# Vaccine Equity in Multicultural Urban Settings

*A comparative analysis of local government and community action, contextualised political economies, and moral frameworks in Marseille and London*

September 2022

Santiago Ripoll
Ashley Ouvrier
Tabitha Hrynick
Megan Schmidt-Sane

The
British
Academy

**About the authors**
Dr Santiago Ripoll is Research Fellow at the Institute of Development Studies (IDS). Dr Ashley Ouvrier is Researcher at the Laboratoire de Sciences Sociales Appliquées (LaSSA). Tabitha Hrynick is Research Officer at the Institute of Development Studies (IDS). Dr Megan Schmidt-Sane is Research Fellow at the Institute of Development Studies (IDS).

**About COVID-19 Recovery: Building Future Pandemic Preparedness and Understanding Citizen Engagement in the G7**
The programme aims to facilitate global and interconnected learning about the contexts, causes and factors leading to vaccine engagement. Through the programme, the Academy has awarded funding to seven research projects exploring vaccine engagement in Canada, France, Germany, Italy, Japan and the UK. The programme, which was funded by the UK's Department for Business, Energy and Industrial Strategy, builds on a series of statements developed in partnership with humanities and social sciences bodies across G7 countries. The Academy has supported another series of projects focused on the USA and UK.

# Contents

# Introduction

At national and aggregate levels, COVID-19 vaccination across G7 countries appears successful. To date, 79.7% of the total population of G7 countries have received a first dose, 73.1% a second, and 46.7% a booster shot (19th of May 2022 data).[1] This research considers two G7 countries in particular, France and the UK, which have similarly high uptake rates at the national level (see Table 1).

**Table 1: Percent of population in two G7 countries who have received first, second and booster doses of COVID-19 vaccines**[2]

| Country | First dose | Second dose | Booster | Update |
|---------|-----------|-------------|---------|--------|
| France | 80.7% | 78.3% | 56.5% | 18th May 2022 |
| UK | 79.5% | 74.3% | 58.8% | 11th May 2022 |

Despite the high overall vaccination rates in these two countries however, significant in-country disparities exist, with lower vaccine uptake among urban areas with lower income and minority ethnic and cultural backgrounds – in short, vaccine uptake is unequally distributed. For example, vaccination rates for a first dose in London for eligible population (over 12 year olds) is 69.7% and within London, in North Acton in Ealing they are 59.1% (18th of May 2022 data).[3]

Building on previous engagement in Ealing (Northwest London),[4] this research investigates these disparities through the lens of 'vaccine (in)equity' across two urban settings – Marseille (Northern Districts) and as comparator, London (Ealing borough). Aiming to a fill a literature gap, we focus on the role of local actors, contending that local governments, health actors, community groups and residents play key roles in shaping vaccine (in)equity. Our teams also situate local vaccine inequities within their communities of place[5] - including broader political, economic and other structural contexts and inequalities - recognising that many factors may interact in complex ways to produce inequities. We also adopt the concept of 'moral frameworks' to understand how people understand and seek vaccination or not. We also sought to understand whether and how such local dynamics are reflected in local government approaches to promoting and delivering COVID-19 vaccines.

## Case study A: The 13th, 14th, 15th and 16th northern districts of Marseille, France

In Marseille, the COVID-19 pandemic exacerbated historical health inequities between the wealthier southern districts (arrondissements), and the northern districts where inhabitants face low incomes, overcrowded housing, and poor access to public services, and were thus disproportionately affected by COVID-19

1       Financial Times, 'Covid-19 Vaccine Tracker: The Global Race to Vaccinate', 2022, https://ig.ft.com/coronavirus-vaccine-tracker/.
2       Financial Times, 'Covid-19 Vaccine Tracker'.
3       UK Government, 'Vaccinations in the UK', Vaccinations in the UK, 18 May 2022, https://coronavirus.data.gov.uk/details/vaccinations.
4       'Evidence Review: Achieving COVID-19 Vaccine Equity in Ealing and North West London' (Social Science in Humanitarian Action Platform, 2021), https://www.socialscienceinaction.org/resources/evidence-review-achieving-covid-19-vaccine-equity-in-ealing-and-north-west-london/.
5       Institute of Community Studies, 'Understanding Vaccine Hesitancy through Communities of Place' (ICS, 2021), https://icstudies.org.uk/repository/understanding-vaccine-hesitancy-through-communities-place.

hospitalisations and deaths.[6] These districts are also highly socially diverse, housing up to 30% of migrants in the city[7] including North and Sub-Saharan Africans, South-East Asians, Comoro Islanders and Eastern European and Turkish migrants.

These neighbourhoods have also lagged in COVID-19 vaccination. For example, only 52.6% of the inhabitants of the northern district 14th arrondissement has received one dose, compared with 75.4% in the wealthier 8th arrondissement (8th of May 2022 data).[8] At its onset, the vaccination programme's centralised and inflexible organisation was insensitive to residents' livelihoods, languages or cultural priorities which deepened their already strong mistrust of the state. Marseille is also home to the controversial Doctor Raoult, whose activities fed local anti-vaccination and anti-establishment sentiments. On the other hand, Marseille has a strong civil society that has mobilised to fight for better health and housing and to promote social justice and equal rights.[9, 10]

## Case study B: Ealing borough in London, UK

The London borough of Ealing is one of the UK's most diverse local areas. Over 54% of people are from Black, Asian and minority ethnic backgrounds (BAME), and migrant residents come from over 170 different countries.[11] Ealing too, particularly its superdiverse and more deprived western areas, was disproportionately impacted by COVID-19 compared to London. Indeed, across the UK, people from BAME backgrounds faced disproportionate COVID-19 infection and death due to forms of structural violence and exclusion.[12, 13] Vaccine uptake across Ealing was lower in more deprived areas, and among certain ethnic groups (especially residents from black or mixed backgrounds) compared with white British residents. Alongside structural racism and economic precarity, hostile migration policies in the UK may also have contributed to this vaccine inequity.[14, 15]

Our methodological approach, is based on (i) a comprehensive review of available grey literature from government sources, media coverage and civil society organisations' reports across the two countries, (ii) stakeholder consultations in Ealing and Marseille, and (iii) ethnographic research and semi-structured interviews with residents in Marseille.[16] This methodology allows for an exploration of nuance between the two countries' diverse populations and political, economic, social and cultural systems in the context of COVID-19 vaccination. Our research has implications for pandemic preparedness across G7 countries, and we provide key considerations for local authorities to achieve vaccine equity.

---

6   Insee, 'Décès En 2020: Hausse plus Forte Pour Les Personnes Nées à l'étranger Que Pour Celles Nées En France, Surtout En Mars-Avril - Insee Focus - 231', 2021, https://www.insee.fr/fr/statistiques/5353976.

7   Insee, 'Quartiers de La Politique de La Ville – Ceux Qui s'installent Sont plus Pauvres Que Ceux Qui Partent - Insee Analyses Provence-Alpes-Côte d'Azur - 96', 21 October 2021, https://www.insee.fr/fr/statistiques/5544563.

8   L'Assurance Maladie, 'Les Données de La Vaccination Contre La Covid-19', 22 May 2022, https://datavaccin-covid.ameli.fr/pages/type-vaccins/.

9   Virginie Baby-Collin and Stéphane Mourlane, 'Histoire et Mémoire Du Grand Saint Barthélémy à Marseille, Entre Immigration, Politique de La Ville et Engagement Associatif', Diasporas. Circulations, Migrations, Histoire, no. 17 (2011): 26–41, https://halshs.archives-ouvertes.fr/halshs-00784522.

10  Hélène Dumesnil, 'Les Arrondissements Nord de Marseille - Etat Des Lieux Socio-Sanitaire et Environemental' (Observatoire Régional de la Santé Provence-Alpes-Cote d'Azur, October 2021), http://www.orspaca.org/sites/default/files/Diagnostic_Arrondissements_Nord_Marseille_2021_ORS_PACA_version_longue.pdf.

11  Ealing Council, 'Equalities Needs Assessment' (Ealing 1.12 WISP Migration, August 2020), UK, https://www.ealing.gov.uk/downloads/download/2043/equalities_needs_assessment.

12  Evangelos Kontopantelis et al., 'Excess Deaths from COVID-19 and Other Causes by Region, Neighbourhood Deprivation Level and Place of Death during the First 30 Weeks of the Pandemic in England and Wales: A Retrospective Registry Study', The Lancet Regional Health – Europe 0, no. 0 (7 June 2021), https://doi.org/10.1016/j.lanepe.2021.100144.

13  PHE, 'Beyond the Data: Understanding the Impact of COVID-19 on BAME Communities', June 2020.

14  Doctors of the World, 'Deterrence, Delay and Distress: The Impact of Charging in NHS Hospitals on Migrants in Vulnerable Circumstances', Research Briefing (Doctors of the World, 2017), http://www.doctorsoftheworld.org.uk/wp-content/uploads/import-from-old-site/files/Research_brief_KCL_upfront_charging_research_2310.pdf.

