDGs), which frame global health strategies within a broader agenda of sustainability and equity. The health policies and community networks discussed in this article now operate – at least conceptually – within this new sustainable development framework. However, the armed conflict between the Ethiopian federal government and the Tigray regional state [3, 4], has profoundly affected the region's social and institutional fabric, interrupting the work of many health centers, extension workers, and community volunteers. While the institutional structure described here has formally remained in place, its restoration after the war is still slow and uneven, especially in rural areas that were most severely impacted by the conflict.

Despite the significant improvements achieved by HEWs in vaccination coverage, hygiene, and reproductive health, challenges soon emerged in reaching every household and maintaining permanent health education for citizens. To address these logistical constraints and strengthen the HEWs' capacity to enhance community self-care, the government institutionalized a volunteer movement of women aged 18 to 55 known as the Women Development Army (WDA).

Officially recognized by the Ministry of Health, the WDA is a nationwide community movement aimed at improving public health conditions. Within it, Women Development Groups (WDGs) were established as grassroots expressions of civil society dedicated to maternal and child health. Over time, this "army" became the cornerstone of community participation in Tigray, working closely with HEWs and playing a decisive role in reducing maternal and infant mortality.

Its main activities include:

- Mobilizing pregnant women to attend regular prenatal checkups;
- Promoting childbirth within healthcare facilities;
- Supporting community-based ambulance systems;
- Providing psychosocial support within the community.

By 2010, the Tigray region counted 29,546 WDGs (25,580 in rural areas and 3,966 in urban areas), encompassing 774,264 WDA members (661,508 rural and 112,756 urban). Each group is composed of 25-30 women, who elect a main leader through a vot-

ing process. These groups are further divided into five- or six-member subgroups, each with its own leader, forming an extended hierarchical network known locally as the *one-to-five* system, which operates in every *ketema* – the smallest administrative unit – and is coordinated by a steering committee at the *tabia* – a subcity administrative unit encompassing several *ketema*.

Each month, WDA leaders report data and results to the HEWs; the two branches of the network then meet to reassess tasks and reformulate both individual and team-based goals, directly tied to the national development agenda and the pursuit of the global development frameworks, particularly in the field of maternal and child health.

Within this process, women act simultaneously as promoters and beneficiaries of the program – active agents in managing specialized knowledge and fostering a form of empowerment grounded in collaboration, participation, and shared responsibility. This model of co-participation reflects an ideal of equitable resource redistribution and the strengthening of shared capacities for collective health. As I will show through the ethnographic accounts presented below, these dynamics emerge clearly in the everyday practices of HEWs, WDA members, and mothers.

## 3. The Influence of Networks Between Persuasion and Control

The Ethiopian state, through multiple forms of coordination among local actors, has implemented a series of strategies relating to acceptance, control, and verification of vaccination practices. As the ethnographic cases presented below suggest, these strategies often operate as systems of persuasion designed to produce a systematic – and largely unconscious – acceptance of vaccines. By this I mean that, beyond any value judgment, and with a focus on understanding local articulations of vaccination policies, the established model of territorial organization forms a network of power primarily aimed at monitoring social adherence to immunization. The subsequent sections illustrate how, in a context of pervasive medicalization, subjectivation [5] can hardly be understood as an autonomous and conscious exercise of freedom of choice – in this case, the freedom to be vaccinated or not.

The work of awareness-raising and monitoring proceeds through a pyramidal organization that begins from the grassroots level, where *Women Development Armies* (WDAs) operate in the field and report to *Health Extension Workers* (HEWs), responsible for their respective catchment areas, the names of mothers who have not yet brought their children for vaccination. This preparatory phase usually precedes vaccination campaigns and involves the *Women Development Group* (WDG) leaders conducting a five-day inspection across the household compounds in their assigned area, recording the number, age, and names of the children scheduled to receive immunogenic antigens.

During an extraordinary vaccination campaign against meningitis A, I was able to observe several days of such patrols in a rural area near Mekelle – difficult to reach by local transport and arduous even on foot. These days of *mobilization* began at sunrise and ended before sunset, ensuring that every compound in the area – sometimes located far apart – was reached.

At the next level of the hierarchy are the HEWs, who, through their constant

presence at the doorsteps of potential 'draft dodgers' of the vaccination campaign, act to ensure that the latter appear at the *Health Centers*, which then report vaccination data to the Tigray Health Bureau.

All of my informants (whose names in the following interviews are pseudonyms) shared a common view. They linked a noticeable change in public awareness of the importance of immunization – and the widespread acceptance of vaccines – to roughly a decade ago, coinciding with the consolidation of HEW and WDA activities.