15  MedAct, Migrants Organise, and New Economics Foundation, 'Patients Not Passports: Migrants' Access to Healthcare during the Coronavirus Crisis', June 2020, https://www.medact.org/wp-content/uploads/2020/06/Patients-Not-Passports-Migrants-Access-to-Healthcare-During-the-Coronavirus-Crisis.pdf.

16  For a detailed account of the research methodology, please read the long report.

# What have we learned about the promotion of vaccine equity in multicultural urban settings?

Lessons for local actors in mitigating vaccine inequities for these groups emerging from our research are listed below.

1. **Local authority engagement of local health providers, community groups and other local actors has helped close vaccine uptake gaps.** Thanks to such collaboration, vaccine uptake was significantly increased amongst low income, minoritised and racialised communities. Although they remain the least vaccinated groups, effective community participation and engagement made a difference.

2. **Decentralisation and adaptation of vaccine programmes can improve vaccine equity.** Local authorities' deep knowledge of local context and their existing relationships with community groups supported more tailored responses to diverse local populations. Decentralised autonomy for decision-making made leveraging this easier, but even where decentralised power was limited, local authorities carved space for tailored action based on personal and institutional commitments to their populations.  Future epidemic responses must support decentralisation and adaptability of vaccine programmes.

3. **Vaccination programmes focused on meeting absolute numerical targets in Ealing delayed vaccination of racialised and minoritised groups by disincentivising tailored approaches.** However, when such targets were complemented by objectives to reach different community groups, equity improved. Targets and prioritisations should be decided in dialogue with relevant ethno-cultural and other community groups. Vaccination targets set for each devolved region must be based on equity as much as absolute numbers.

4. **Improvements to vaccine equity were greater when relationships between local authorities and community groups and residents were longstanding.** Reactive engagement has had a positive impact, but the building of trust was delayed, and community organisations indicated they had not been financed appropriately, leading to burnout. Funds should be readily available and new relationships that have emerged during COVID-19 should be consolidated and sustained beyond the pandemic.

5. **Tailored vaccine services designed and delivered with community groups work best in multicultural urban contexts.** Carefully chosen sites staffed by local people using relevant languages can provide a sense of safety. This requires working with community organisations and supporting and building on the work

of community engagement officers in local authorities.

6. **Vaccination uptake is higher when sites and venues are close to communities.** Mass vaccination sites should be complemented by smaller sites nearest to communities including pop-up or mobile clinics, GP clinics, pharmacies, and even door-to-door services. These should be planned with community groups rather than reactive, although flexible and adaptive.

7. **Complex booking systems and registration requisites are important barriers to vaccine equity.** People lacking digital access or skills, or command of official languages, struggled to navigate online booking systems. Systems should be easily navigable in key local languages, and walk-in options should also be available. NHS registration in London also discouraged migrants unsure of their status or entitlements, and fearful of criminalisation or deportation.

8. **COVID-19 requires adaptation and sensitivity to structural inequalities.** Low incomes and precarious frontline work forced people to work throughout the pandemic, making it difficult for them to go to vaccination centres. Uptake increased when opening hours were extended to include evenings and weekends.

9. **Mistrust stemmed from historical inequities and social injustices in health and other areas.** Communities which have faced historical discrimination, racism and inequality in housing, transport, employment, welfare, policing, health and/or other services may feel 'left behind' by, and be suspicious of the state. This mistrust undermines vaccination. Local authorities should work towards repairing this historical neglect and even direct hostility. The state and local authorities must invest in public services, not only in terms of medical provision, but also in other sectors such as housing, transport, welfare and economic opportunities. Health clinics and other health infrastructure in the community should be supported, as well as making them accessible.

10. **Language is a key driver of health inequity.** Trust is better where local languages in which people are most proficient are used, and where staff are from local communities. Translation should go beyond mechanical translation of information, to support dialogue to build respect for the different priorities and needs of diverse cultural groups in vaccine response. This burden of translation should not be left to overstretched community organisations.

11. **Community engagement in which local authorities 'go to' residents were successful.** Conventional community engagement usually involves inviting community groups and residents to discussions and events (e.g., online town hall meetings). While useful, mostly already engaged residents tend to join. Authorities who identified and engaged smaller community groups, such as by attending their pre-programmed events, were successful in reaching more diverse groups.

12. **Successful vaccine engagement is not just about 'getting the message right' but establishing trusting relationships.** Many residents who were able to voice their fears and ask questions of experts without judgement – such as through helplines, Q&A sessions and safe conversations with doctors - chose to get vaccinated. Two-way conversations also built trust when community feedback was incorporated into programming, and when community organisations and residents were involved in decision-making. Such approaches require interpersonal and intercultural skills, including empathy, non-judgement, and culturally safe spaces.

13. **Collaboration and joined-up approaches between local authorities, health providers, community groups and other civil society organisations must be supported.** This collaboration should not be reactive, but built up over time, and can leverage other issues around health equity. Build on existing relationships and initiatives, and nurture other community-led initiatives that have emerged because of the pandemic. Local community groups must be financed so they have the financial and human resources for this long-term engagement with local authorities and their ongoing work with residents.

14. **Who different social groups trust, and the formats and channels they are confident in varies widely.** Whether public health specialists, medical doctors, religious scholars, faith leaders or others are trusted on the issue of vaccination, may vary at a granular level. Collaboration between health communication teams, community engagement staff in local authorities, and community groups resulted in appropriately tailored vaccine communication strategies. In future vaccination programmes, local government should identify locally trusted leaders for support, yet they must consider that who is trustworthy changes depending on the social group. Local government engagement teams should avoid making generalisations on religious or ethnic terms and seek the diversity of views within social groups. Local government should support and recruit mediators that bridge social work and health workers activities, 'translating' between vaccination teams and communities.

15. **Communication was most successful when built on existing moral frameworks of target audiences.** Different communities may respond more readily to moral arguments around autonomy and individual rights, community and social roles, or divinity and the sacredness of life and the body. Messaging that links vaccination to ideas of what is good, and what it is to be a good person within a particular moral framework, may be effective. Vaccination campaigns should adapt communication messages, formats and channels to the specific needs of communities at a granular level. The channels that are most trusted by different communities must be identified and information conveyed in different formats and identify with communities those messages and formats that will be accepted, appropriate and preferred.

16. **Health data on social diversity was necessary for effective action, but 'measuring' and 'targeting' are politically sensitive practices that should be defined alongside racialised and minoritised communities.** In some contexts, such as France, official data is not disaggregated by ethnicity or other social dimensions. This impedes identification of and responding to health disparities. In the UK, having such data allowed addressing vaccine disparities earlier. Still, it was important to communicate this sensitively to avoid stigmatising or scapegoating populations.

# Research questions

We sought to understand the ecosystem of vaccine (in)equity - understood as (un)
fair and (un)just access to vaccines for all people - at multiple levels, from different
points of view and as embedded in particular social, political, economic and cultural
contexts.[17]

- How do relationships between and within local government, health system actors
and community groups and residents shape vaccine (in)equity in urban settings?

- How have community engagement activities supported (or hindered) trust in the
COVID-19 response and vaccination efforts in London and Marseille?

- How have structural inequalities shaped vaccine (in)equity locally?

- How do different social and moral frameworks shape social groups' vaccine
engagement?

---

17      Hrynick and Ripoll, 'Evidence Review'.

# 1.0 Structural inequalities in the northern districts of Marseille and Ealing

**Unpacking vaccine (in)equity**

Conventional explanations of low vaccine uptake tend to emphasise knowledge deficits, misinformation and conspiracy theories. This overlooks the critical role of context, including structural inequalities and political dynamics, and how these impact different people's access to and confidence in vaccines, and the actors involved in their production, communication and delivery (vaccine equity).

Historical mistrust and/or experiences of discrimination can provide fertile ground for misinformation to gain traction and become 'plausible'. Indeed, vaccine hesitancy is more likely in contexts of high inequality and limited citizen participation in decision-making as people may perceive the state (and its partners) to have malevolent motives.[18] Relatively low COVID-19 vaccine confidence in France (among other G7 countries) for instance, cannot be considered in isolation from an erosion of public trust (evident in the recent political turbulence), the state's handling of the pandemic, and even historical vaccination controversies (e.g. pertussis in the 1970s).

Legacies of racism, xenophobia and inequality, embedded in mainstream culture, social norms and formal policy, can also contribute to a sense among migrants, their descendants and marginalised groups, that authorities do not care about them, or may even be trying to harm them. For instance, in Marseille's northern districts, inhabitants face daily discrimination through a lower access to transport, healthcare, housing and schools, and mistrust of public administrations is common.[19] Poorer people may also struggle to access services as travel may be unaffordable or impractical, or they may simply have more pressing priorities.

Ultimately, different forms of exclusion lead to poor and unequal health outcomes – it is essential to understand the localised ways in which this occurs. Below, we explore different forms of exclusion and their implications for vaccine inequity across our research sites.

**Economic inequalities and precarity**

Precarious employment and low incomes have been key drivers of COVID-19 vulnerability across the two settings.

---

18     Luisa Enria et al., 'Power, Fairness and Trust: Understanding and Engaging with Vaccine Trial Participants and Communities in the Setting up the EBOVAC-Salone Vaccine Trial in Sierra Leone', BMC Public Health 16, no. 1 (8 November 2016): 1140, https://doi.org/10.1186/s12889-016-3799-x.

19     Nadine Roudil, 'De l'indifférence à La Différence : La Relation Entre Le Centre Social de La Castellane et La Population d'origine Étrangère Dans Les Quartiers Nordde Marseille.', Ethnographiques.Org, no. 12 (February 2007), https://halshs.archives-ouvertes.fr/halshs-01321080.

### Frontline workers exposed to COVID-19 and little time to vaccinate

Living on low incomes, including in-work poverty, means COVID-19 concerns may be low priority for people struggling to make ends meet. The pandemic affected often precariously employed frontline workers for whom remote work, self-isolation, and taking time off for vaccination have not really been feasible options. Economic inequality can also damage trust, making people feel neglected.

Nearly half of the Provence-Alpes-Côte d'Azur (PACA) region's poorest people are concentrated in the north districts of Marseille, and its working-class residents[20] were disproportionately affected by COVID-19. Despite the presence of some economic and industrial enclaves, the average poverty rate is particularly high in the area which exacerbated vulnerability locally, especially during the first lockdown (March-April 2020).[21] Indeed, many social, health and education workers raised concerns about the challenges many families in the area faced just to feed themselves at the time.[22] Civil society, including community groups and NGOs stepped in to meet basic needs in the absence of the State. Poor and migrant residents (particularly women) as more likely to be vaccine reluctant than the majority of the population.[23]

Increasing work precarity and low pay has also affected Ealing which has experienced a substantial increase in gig-work,[24] and has many 'zero-hours' workers (who are not guaranteed work despite being employed).[25] The borough is also home to many undocumented residents engaged in informal work, precluding them from receiving pandemic furlough support. Overall, many people found it difficult to meet their basic needs even before the pandemic, and thus may understandably be more concerned with ensuring their food and housing security than seeking vaccination. Economic hardship may also contribute to a sense of abandonment, orienting people towards mistrust of the state and its intentions in advocating vaccines.

### Poor housing as a key driver of inequity

Marseille's northern districts are home to the most social housing and low-cost private rented apartments in the city, although more expensive private yet low-quality flats rented by unscrupulous landlords to inexperienced migrants are also present.[26] Despite regeneration attempts, housing conditions have not sufficiently improved, and overcrowding has been a key driver of intergenerational COVID-19 transmission. Deterioration of housing in Marseille has been on the political agenda since several buildings collapsed in 2019 killing eight people.[27] Ealing too, struggles with both an inadequate supply and quality of housing meaning many people live in sub-optimal, often overcrowded conditions. The borough ranks eighth in London for overcrowded housing.[28]

20    Insee, 'À Marseille, Le Regain Démographique Modifie Peu Les Disparités Spatiales - Insee Analyses Provence-Alpes-Côte d'Azur - 74', 9 November 2019, https://www.insee.fr/fr/statistiques/4211491.

21    Myriam Hachour, 'Etude Des Connaissances, Attitudes et Pratiques et Des Facteurs de Susceptibilité Socio-Comportementale à La COVID-19 Dans Une Population Socio-Économiquement Vulnérable Des Quartiers Nord de Marseille : Parcours NORCOVID' (Marseille, Faculte de Sciences Medicales et Paramedicales de Marseille, 2020).

22    Olivier Bertrand, 'Dans les quartiers nord de Marseille, «le confinement est une gageure»', Mediapart, 31 March 2020, https://www.mediapart.fr/journal/france/300320/dans-les-quartiers-nord-de-marseille-le-confinement-est-une-gageure.

23    Nathalie Bajos et al., 'The Social Specificities of Hostility toward Vaccination against Covid-19 in France', PloS One 17, no. 1 (2022): e0262192, https://doi.org/10.1371/journal.pone.0262192.

24    GMB, 'Insecure: Tackling Precarious Work and the Gig Economy', 2017, https://gmb.org.uk/sites/default/files/GMB17-InsecureWork.pdf.

25    Skills for Care. 'A Summary of the Adult Social Care Sector and Workforce in Ealing 2020/21'. Ealing: Skills for Care, 2021, https://www.skillsforcare.org.uk/adult-social-care-workforce-data-old/Workforce-intelligence/documents/Local-authority-area-summary-reports/London/2021/Ealing-Summary-2021.pdf

26    Johanna Lees, 'Ethnographier La Précarité Énergétique : Au-Delà de l'action Publique, Des Mises à l'épreuve de l'habiter' (2014), https://halshs.archives-ouvertes.fr/tel-01117039/document.

27    Coralie Bonnefois, 'Trois personnes meurent dans l'incendie des immeubles squattés des Flamants', Marsactu (blog), 17 July 2021, https://marsactu.fr/trois-personnes-meurent-dans-lincendie-des-immeubles-squattes-des-flamants/.

28    PHE, 'Overcrowded Households - Ealing', Public Health England, accessed 10 June 2021, https://fingertips.phe.org.uk/search/overcrowding#page/4/gid/1/pat/6/ati/101/are/E09000009/iid/90416/age/-1/sex/4/cid/4/tbm/1.

**Systemic racism in Ealing and Marseille**

Racism is more than just the attitudes of certain 'racist' people - it also refers to unequal systemic and institutionalized features of social life that are reproduced in routine activities.[29] Racism has played a role in people's trust in vaccination programmes in Marseille and Ealing.

Making difference visible or invisible

Each context differs in how they measure difference, communicate and act on racial or ethnic difference. In France, gathering ethnic or racial health statistics is widely considered to be against its republican universalism and constitution (although many politicians and scientists have challenged this).[30] While data by migration status is available, differences between citizens with and without migrant backgrounds (e.g., second generation) are also not captured. The obscurement of these social differences makes it challenging or impossible to recognise and address inequities.

In contrast, the UK has historically collected data on ethnicity and race but has struggled to communicate about COVID-19 disparities sensitively. For instance, the UK government suggested prioritising ethnic groups with higher vulnerability to COVID-19 for vaccination, but this was perceived as stigmatising and racist by these groups. Communication leading to scapegoating also occurred in France where the media's reporting of higher cases on Comoros Island led to racist discrimination against its population.

Racialised inequities in health outcomes may lead to mistrust in vaccination

Across Ealing and Marseille, racialised and minoritised communities, including migrants, have lower access to health care, poorer health outcomes and lower patient satisfaction in clinical settings.[31, 32] Examples the UK include higher rates of diabetes and hypertension among racialised groups (even when other factors are accounted for), and lesser chance of receiving adequate mental health care for non-white ethnic groups.[33]

Disparities also emerged in the COVID-19 pandemic. In Marseille, higher mortality rates were detected among migrants compared to French-born citizens.[34] In the UK, it was clear that COVID-19 was disproportionately affecting people from ethnic minority backgrounds, leading to the issue of systemic racism being thrust into public discourse in an unprecedented way.[35]

In the UK, mistrust is also linked to broader and long-standing issues relating to racism and discrimination, including historic unethical medical research on black populations, under-representation of minority groups in medical research and vaccine trials, and poor experiences with health systems and services.[36] Such systemic racist bias in health service provision has led to vaccine hesitancy amongst

29      Roxana Ng, 'Immigrant Women: The Construction of a Labour Market Category', Can. J. Women & L. 4 (1990): 96.
30      Didier Fassin, 7. Du déni à la dénégation. Psychologie politique de la représentation des discriminations (La Découverte, 2006), https://www.cairn.info/de-la-question-sociale-a-la-question-raciale--9782707158512-page-131.htm.
31      NHS Race and Health Observatory, 'Ethnic Inequalities in Healthcare: A Rapid Evidence Review' (London: NHS Race and Health Observatory, 14 February 2022), https://www.nhsrho.org/publications/ethnic-inequalities-in-healthcare-a-rapid-evidence-review/.
32      Insee, 'Décès En 2020 : Hausse plus Forte Pour Les Personnes Nées à l'étranger Que Pour Celles Nées En France, Surtout En Mars-Avril - Insee Focus - 231'.
33      NHS Race and Health Observatory, 'Ethnic Inequalities in Healthcare: A Rapid Evidence Review'.
34      Insee, 'Décès En 2020 : Hausse plus Forte Pour Les Personnes Nées à l'étranger Que Pour Celles Nées En France, Surtout En Mars-Avril - Insee Focus - 231'.
35      Mohammad S. Razai et al., 'Covid-19 Vaccine Hesitancy among Ethnic Minority Groups', BMJ 372 (26 February 2021): n513, https://doi.org/10.1136/bmj.n513.
36      NHS Race and Health Observatory, 'Ethnic Inequalities in Healthcare: A Rapid Evidence Review'.

racialised and minoritised people in the UK.[37] In Marseille, there is a process of 'ghettoisation', which includes a cumulation of social disparities in low-income neighbourhoods hosting a large proportion of migrants and their descendants.[38] This process, together with the neglect by local political leaders of social problems in these territories has contributed to vaccine hesitancy. Racism beyond health service provision, such as the UK government's unjust deportation of Afro-Caribbean residents who have lived in the UK their whole lives generated mistrust.[39] In Marseille a clear 'us versus them' feeling and discourse revealing faultlines between authorities and the inhabitants of the Northern districts of Marseille has emerged.