> Interview with Nigisti, HEW (06/10/15):
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> "Today no one refuses vaccines for religious or traditional reasons. In the past, mothers were afraid of the needle and of injections because of religious beliefs – they thought the OPV [Oral Polio Vaccine] was a bad practice. They said, 'it makes me fall into *mugurae*' [*mugurae* refers to any involuntary movement of the body, a song, or a dance caused by an evil spirit]. Sometimes they believed that through the vaccine they were being injected with *buda* [the evil eye]. But now this no longer happens – we are a modern country. Even if people sometimes don't understand or accept things quickly, if you keep persuading them, eventually they believe!".

In Mekelle, the term *vaccine* often becomes synonymous with the polio vaccine, as since 1988, when all WHO member states committed to eradicating poliomyelitis, numerous mass vaccination campaigns have been launched for the administration of OPV. Since the beginning of the initiative, reported polio cases have decreased by more than 99%, from an estimated 350,000 cases in 1988 to 1,285 cases in 2007 [6].

Before the introduction of the HEWs, non-compliance with vaccination was mainly linked to the local explanatory model of *injection*, in which the connection between vaccination and prevention was not yet embedded in community practices or worldviews. It also reflected a tension between the local etiology of *almsi* and its biomedical correlate, poliomyelitis.

In many rural and peri-urban areas around Mekelle, injections are still believed to aggravate illness or even cause death when a person is afflicted by *buda* (evil eye) or *ideseb* (a condition caused by envious individuals whose negative emotions can make others ill) [7].

Until a few years ago, treatment for *almsi* – attributed to the presence of a *zar* spirit – was carried out by mothers within the domestic sphere or by traditional healers. As one of them, Solomon (interview, 11/09/15), explained, the treatment involved food offerings to the spirit and tying a *kitab* (amulet) around the child's neck to prevent further attacks by the *zar*.

The *zar* complex in Ethiopia refers to a broad pantheon of possessing spirits [8, 9, 10, 11]. The *kitab*, moreover, reveals a striking linguistic and conceptual parallel with the Amharic word *kitabet* (vaccine). Both derive from the same root and are linked to protection and prevention. The *kitab* is a protective amulet prepared by healers who wrap local leaves, pieces of parchment inscribed with prayers or magical formulas from the *asmat* (a body of sacred literature invoking the true names of God), and the name of the wearer in a strip of leather. Among these protective texts are the heal-

ing scrolls, known in Amharic as *yä branna ketab* – literally "written on the skin".

The goal of eliminating cultural beliefs regarded as "backward" by health workers repeatedly emerges in conversations with HEWs. This stance also exposes the asymmetric relationship between the health network and community members, insofar as it positions biomedical knowledge as superior to local explanatory models. In this process, persuasion functions as a rhetorical, paternalistic, and coercive tool of awareness raising. The stated aims of health extension workers coincide with the directives established by the Health Extension Program (HEP) – notably, the improvement of health-seeking behavior – in order to produce healthy and, as Nigisti puts it, "modern" citizens. In Ethiopia, the rhetoric of modernity – across health, technology, and politics – has become both an aspiration and a moral code, a watchword and a promise of salvation.

HEWs explain the importance of immunization by appealing to the emotional sphere, aiming to induce a state of alert and anxiety. They often draw on memories of severe illnesses that afflicted a neighbor's child who had not been vaccinated, since ways of thinking about epidemics are anchored to iconic images of past plagues.

> Interview with Tsehai, HEW (21/09/15):
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> "Today, no one refuses vaccines. If a woman does refuse, I show her a picture of a paralyzed child and say: 'If you don't vaccinate, your child will die!' If she still doesn't come to the Health Center, I go back to her house! Vaccination is not an obligation – it works by agreement! We return to homes again and again, we say: 'you must vaccinate your child!' again and again, until she is convinced – until she agrees".

Among the principal tools of persuasion is suggestion, which orients and conditions recipients' choices and behaviors.

> Interview with Abeba, HEW (03/11/15):
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> "We have to explain the danger of diseases. We do this by showing images of children with poliomyelitis and tuberculosis; we teach them that if they don't vaccinate their children, they will become like the ones in the picture. We provide health education, we have a schedule of visits, and we go house-to-house with these images".

Because major epidemics mark individual and collective memory, the photograph of a paralyzed child functions as a semiotic image: it triggers a double, concatenated effect – immediately recalling the specter of *almsi* (Tigrinya word for poliomyelitis, locally glossed as 'the disease that paralyzes children') and making the risk of non-immunization starkly visible.