## Hostile environments for migrants lead to fear and mistrust in Ealing

In the UK, formal and informal data sharing practices between public services and the Home Office [40, 41] which criminalises and deports irregular migrants, has caused fear among migrants – even those with legal entitlement – to seek needed care, safety and support.[42, 43] Such fears were raised by local Ealing responders as contributing to lagging vaccine uptake among migrants, although these fears appeared to ease for many when it was made clear that formal registration was not needed for vaccination.

## Diasporic linkages

Residents' migrant backgrounds, or membership within diaspora communities can also influence their perceptions, thoughts and decision making around COVID-19 vaccination. Home country affinity, as well as feelings of exclusion in current communities of place may drive their greater trust in the knowledge of these networks. In Ealing for instance, a group of Somali residents insisted on the approval of a specific Islamic Somali scholar before deciding to get vaccinated, while members of a local Afro-Caribbean group expressed mistrust in Covid-19 vaccines due to past ill-fated Pfizer medical trials conducted on black people elsewhere.[44]

## Racialised and minoritised communities are not victims, they are mobilising against racism

People may have faced systematic discrimination, but they have also mobilised against racism. Ealing (Southall in particular) has a long and ongoing history of anti-racist activity addressing recently for instance, issues of racial discrimination in housing[45] and exposure to environmental hazards.[46] In Marseille, community groups campaign in health, housing and social justice and equal rights.[47, 48]

37     Razai et al., 'Covid-19 Vaccine Hesitancy among Ethnic Minority Groups'.
38     Zoé Carle and Élise Olmedo, 'Marseille est trop grande pour Marseille. Avant-propos', Vacarme 89, no. 4 (2019): 3–11, https://doi.org/10.3917/vaca.089.0003.
39     Huon Wardle and Laura Obermuller, '"Windrush Generation" and "Hostile Environment": Symbols and Lived Experiences in Caribbean Migration to the UK', Migration and Society 2, no. 1 (1 June 2019): 81–89, https://doi.org/10.3167/arms.2019.020108.
40     Gracie Mae Bradley, 'Care Don't Share: Hostile Environment Data-Sharing - Why We Need a Firewall between Essential Public Services and Immigration Enforcement' (Liberty, 2018), https://www.libertyhumanrights.org.uk/issue/care-dont-share/.
41     Vasiliki Papageorgiou et al., 'Patient Data-Sharing for Immigration Enforcement: A Qualitative Study of Healthcare Providers in England', BMJ Open 10, no. 2 (1 February 2020): e033202, https://doi.org/10.1136/bmjopen-2019-033202.
42     Doctors of the World, 'Deterrence, Delay and Distress: The Impact of Charging in NHS Hospitals on Migrants in Vulnerable Circumstances'.
43     MedAct, Migrants Organise, and New Economics Foundation, 'Patients Not Passports: Migrants' Access to Healthcare during the Coronavirus Crisis'.
44     Hrynick and Ripoll, 'Evidence Review'.
45     Sharmarke Diriye, 'The Impact of COVID-19 on Ealing's BAME Communities' (GOSAD, September 2020), https://www.gosad.org.uk/sites/gosad.hocext.co.uk/files/2020-09/THE%20IMPACT%20OF%20COVID-19%20ON%20EALING%27S%20BAME%20COMMUNITIES.pdf.
46     Anahita Hossein-Pour, 'Ealing Council Accused of Ignoring BAME Residents over "Mounting Cancer Cases"', MyLondon, 18 June 2020, sec. West London News, https://www.mylondon.news/news/west-london-news/we-cant-breathe-southall-waterside-18446411.
47     Baby-Collin and Mourlane, 'Histoire et Mémoire Du Grand Saint Barthélémy à Marseille, Entre Immigration, Politique de La Ville et Engagement Associatif'.
48     Hélène Dumesnil, 'Les Arrondissements Nord de Marseille - Etat Des Lieux Socio-Sanitaire et Environnemental' (Observatoire Régional de la Santé Provence-Alpes-Cote d'Azur, October 2021).

**Health inequalities and trust in health services**

Those likely to bear the highest or worst COVID-19 burden are also those most underserved by public services, including health systems. This section discusses and compares health inequities at the local level in Marseille and Ealing, and how they can shape residents' perceptions of the vaccines and the vaccination programmes.

Poorer health outcomes

Due to their location, northern district residents of Marseille are highly exposed to atmospheric pollution and noise, increasing their risk for a range of health issues including lower life expectancy, respiratory disorders, and depression. [49] Drug trafficking and police violence also generate insecurity and lower quality of life. A significant excess of mortality and morbidity has been recorded here recently (compared to Bouches-du-Rhône as a whole for instance) with higher rates of health problems such as flu, HIV/AIDS, child mortality, respiratory diseases, accidents, diabetes and lung cancer, and one in five inhabitants suffering from chronic disease.[50]

Health inequalities clearly map on to socio-economic gradients, deprivation and race/ethnicity in Ealing. Long-standing and in some cases worsening health disparities in the UK have been linked to inequities in housing, education and employment.[51] As of 2019, men and women in the least deprived parts of Ealing can respectively expect to live nearly five and three and a half years longer than their counterparts in the most deprived area.[52] These more deprived areas also happen to have higher proportions of ethnic minority residents. Conditions such as diabetes, asthma, obesity and hypertension, also tend to be more prevalent in areas where there are higher concentrations of residents from ethnic minority backgrounds.[53]

Challenges to availability or access

Regularly labelled a 'medical desert' the northern districts' health system is under-resourced and understaffed compared to the rest of Marseille and the Bouches-du-Rhône region. Indeed, they have around 10% fewer health workers than the city average, meaning health services are less accessible.[54]

In Ealing, some residents have also struggled to access the health system or had negative experiences. For example, research with elderly eye patients from Indian backgrounds in Southall found that several had difficulty making appointments, encountered dismissive health workers, experienced linguistic challenges, or were not followed up or referred despite promises to do so.[55] Research with superdiverse communities elsewhere in the UK also found that patients experienced similar

49      Dumesnil, 'Les Arrondissements Nord de Marseille - Etat Des Lieux Socio-Sanitaire et Environemental'.
50      Dumesnil, 'Les Arrondissements Nord de Marseille - Etat Des Lieux Socio-Sanitaire et Environemental'.
51      Michael Marmot, 'Health Equity in England: The Marmot Review 10 Years On', BMJ 368 (25 February 2020): m693, https://doi.org/10.1136/bmj.m693.
52      PHE, 'Ealing - Local Authority Health Profile 2019', 2019, https://fingertips.phe.org.uk/static-reports/health-profiles/2019/E09000009.html?area-name=Ealing.
53      NHS Race and Health Observatory, 'Ethnic Inequalities in Healthcare: A Rapid Evidence Review'.
54      Hélène Dumesnil, 'Les Arrondissements Nord de Marseille - Etat Des Lieux Socio-Sanitaire et Environemental'.
55      Daksha Patel, Helen Baker, and Ian Murdoch, 'Barriers to Uptake of Eye Care Services by the Indian Population Living in Ealing, West London', Health Education Journal 65, no. 3 (1 September 2006): 267–76, https://doi.org/10.1177/0017896906067777.

challenges.[56, 57] Inequities and negative experiences can manifest in lower trust and engagement with health interventions, including vaccination.

Despite what can be negative experiences with a wider system, there can be pockets of trust within communities. People in the northern districts of Marseille did express confidence in some smaller community-based health centres including one with an expressly 'horizontal' approach to patient relationships. The presence and involvement of established, human-sized health facilities in the life of the neighbourhood has played a central role in residents' trust in vaccination campaigns.

56      Hannah Bradby et al., '"If There Were Doctors Who Could Understand Our Problems, I Would Already Be Better": Dissatisfactory Health Care and Marginalisation in Superdiverse Neighbourhoods.', Sociology of Health & Illness 42, no. 4 (May 2020): 739–57, https://doi.org/10.1111/1467-9566.13061.

57      Jenny Phillimore, 'Approaches to Health Provision in the Age of Super-Diversity: Accessing the NHS in Britain's Most Diverse City', Critical Social Policy 31, no. 1 (1 February 2011): 5–29, https://doi.org/10.1177/0261018310385437.

# 2.0  The role of local government in promoting vaccine equity

While considerable attention has focused on actions of national governments, local governments and other statutory and community structures, organisations and networks have tended to be overlooked. Yet, being much closer to and part of local populations, they can play critical roles ensuring that public health interventions, including COVID-19 vaccination, are locally appropriate.

In Ealing for instance, we found that while the National Health Service (NHS) quickly established mass vaccination sites and generic messaging, it was local authorities who rendered these strategies into context-appropriate activities, especially in relation to reaching and accommodating marginalised, vulnerable, or especially hesitant people and groups with less accessibility to or trust in vaccines and/or the state. The same dynamics were identified in Marseille where local authorities – through the city hall and the regional health agencies – have developed strategies to reduce vaccine inequality.  Local authorities, in conjunction with community partners, can identify and map networks of trust, vulnerable people or groups, locally influential people, trusted communication channels; and design and implement appropriate strategies.[58]

## Local government's role in vaccination programmes

As with infectious disease response more broadly, local government actors can play key roles in supporting and rolling out vaccination, including by 'localising' it in ways that make it more accessible and acceptable to local populations. The role of local government in vaccination campaigns among local populations has been historically documented in the case of smallpox vaccination in Sweden in the early 19th century.[59] Here, local governors were charged with ensuring that vaccination for the disease – compulsory from 1812 – was carried out locally. By enlisting local clergy as public communicators, training lay people as vaccinators (instead of physicians who were not often trusted by ordinary people), and visiting people in their homes to administer vaccines, they were able to achieve high coverage with only "slight law force".[60]

More recently, research in Japan showed different local strategies were more or less successful in promoting human papillomavirus (HPV) vaccination, and thus

---

58      Rochelle Ann Burgess et al., 'The COVID-19 Vaccines Rush: Participatory Community Engagement Matters More than Ever', The Lancet 397, no. 10268 (2 January 2021): 8–10, https://doi.org/10.1016/S0140-6736(20)32642-8.
59      Peter Sköld, 'The Key to Success: The Role of Local Government in the Organization of Smallpox Vaccination in Sweden', Medical History 44, no. 2 (April 2000): 201–26, https://doi.org/10.1017/S0025727300066400.
60      Sköld, 'The Key to Success'.

illustrating that local government actions can have significant impact on uptake,[61] even in the absence of national leadership.[62] Researchers looking at local vaccination promotion in Poland where local authorities are responsible for financing and delivering recommended vaccinations, found enthusiasm and dedication among local authorities, and particularly among the most local units who have a "closer bond" with residents.[63]

There is less research about the role local governments have played in the context of vaccination for serious outbreaks of infectious disease. This may be due to the fact that outbreaks of infectious disease requisite of (and amenable to) immediate vaccination response (for example cholera and Ebola) occur more often in low resource settings where local governments may have limited capacity to respond, and where it is higher level governmental actors, often in partnership with non-state (and often international) actors (NGOs, humanitarian organisations, and so on) who tend to lead response, or who have been most focused on by researchers and other observers and analysts. This has begun to shift in the context of the COVID-19 pandemic as vaccination against the virus has occurred across the globe. Indeed, due to gross global political economic inequities, vaccination is occurring more robustly in wealthier countries. Thus, research on the role of local governments in rolling out vaccination programmes is beginning to emerge from these settings.

Liu and Huang for example, hypothesised and confirmed through survey-based methods that the quality of local government-public relationships is positively associated with pro-vaccine outcomes among local people in Houston, Texas in the United States.[64] They found that people with more of a sense of control when interacting with public organisations, and a commitment to maintaining positive relationships with them significantly predicted vaccination intention. Thus, the researchers recommend it is "imperative for public agencies to build more equitable relationships and foster a sense of control – such as through dialogues, inviting feedback, or participatory decision making [...] – as well as focus on cultivating loyal relationships with the communities that they serve" to facilitate COVID-19 vaccination uptake. Published academic literature is otherwise sparse on the role of local governments in COVID-19 vaccination. However, many local authorities have detailed their own activities. For instance, the Local Government Association in the UK has collated examples from across the country of strategies taken by local governments and their partners to implement vaccination activities.[65] They include descriptions of how councils have deployed roving vaccination teams to work with marginalised groups, engaged asylum seekers, provided women-only vaccine clinics, addressed low uptake in men through sports, set up outreach clinics for homeless people, trained local advocates and "community champions", strategically selected local venues, provided transport to people needing it to reach vaccination sites, worked with faith communities and more.

Aside from these examples, little has been published on how local governments can and have – or have not – enacted strategies to ensure vaccines reach the most vulnerable members of society. Overall, there tends to be a focus on the population

61    Hiroyuki Fujiwara et al., 'Community-Based Interventions to Improve HPV Vaccination Coverage among 13- to 15-Year-Old Females: Measures Implemented by Local Governments in Japan', PLOS ONE 8, no. 12 (16 December 2013): e84126, https://doi.org/10.1371/journal.pone.0084126.

62    Yutaka Ueda et al., 'The Last Strategy for Re-Dissemination of HPV Vaccination in Japan While Still under the Suspension of the Governmental Recommendation', Scientific Reports 10, no. 1 (30 September 2020): 16091, https://doi.org/10.1038/s41598-020-73120-1.

63    Anna Augustynowicz, Janusz Opolski, and Michał Waszkiewicz, 'Resilient Health and the Healthcare System. A Few Introductory Remarks in Times of the COVID-19 Pandemic', International Journal of Environmental Research and Public Health 19, no. 6 (2022): 3603.

64    Wenlin Liu and Yan Huang, 'Does Relationship Matter during a Health Crisis: Examining the Role of Local Government- Public Relationship in the Public Acceptance of COVID-19 Vaccines', Health Communication 0, no. 0 (28 October 2021): 1–11, https://doi.org/10.1080/10410236.2021.1993586.

65    Local Government Association, 'COVID-19: Vaccination Case Studies', accessed 17 January 2022, https://www.local.gov.uk/our-support/coronavirus-council-information-and-support/covid-19-good-council-practice/covid-19-0.

level to assess whether or not interventions have been successful. This may mask continuing inequalities in uptake, likely to manifest along social structural lines such as socio-economic status, or racial, ethnic, migrant or other aspects of social difference.[66] Furthermore, research which has looked at the role of local government in promoting vaccination tends to look at specific interventions directly related to vaccination itself (for instance, considering how linguistic 'nudges' can support greater uptake[67]), and does not often consider the broader social, economic and political contexts in which local government actors operate. This includes the ways in which they may (or may not) leverage existing or aim to build new relationships of trust with local people – a critical factor in vaccine uptake.[68][69]

## Local government's role in community engagement

Given the importance of trusting relationships between citizens and governments in the context of vaccination, ways of building and nurturing such relationships are critical. "Community engagement" is often recommended as a route to doing this. While there is no universal definition of what this means, a recent review identified the following themes as important in the literature on community engagement: the importance of diverse knowledge, community assets and ways of knowing; the co-development of mutually beneficial outcomes; collective responses to shared challenges and opportunities through collaboration-based and participatory approaches; and the role of collaboration in fostering trust, reciprocity and social capital to maintain partnerships and relationships.[70] Thus, community engagement has been conceptualised not just for the purposes of building trust and relationships as is often emphasised in discussions of how to improve public health, but for collectively generating and implementing solutions. In the context of local challenges and decision-making (such as on how to conduct a vaccination campaign) community engagement can bring different forms of relevant knowledge to the table and serve the productive purpose of co-creation and co-action for an effective campaign.

What is often practised as community engagement in the field, however, often falls short of this more productive and collaborative potential. In the field of epidemic response, community engagement is usually paired with "risk communication". This often results in their conflation, or the reducing of the former into activities related to the latter. The emphasis is on messaging around risk, rather than more comprehensive acknowledgement and leveraging of their knowledge, skills and capacity to co-design solutions.

## The different roles of local government in Marseille and Ealing

We here briefly highlight the differences between the vaccine programmes in Marseille and Ealing in terms of the role played by local governments.

66      Harriet Fisher et al., 'Examining Inequalities in the Uptake of the School-Based HPV Vaccination Programme in England: A Retrospective Cohort Study', Journal of Public Health 36, no. 1 (1 March 2014): 36–45, https://doi.org/10.1093/pubmed/fdt042.

67      Florian Keppeler, Martin Sievert, and Sebastian Jilke, 'Increasing COVID-19 Vaccination Intentions Through a Local Government Vaccination Campaign: A Field Experiment on Psychological Ownership', SSRN Scholarly Paper (Rochester, NY: Social Science Research Network, 17 September 2021), https://doi.org/10.2139/ssrn.3905470.

68      Eva Schernhammer et al., 'Correlates of COVID-19 Vaccine Hesitancy in Austria: Trust and the Government', Journal of Public Health, 5 May 2021, fdab122, https://doi.org/10.1093/pubmed/fdab122.