Stored in personal and collective memory, the recollection of past pestilences – recalled through the concreteness of a deformed body – erupts into the present so forcefully that it becomes the key lens through which the vaccine is reconfigured as salvific. What further sustains adherence is the door-to-door method, an instrument to manage and expand consent. Entering domestic spaces – interrupting everyday life day after day – is part of a persuasive script that seeks to weave an aura of intimacy, proximity, and recognition, so that health promoters are seen

not only as institutional agents but also as members of the community.

> Interview with Tamirat, HEW (06/11/15):
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> "I go into their homes and greet them! If there is a woman who has just given birth, I start with our traditional blessing: 'I am grateful that Saint Mary assisted you during your pregnancy'. If I go to a rural area, I dress like a farmer! Here women do not wear trousers, so I wear a dress! I approach them exactly as the rest of the community does. Then I ask: 'How are you? How are your children?'. At first, farmers respond harshly – they are not persuaded quickly. But I return the next day, and the next, and so on".

As this ethnographic testimony shows, empathy emerges as one of the ethical principles expected to guide HEW conduct, grounded in practices of proximity and culturally attuned interaction.

Gossip – whether real or presumed – remains a form of social control, an indirect power, and a deterrent against vaccine non-compliance, driven by the fear of negative repercussions on one's reputation within the community. This tactic leverages *yiluññta* (Amharic), a capacious emotional repertoire centered on shame triggered by actual or anticipated negative judgment from others. In Tigray, the equivalent term is *sikfta* [12]. In Mekelle's society this is a constant fear of compromising one's public image: *yiluññta* is "like a mosquito" whining softly in the ear; it is a reminder that others are watching and judging you [13, p. 660].

Illustrative here is the story of Hiwot, a young mother encountered during a BCG vaccination session in a rural area while I accompanied health staff transporting the vaccine in a small cooler. BCG – an anti-tuberculosis vaccine included among the basic antigens – can only be administered on specific days because, unlike other immunogens, it is not a single-dose vaccine: each vial provides twenty intradermal doses and, once reconstituted, should be discarded within six hours.

> Interview with Hiwot (06/01/16):
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> "Why do you ask me about vaccines? I think they are a good thing; otherwise HEWs would not walk so far to come to my house and tell me to vaccinate my children. They were vaccinated at birth and I thought that was enough... but after a while the HEWs began coming to my door to tell me about new vaccines. They came more and more often, and when they didn't find me at home, they spoke to my neighbors. I had no time to take my children to the Health Center. I am a widow, with a livestock enclosure and animals to look after. At some point they stopped coming – and my neighbors stopped talking to me. One morning I noticed a zebu had escaped my pen and fallen into a ravine. I asked all my neighbors for help to pull it up, but no one seemed to listen. I cried because the animal was hurt – and here a zebu costs a lot of money. Then I saw a neighbor – my childhood friend – coming. I ran to her to show what had happened; she didn't even look at me, saying that if I wasn't a good mother, I couldn't be a good herder either! I asked why she would say that – my children had always been good and she knew it! She replied that the HEWs had told her I hadn't brought my children to be

> vaccinated and that I would make everyone sick: the children, the animals, and all my neighbors' children! That is why I am here today. I am a good mother, and my community must know it; my children can play with the others again – they will no longer be dangerous; they will be normal with the vaccine. I can trust them, and they must trust me".

A common influence technique is to instill within the neighborhood the idea that a mother who avoids vaccinating her child is not a good parent. To avoid gossip and guilt, recalcitrant parents often yield to pressure and conform to the prevailing rule.

As these interview excerpts suggest, women often comply with vaccination more in response to community expectations than out of personal critical conviction. Hiwot's words also clarify a now widespread local conception: while the unvaccinated body might appear "natural" or "normal", among many of my interlocutors it is instead the vaccinated body – into which a modified pathogen has been introduced – that is considered unaltered, incorrupt, or incorruptible. The unvaccinated child is simultaneously exposed to disease and a potential threat to others – a contaminating and contaminable body.

HEW oversight unfolds through two modalities of control: (1) centralized, formal control from above, and (2) informal, reciprocal control at the community level. The first involves ongoing institutional supervision of HEW performance by the relevant Health Centers; in parallel, health professionals monitor the activities of the WDA, who – as noted – collect information on candidates for the vaccination draft. Formal control also relies on codified instruments such as the vaccination booklet, which records household data – number of children under five and vaccines received. This document functions as a tool that serves both surveillance and accountability: beyond preventing anyone from slipping through the lists of vaccine candidates, it also attests to the HEW's work. By writing the date when women should present their children for vaccination, the health promoter also proves her presence in each household, as explained by Genet, a HEW.