69      Nik Stoop, Kalle Hirvonen, and Jean-Francois Maystadt, 'Institutional Mistrust and Child Vaccination Coverage in Africa', BMJ Global Health 6, no. 4 (1 April 2021): e004595, https://doi.org/10.1136/bmjgh-2020-004595.

70      Caroline Osborne, Liam Mayo, and Marcus Bussey, 'New Frontiers in Local Government Community Engagement: Towards Transformative Place-Based Futures', Futures 131 (1 August 2021): 102768, https://doi.org/10.1016/j.futures.2021.102768.

## Degrees of decentralisation

In France, the regional health agency for PACA region was responsible for distribution and delivery of vaccines while coordination of vaccination in Marseille fell to the office of the first deputy mayor. Coordination efforts by the local authority brought together representatives of political, social and public health institutions in the city, and regional and national health actors including the Prefecture, Regional Health Agency, French Medical Association, Public Hospitals of Marseille, Maternal and Child Protection, Health Care Insurance Fund, and the Marine Fire Department. Local civil society organisations were also invited. Eventually a sub-commission dedicated to more tailored strategies was created within the city vaccine rollout.

In the UK, responsibility for vaccination lay primarily with the NHS which set numerical targets. This was implemented locally by the Ealing NHS Clinical Commissioning Group ultimately charged with administering them. Ealing Council supported the vaccine rollout through identification of sites for delivery, and communication and community engagement around the programme. As an English local authority, responsibility for public health is housed in the council, and the team convenes a wider Vaccine Working Group with representatives from different council teams including community engagement, communications and data, well as from the Ealing NHS Clinical Commissioning group. The Working Group meets regularly to share information, discuss the situation and make decisions. The council is responsible for supporting national level directives in the vaccination rollout, including by developing localised communication materials based on national messages developed by the NHS.

## Pushing beyond mass vaccination sites through stakeholder collaboration

The initial tendency was to set up mass vaccination sites in the two sites until local authorities, in coordination with key local stakeholders promoted and facilitated more decentralised forms of delivery such as pop-up sites.

In Marseille, city authorities had predicted vaccine inequities as the number of public hospitals and vaccine doses were more limited in the northern districts. They decided to open a vaccination centre in April 2021, in the city hall of the 15th and 16th arrondissements managed by the Marine Fire Department with support from district authorities and organisations. Yet, most people accessing this vaccine centre were not from the northern districts. This was mainly due to a digital divide as appointments could only be made online. Thus, community engagement strategies were deployed in partnership with a local organisation devoted to fighting inequalities in the area, and which had already been engaged in the framework of a wider civil society response to COVID-19 since March 2020. During the first half of 2021, pop-up vaccination sites and improvised screening and vaccine awareness activities were coordinated in virus hot spots where operational northern district MEDILAC actors could conduct immediate actions, such as at the bottom of buildings. COVID-19 mediators in the northern districts also slowly multiplied vaccination awareness and facilitated activities in pop-up sites in collaboration with local health professionals and public structures. A MEDILAC vaccine pop-up site in front of the local public health insurance service – an unusual collaboration with the Social Insurance Funds – appeared particularly efficient and became regular.

In Ealing, the local authorities also began with two mass vaccination sites, as well as a handful of local surgeries. Over term, the Vaccine Working Group become more agile, considering data on vaccine uptake across the borough alongside other forms of information to guide decisions on further activities such as whether, where and when to set up pop-up vaccination clinics. Some perceived tensions between the

council and NHS actors were noted by members of this group – with the council for instance arguing early on for more decentralised delivery while the NHS was more concerned with opening mass sites. In general, this cross-institutional (and cross-team intra-institutional) collaborative working was noted as extremely positive by members, who credited it with improving response over time. Other opportunities for cross-area learning from other boroughs in the North West London region – such as the North West London Integrated Health and Care Partnership's "vaccine equity huddles" – have also been available, which Ealing team members have attended.

### Taking into account diversity in vaccination policy

Interestingly, policies relating to vaccination needs of minorities were established at different levels in the two countries. In France, the PACA Regional Health Agency and national government regulated the importance of reaching minorities. In December 2020, a French decree authorised the establishment of COVID-19 health mediators. In Ealing it was the council and the North West London Clinical Commissioning Group that considered NHS data identifying disparities in vaccine uptake by ethnicity and race. Then, through stakeholder engagement, they took the lead in addressing disparities in line with their efforts towards health equity.[71]

### Local community groups having to step in in Ealing and Marseille

In Marseille, despite the drive towards pop-up sites in the northern districts, bureaucratic and logistical delays related to a lack of flexibility of both national and local authorities required civil society groups and volunteers to step in. These undermined efforts for vaccine equity in the city. For instance, the northern districts' medical mobile unit was limited to ordering two vials per physician per week even though the dedicated mobile clinic could serve 150 people a day. The mobile team requested within their network of medical doctor peers who were not themselves actively vaccinating to delegate their ordering rights to the unit. Delays to authorisations from city hall and the Regional Health Agency for operational actors to undertake certain activities such as the launch of pop-up sites presented another challenge. Finally, delays in providing financial support to local teams also complicated working conditions. Volunteer workers had to complement the outreach teams which included civil society organisations and mediators, and played key roles providing more localised tailored approaches.

In Ealing, the community engagement team of the local council was small, with very few resources for reaching such a large and diverse population. Nevertheless, engagement with local community and faith leaders was seen as highly valuable to setting up pop-up sites, disseminating information, and feeding information about community concerns back to responders.  Community groups co-hosted public webinars with local authorities and carried out engagements with smaller specific groups but there are still concerns that many less engaged residents remained out of reach.[72] Ealing Council's health communication and community engagement teams collaborated with community groups to produce culturally appropriate messaging in different relevant languages (e.g., Punjabi, Somali, Polish etc.). Community groups were recognised as highly agile, responsive and keen to support local vaccination efforts. However, community groups raised concerns of inadequate compensation, particularly for smaller and more informal organisations.[73]

---

71      NWL Health and Care Partnership, 'Towards Vaccine Equity - through Reducing Variation in NWL CoViD-19 Vaccination Uptake', March 2021, https://www.nwlondonccg.nhs.uk/application/files/5516/1770/2590/NWL_ICS_CoViD_Towards_Vaccine_Equity_Huddles_30.3_ synthesis.pdf.

72      Hrynick and Ripoll, 'Evidence Review'.

73      Diriye, 'The Impact of COVID-19 on Ealing's BAME Communities'.

# 3.0 Social and moral frameworks and vaccine hesitancy

In addition to structural inequalities, past experiences, and available (mis) information, health-seeking and vaccination behaviours are also shaped by moral frameworks. Different social groups (including public health and local government workers) have different priorities, and understandings of 'what is right' when dealing with different risks and ethical conundrums.

**Moral frameworks and vaccine engagement**

Policymakers facing public health emergencies, often have a lay model of how change happens underpinned by assumptions that providing the 'right' information, will lead people to choose to engage in behaviours that promote personal and public health. The more elaborate health belief model sees behaviour as the result of people's beliefs, such as perceived susceptibility to disease, or benefits and risks of the actions they may take to respond (for example seeking vaccination). The COM-B model, used by national and local authorities in the UK, sees behaviour change as emerging from psychological and physical capabilities, opportunities and motivation.[74] It is a step forward in that it also explores people's barriers to act.

The problem with these models is that while the theoretical constructs they are based on (e.g., beliefs, motivations, and norms) do relate to behaviour change, they offer little in understand which, among a multitude of factors, are most important in a particular context, or how these interact dynamically. They overlook aspects such as identity, social positionality, political economy and power, and do not explain why change occurs in certain populations and not others. They are homogenising models rather that fail to explain differences in behaviour within populations. This is particularly important in the case of vaccine inequity in which the uptake varies significantly according to a diversity of dimensions (economic, cultural, ethnic, professional, and so on).

Anthropological approaches can play an important role by foregrounding the contexts in which vaccination programmes are rolled out. Recognising this in the context of COVID-19, the WHO has incorporated some contextual aspects into its COM-B guidelines.[75] For vaccination, they encourage:

---

74    Robert West et al., 'Applying Principles of Behaviour Change to Reduce SARS-CoV-2 Transmission', Nature Human Behaviour 4, no. 5 (1 May 2020): 451–59, https://doi.org/10.1038/s41562-020-0887-9.
75    World Health Organization, Behavioural Considerations for Acceptance and Uptake of COVID-19 Vaccines: WHO Technical Advisory Group on Behavioural Insights and Sciences for Health, Meeting Report, 15 October 2020 (Geneva: World Health Organization, 2020), https://apps.who.int/iris/handle/10665/337335.

- an enabling environment: making vaccination easy, quick and affordable;

- harnessing social influences: identifying social norms, recruiting trusted community interlocutors; and

- increasing motivation: creating an open and transparent dialogue with communities.

While useful in helping address the need for context, the emphasis on social norms and social influence does not fully explain: (1) the way people have ethical demands that pull them in different directions; (2) the nature of the drive to fulfil these social norms in the first place; and (3) the actual phenomenological experience of being in a pandemic. Thus, a moral framework analysis is incomplete if it only explores the layer of context encompassing social norms and obligation (the 'the moral order').[76] An emphasis on experience and virtue is also needed.

In the case of the ethical drivers of obligation: autonomy refers to the drive to protect individuals' agency and integrity; community refers to people's duty to others and to fulfil their family and other social roles; and finally, divinity is the protection of the sacredness of one's life and one's body.

In terms of experience, epidemics involve a great degree of uncertainty, making people's horizons of possibility fluid and emergent. This is what Al Mohammad and Peluso called the rough ground of the everyday, "living in action – phenomenologically, experientially and sensibly grounded".[77] This experience can be more telling than socio-demographic characteristics. Understanding health seeking experiences as "navigation" rather than a pathway is a good metaphor for this.[78] In turn, virtue ethics pushes us to understand why people strive to act ethically in a pandemic. Having an understanding of what constitutes being a 'good person' in a particular context and how this is embodied, helps us understand how certain behaviours are not a result of conscious reflection, but rather of practical action.

**Table 2: A social and moral frameworks approach based on Shweder et al (1997),**[79] **Zigon (2007),**[80] **Mattingly (2017)**[81] **and Laidlaw (2013)**[82]

| | Obligation | | | Experience | Virtue |
|---|---|---|---|---|---|
| Autonomy | Community | Divinity | | | |
| Individual-focused | Duty | Sacredness of living one's life | | Emergence | Embodied practices towards the good |
| Rights | Social roles | The sacredness of the body | | Being in the world | |
| | Commitment to others | | | Entanglement with others | |

Shweder and colleagues'[83] three drivers of obligation can partially explain the conundrums that people may face, while accounting for different social groups

76    Richard A Shweder et al., 'The" Big Three" of Morality (Autonomy, Community, Divinity) and the" Big Three" Explanations of Suffering.', 1997.
77    Hayder Al-Mohammad and Daniela Peluso, 'Ethics and the "Rough Ground" of the Everyday: The Overlappings of Life in Postinvasion Iraq', HAU: Journal of Ethnographic Theory 2, no. 2 (2012): 44.
78    Henrik Vigh, 'Motion Squared: A Second Look at the Concept of Social Navigation', Anthropological Theory 9, no. 4 (1 December 2009): 419–38, https://doi.org/10.1177/1463499609356044.
79    'The" Big Three" of Morality (Autonomy, Community, Divinity) and the" Big Three" Explanations of Suffering.'
80    Jarrett Zigon, 'Moral Breakdown and the Ethical Demand: A Theoretical Framework for an Anthropology of Moralities', Anthropological Theory 7, no. 2 (2007): 131–50.
81    Cheryl Mattingly et al., Moral Engines: Exploring the Ethical Drives in Human Life, vol. 5 (Berghahn Books, 2017).
82    James Laidlaw, The Subject of Virtue: An Anthropology of Ethics and Freedom (Cambridge University Press, 2013).
83    'The" Big Three" of Morality (Autonomy, Community, Divinity) and the" Big Three" Explanations of Suffering.'

different ontologies, and understandings of where morality lies. For example, in terms of COVID-19:

- Autonomy: can be the driver of resistance to lockdowns, transport bans or vaccination amongst particular groups, which force individuals to give up freedom or risk individual injury for the sake of public health. This is exacerbated when these social groups have historical or current reasons to mistrust government. However, autonomy can also be used to justify the choice to vaccinate to promote one's capacity to "move around" more freely, or to enable those who are shielding to be able to leave their homes.

- Community: People's belonging to a particular community may come with social obligations to others. People may feel social pressure to refuse or accept vaccination to remain in that community. Some faith groups or conservative families may discourage other members from getting vaccinated. Alternatively, vaccination can be promoted as a responsibility to the community, using arguments of togetherness and belonging, or protecting elders.

- Divinity: Ideas of pollution and purity of body used by certain religious communities and alternative or health-conscious communities to reject vaccination (e.g., on grounds of suspected use of prohibited animal products or embryonic stem cells). Religious leaders have also countered such claims and backed vaccination. Which leaders are trusted leaders by people varies by religious denomination, and the specific group of believers.[84]

These dynamics mostly belong in the discursive Durkheimian space of social sanction. But from where does the desire or drive to meet these 'community' standards come? What is the role of the self in this process? They also imply a degree of reflexivity, or even conscious disembodied rationality, openly discussed and shared, rather than something more embodied.

Uncertainty, emergence and experience itself must be integrated, using phenomenological approaches. For example, work carried out during the COVID-19 pandemic on the lived experiences of pregnant women seeking antenatal care in an ever-changing environment, uncertain about their vulnerability to COVID-19 and eligibility for vaccination, revealed experiences of fear and anxiety, but also of connection and resilience.[85]

Finally, in terms of virtue ethics, the readiness of healthcare workers and those involved in civil society response can come from an embodied character of generosity and courage. In the first wave, before there was any certainty about the risks of COVID-19, the immediate readiness of civil society in the UK to help people in need during the initial lockdown was a form of embodied virtue. In turn, many got vaccinated out of a sense of being a 'good citizen', even if they had not reached a rationalised and final decision about the risks involved.[86]

## Potential social and moral dynamics in the two contexts

To our knowledge, this is the first time moral framework analysis has been used

84      Mariz Tadros and Claire Thomas, 'Evidence Review: Religious Marginalities and COVID Vaccination-Access and Hesitancy' (SSHAP, 2021), https://www.socialscienceinaction.org/resources/evidence-review-religious-marginality-and-covid-19-vaccination-access-hesitancy/.
85      Forough Mortazavi and Fatemeh Ghardashi, 'The Lived Experiences of Pregnant Women during COVID-19 Pandemic: A Descriptive Phenomenological Study', BMC Pregnancy and Childbirth 21, no. 1 (8 March 2021): 193, https://doi.org/10.1186/s12884-021-03691-y.
86      Gregory Luke Larkin, 'Caring in a Time of COVID: The Vaccine of Virtue', European Journal of Emergency Medicine : Official Journal of the European Society for Emergency Medicine 28, no. 2 (1 April 2021): 88–89, https://doi.org/10.1097/MEJ.0000000000000805.

at local level to explore the everyday moral realities of people in hyperdiverse, multicultural settings. This research project funding enabled us to pilot the use of these approaches during fieldwork and data analysis in the Marseille case study.

Existing work on the Community, Autonomy and Divinity scale (the "Obligation" aspects introduced above), has been mostly used to compare countries, or conservative-liberal political leanings. It has been useful to show how divergences of moral values result from emphases on different moral dimensions, but they tend to generalise in terms of the nation state or ideological leaning. In Haidt's work on moral psychology[87] for example, he explored how North Americans of European backgrounds and Latin Americans may score higher in individualism and autonomy relative to community, while for East Asians, African and Middle Eastern people, the inverse may be true. [88] Conservatives (including across many countries) score as highly on autonomy and community as their liberal peers (for different reasons), but much higher on divinity.[89]

Whilst interesting, transferring these findings to our field sites would obscure the uniqueness of migrants' and their descendants' experiences, and the intercultural influences of hyperdiverse neighbourhoods. Hyperdiversity, conceptualised by Dean et al[90] explores how cultural pluralism and diversity exist beyond categories of ethnicity as immigrants interact with their local community. Further, migrants do not exhibit exactly the same behaviours as residents in their countries of origin; they are influenced by national narratives, and relationships with people of other cultures, nationalities and ethnicities in their communities.[91] In France, ideas of 'good citizenship' can also generate collectivist attitudes towards the host country, particularly among first generation migrants. For example, an allegiance to 'Frenchness' among older migrants in Marseille may contrast with the sensibilities of younger migrants. What is important here is to understand what moral discourses are articulated by whom, and why, and how this relates to their social group and their experience of the state, COVID-19, and the vaccination programme. This research takes the preliminary steps into this awareness and seeks to identify the strategies to make the vaccination programmes more equitable, by building on people's own moral priorities.

87      Jonathan Haidt, The Righteous Mind: Why Good People Are Divided by Politics and Religion (London: Penguin UK, 2013).
88      Daphna Oyserman, Heather M Coon, and Markus Kemmelmeier, 'Rethinking Individualism and Collectivism: Evaluation of Theoretical Assumptions and Meta-Analyses.', Psychological Bulletin 128, no. 1 (2002): 3.
89      Jesse Graham, Jonathan Haidt, and Brian A Nosek, 'Liberals and Conservatives Rely on Different Sets of Moral Foundations.', Journal of Personality and Social Psychology 96, no. 5 (2009): 1029.
90      Jennifer Dean et al., 'Beyond the Cosmopolis: Sustaining Hyper-Diversity in the Suburbs of Peel Region, Ontario', Urban Planning 3, no. 4 (2018): 38.
91      Dean et al., 'Beyond the Cosmopolis: Sustaining Hyper-Diversity in the Suburbs of Peel Region, Ontario'.