> Interview with Genet, HEW (06/10/15):
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> "I write the date of vaccination so mothers can remember it – and how would the Health Center know I came to this house if I don't write anything or leave them this slip? When they go there, they have to show it!".

Informal control, by contrast, is enacted at the neighborhood level through a kind of grassroots surveillance in which community members report to HEWs or WDAs those who have missed vaccination – most often due to forgetfulness rather than resistance. In this way, HEW intervention forms part of a broader logic of capillary control: vaccination is perceived as a social norm, and non-adherence as a transgression that undermines the well-being and public health of the community as a whole. Health professionals frequently stress the need for coordination across territorial levels to ensure adherence, as noted by Mahari, a Health Center coordinator:

> "The *balemegezati* must be tracked down by the WDA and the community so that the HEWs can report them to us and bring them here". (22/11/15)

In Amharic, *balemegezati* (defaulter, delinquent) – applied to those who evade vaccination – carries a moral judgment, signaling a failure to meet the moral obligation of the vaccination social contract. Through community responsibility at multiple levels and organized initiatives of outreach and propaganda, these practices have fostered a sphere of influence – a dominant network of pro-vaccine supporters within the community.

## 4. Dialectics of Power, Consent, and Conflict

In the field of vaccination, relationships of power and authority intertwine between the state, systems of expertise, and citizens [14]. Health workers deployed by the state were tasked with achieving the former Millennium Development Goals (MDGs) and, later, the Sustainable Development Goals (SDGs). Their work was therefore also part of a broader process aimed at making the country more attractive to foreign donors and investors. In this sense, the concept of the state at the service of the individual in good health replaces the concept of the individual in good health at the service of the state [15, p. 41].

The goal of improving vaccination coverage thus appears closely linked to the exercise of medical authority and control. This can be measured by reflecting on the sphere of rights and freedoms expressed through the notion of *informed consent*. According to my interlocutors, the antigen protects not only against exanthematous diseases such as *deramal* (measles) and acute conditions like *almsi* (poliomyelitis), but also against *eneweshin*, a broad nosological category of spiritual illnesses that affect children and are attributed to supernatural causes.

Although the dissemination of vaccination information formally falls within the duties of the HEWs, most of the mothers I interviewed during routine immunization days demonstrated no real knowledge of vaccines. Even though the statute regulating HEW organization encourages the promotion of informed consent – as several health workers told me in principle – my field research revealed that almost all the mothers interviewed were unaware of the vaccine names, the diseases they prevent, and possible side effects.

Information provided to parents is rarely explained in greater detail within public schools, where vaccinations are often carried out during extraordinary campaigns, such as the meningitis A campaign I observed during fieldwork. The parents' lack of knowledge is further compounded by that of teachers, as illustrated in the following interview with Semret, a primary school teacher.

> Interview with Semret (Teacher, Lem Lem Da'ero School, 30/10/15):
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> "Usually, the doctors come to this school once a year to give vaccinations. Last year they didn't come – maybe because there were no diseases. They never tell us which vaccine it is or for what illness; they just come and tell us there's a vaccination, and ask us to gather the children. This time I know what it is – it's the meningitis vaccine; they're giving it everywhere in the city! Maybe because there's so much sun and, with the heat and the drought, the disease appears... Parents are usually not informed that a vaccine will be given at school; they don't have to give their consent. When they do know, they never

> ask anything – the responsibility lies with the doctors! In fact, yesterday one child was vaccinated twice, once at the Health Center and again at school, because the parents didn't know the doctors would come here to vaccinate everyone".

Asserting that responsibility and competence belong exclusively to doctors and HEWs confirms the assumption that only health professionals can know and decide what is best for patients. The doctor-parent relationship thus materializes as the ratification of the former's authority and the alienation and disempowerment of the latter, often deprived of the possibility of expressing critical thought.

Through observation and dialogue with those involved in the immunization process, it became clear that decisions about vaccination are unilateral, directed entirely by health promoters and professionals in pursuit of political consensus. Yet, given that complete reliance on biomedical therapeutics has been directly proportional to Ethiopia's successful vaccination coverage, certain questions arise – about the actual need or desire for informed consent among communities, and about the very relevance of reflecting on freedom of choice as self-determination independent of external influence.

Perhaps it is within a nascent form of dissent toward immunization, now emerging among young urban students, that an answer may be found, as Aberash, a 22-year-old student at Mekelle University, explained during our conversation.

> Interview with Aberash (11/12/15):
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> "For some time I've been asking myself questions about vaccines. These weeks they're vaccinating against meningitis – on the radio, on TV, everywhere they tell us to get vaccinated, but they don't tell us anything else. For example, why do they vaccinate only people up to 29 years old? Online I read that vaccines can be harmful in some cases – so why don't the government and the doctors explain it? Maybe there are interests behind it that they don't want to tell us about... Think of the tetanus vaccine: I never received it at school or university, while girls did. I thought it might be a contraceptive method injected into young women without their knowledge to achieve the Millennium Development Goals, to control births. I thought of not getting vaccinated, but my neighbor is a WDA member, and I couldn't refuse".

Consent toward vaccination in Mekelle is therefore not a fixed or homogeneous phenomenon, especially if we consider how, in Aberash's account, uncertainty, fragmented information, and mistrust shape young people's reflections on vaccines. This emerging landscape of doubts – fueled less by structured opposition than by informational gaps – helps explain why forms of hesitation are beginning to surface. This should not surprise us, particularly in light of the broader international debates on vaccination skepticism, including the radicalization of dissent documented in Europe and in Italy [16, 17]. Although the HEWs' immunization strategy has so far achieved more than 95 percent coverage in Mekelle, the increasing lack of transparency and the opaque political maneuvers that blur both ends and means have become key reference points around which

young people are polarizing and uniting symbolically.

Young students like Aberash – thanks also to new communication technologies – have begun to articulate forms of resistance against the perceived annihilation of their autonomy and the fear of being manipulated by power. It is for this reason that the ambivalences and tensions simmering within society, and the complex relationship between state and citizens, between information and freedom of choice, cannot be ignored. Decision-making processes must be understood as political processes, situated within specific configurations of power, historical-social contexts, and cultural traditions [18].

## 5. Conclusions

Throughout the article, I refer to certain military metaphors used by health workers themselves – terms such as *campaign*, *draft*, or *mobilization* – which circulate widely in local discourse about immunization and shape how vaccination practices are imagined, organized, and enforced. These metaphors find legitimacy not only in the fact that vaccination programs can be regarded as among the most powerful weapons in the political arsenal of public health, but also in the very essence of the immunization strategy implemented by HEWs – as an expression of control and population management aimed at eradicating predictable and preventable diseases. The work of HEWs and WDAs thus takes on a performative dimension, in which the act of speaking – the use of metaphor, analogy, and comparison – becomes a linguistic and persuasive instrument through which action is realized: the inoculation of the attenuated pathogen. Through these networks, biomedical knowledge becomes operational through its performative use, not primarily as a means of diffusing knowledge, but as a way of inducing interlocutors to adhere to the vaccination.

The image of a child crippled by disease, shown to the parents of those enlisted in the *vaccination draft*, constitutes a crucial element in the mediatization of the immunogen. It not only displays, with striking clarity, the threat of what would be faced by violating the social contract of vaccination, but also gives a face – a dramatic concreteness – to parental fears, while simultaneously reaffirming a promise of salvation for their child, achievable through the "gift" of the protective substance. The parables of epidemics such as poliomyelitis are fixed in print to be remembered, reinforcing the fear of their resurgence. Yet, while each epidemic within scientific discourse becomes an opportunity for advancing biomedical knowledge, such knowledge must also contend with the ripple effects these events have across the local world.

Systematic biomedical practice, through herd immunity, produces a redefinition of norms and social order, and establishes a selective distinction between the body normalized by inoculation and the body of the unvaccinated. Vaccination thus assumes the character of an initiation ritual, in which the introduction of the substance strips the individual of their dangerous potential toward others – paradoxically becoming "natural" once rendered artificial by the reforming matter. The "other" becomes the unvaccinated person – an obstacle and a threat to social coexistence, and therefore alien to the communal order.

The application of a standardized and universal immunization program, while ensuring high coverage, seems to conceal the latent link be-

tween adherence and surveillance. The individual body thus appears to become a function of biopolitical planning, a moment in which the transformation of the collective body takes on the physiognomy of an administrative act. Within the issue of mass immunity, relations of power between states, networks, and communities remain central, as does the unidirectionality of the doctor-patient relationship.

At the same time, the threat of epidemic disease remains imminent – especially in the African context, where inequalities shape the very definitions and trajectories of life, illness, and death, and every outbreak of tuberculosis or meningitis reaffirms the importance of vaccines.

However, if on the continent the state of epidemic emergency – continually claiming lives – has become an almost constant dynamic that calls for swift interventions, this does not justify the underlying assumption that, in order to vaccinate the body, one must inevitably immunize critique.

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