# Overarching findings

Here we present the overarching findings from across the two study sites, emphasising the similarities and differences between them. Please see the case studies for in-depth description of the findings in the specific sites.

**How do relationships between and within local government, health system actors, and community groups and residents shape vaccine (in)equity?**

Multi-level governance of vaccination and the importance of local authority autonomy

Across the two contexts, national and regional authorities are involved in vaccine procurement and delivery; yet it was the autonomy and initiative of local public and civil society actors that led to their more equitable distribution. The capacity of local authorities to manoeuvre within their assigned roles was crucial. Local public actors, such as the Deputy Mayor in Marseille (*Première adjointe au maire de Marseille*), and Ealing Council staff used their relative autonomy to adapt vaccine programmes to the specific needs of their populations, and took steps beyond national recommendations and guidelines.

In Marseille, health is managed by regional agencies for health (*Agence régional de santé,* or RHA) who are responsible for vaccine rollout and to ensure health equity. Guidance is also provided by a consortium of national health agencies. In Marseille, the Deputy Mayor of Marseille, who herself had a public health background, played a key role in implementing a national programme whilst at the same time catering for minoritised groups in the city. Stepping in to take on responsibilities of the RHA, she convened different public and civil society actors to carry out more inclusive vaccination, sometimes bending the rules to do so. This resonates with initiatives taken by Ealing Council, as they also took initiative to shape the vaccine rollout, pointing to the importance of institutional and personal commitments.

In Marseille, the national MEDILAC programme promoted outreach to minorities that did not seek vaccination in the mass vaccination centres. This came through the RHA, and it linked with locally based health organisations in the northern districts. These organisations were also concerned about issues beyond public health (e.g. housing), and had long experience working in the communities. Mediators, figures between social workers and health workers in France, linked health workers with the communities, carrying out door-to-door awareness raising and answering queries. These organisations organised mini-pop up vaccination sites at the base of buildings to make it as convenient as possible.  Trusted local figures and activists were brought into the efforts to enhance trust. This civil society outreach initially emerged as a form of self-help within the communities during the first lockdown, and then developed into a collaboration between community organisations, health workers and local authorities. In Marseille, 'atypical' institutions were also recruited into the vaccination efforts, like the Marine and Fire Brigades.

Ealing Council initiated similar activities, such as convening civil society organisations to set up convenient pop-up sites (e.g. in faith and community spaces).

In Ealing trusted people within communities, who were recruited on occasion to campaign for vaccines, organised no-judgement question and answer sessions between medical doctors and residents. Community and civil society initiatives, and their willingness to connect and engage horizontally with others, was thus critical. These groups put many of their (sometimes scant) resources into the vaccine rollout, and although local authorities benefited from this, there were outstanding questions about how to ensure this engagement was sustainable and equitable. Civil society groups need sustainable sources of funding to enable their outreach and mediation during emergencies, as well as 'normal times'. Civil servants working in community engagement for the councils perceived they did not have the human resources necessary to adequately address the situation, or to be able to 'go to' communities as much as was needed themselves.

The creation of localised vaccine taskforces played an important role in Ealing. Ealing council has its own task force. They worked to inform communities about the virus, testing and vaccinations in relevant languages and through channels residents trusted. In the UK and France, trust in public authorities – and by extension in vaccination programmes - was low among historically neglected communities which have faced racism, xenophobia and economic inequality. However, horizontal non-judgemental conversations with and through trusted local people and communication channels, was perceived as a critical way to build trust. Ultimately other systemic inequities also need to be addressed (housing, precarity, and so on); currently, relationships between citizens and states are being renegotiated, and states must be responsive to citizen needs.

Articulation of social difference for vaccination outreach and community engagement is different in each country. Despite the usefulness of providing vaccination clinics tailored for specific minority groups, in France, singling out difference (even if real), is seen as discriminatory under the secular nation's doctrine; thus, data or services cannot explicitly target particular groups. For example, despite higher COVID-19-related hospitalisation of migrants from Comoros at the pandemic's onset, health actors were not allowed to communicate this. For example, the UK takes a middle ground approach to acknowledging and measuring difference. The NHS has granular data on ethnicity and vaccine uptake at local levels, but it is not publicly available. Vaccination may be offered in spaces to cater for minoritised groups, but this is not targeted as specifically to particular minorities. How 'difference' is managed within the construction of the nation state and its relationship to health systems is different across different countries and their experiences of integration, and critical to understanding vaccine equity. Different models of integration are likely to yield different public attitudes towards difference. French integration envisages a convergence of immigrant characteristics towards French-speaking and secular values and an average 'French behaviour', [92] whereas in the UK, multiculturalism shares the view that "cultures, races, and ethnicities, particularly those of minority groups, deserve special acknowledgment of their differences within a dominant political culture".[93] Another difference is evident in the readiness of public actors to link with civil society organisations. In Ealing, long-standing (if unequal and inadequately funded) collaborations and exchanges between community groups and local authorities were leveraged. In Marseille, new kinds of collaboration emerged because of the pandemic. There is a need to establish and strengthen long-term civil society-local authority relations beyond COVID-19 to work towards health equity more broadly to transcend only reactive engagement. Community groups in both contexts proved they have unique local knowledge, and

92      Mirna Safi, 'The Immigrant Integration Process in France: Inequalities and Segmentation', Revue française de sociologie 49, no. 5 (2008): 3–44, https://doi.org/10.3917/rfs.495.0003.
93      Jennifer L. Eagan, 'Multiculturalism', in Encyclopedia Britannica, 2022, https://www.britannica.com/topic/multiculturalism.

access to residents who are otherwise invisible to public actors.

Vaccination programmes in the UK and Marseille required adapting to people's economic situations and identifying those most vulnerable. This was particularly the case for those in low income, precarious employment with limited access to transport and living in 'medical deserts'. They were more vulnerable to workplace outbreaks, and yet could not afford not to work, while their hectic working hours made accessing conventional vaccination services untenable; they needed vaccine provision adapted to their realities.

Who different people trust, and the formats and channels they are confident in varies widely. Whether public health specialists, medical doctors, religious scholars, faith leaders or others are trusted on the issue vaccination, may vary at a granular level. In Ealing, collaboration between health communication teams, community engagement staff in local authorities, and community groups resulted in appropriately tailored vaccine communication strategies. Local government should support and recruit mediators that bridge social work and health workers activities, 'translating' between vaccination teams and communities.

## How have community engagement activities supported (or hindered) trust in the COVID-19 response and vaccination efforts?

### Prior and ongoing community-engagement is key to providing equitable vaccine access

Local community groups in Ealing formed informal vaccination task forces, using faith spaces and community centres and other local sites to advocate and provide vaccination. Across contexts, decentralised, locally-based, adapted provision (e.g. 'after dark' clinics beyond normal working hours) and engagement within existing community spaces were perceived to increase uptake among minoritised groups.

In Ealing and Marseille, while local groups carried out vaccination activities on behalf of public health authorities, they felt they were given too much responsibility and too little guidance and support. In Ealing, the council and NHS did more to support community groups in localised provision, yet timelines were very tight, and much improvisation took place. Stress was heightened by public announcements on vaccination eligibility changes being made with no forewarning to public health workers across the countries. Yet, uptake increased in part due to close collaboration between local government and community organisations.

Two-way communication is a key part of community engagement. Vaccine engagement is not just about 'getting the message right' but establishing trusting relationships. In Ealing and Marseille, the most successful initiatives have been those in which people were able to talk about their lived experiences, ask specific questions and give feedback on services. Q&As with health workers in community spaces, helpdesk phone services, peer-to-peer conversations among health workers, and other similar initiatives have encouraged hesitant people to get vaccinated. In Marseille, mediators facilitated two-way dialogue in communities to great effect. The inter-personal and inter-cultural skills, as well as motivation to do this well, would benefit other health actors who traditionally do not prioritise this.

### Language is a key driver of vaccine (in)equity

Communication was undertaken by local governments using multiple languages

in Ealing but not in Marseille. In Ealing, the local authority website offered multi-lingual options for Coronavirus advice and guidance, and translation of COVID-19 related messages was done by community engagement officers and the communication team in partnership with local groups. The French system did not consider translation, despite the realities and language needs of migrants. Thus in Marseille, translation was mostly done informally by community groups and mediators. They reported this was an enormous burden on them.

In Ealing, stakeholders indicated that residents tended to prioritise news channels for information, and also relied on international social networks for their insights on vaccines. People appealed to both local and diasporic networks for their information, via social media. Recruiting trusted interlocutors is crucial, and understanding how who is trusted varies at a granular level is important. For example, a Somali group in Ealing trusted a Somali religious leader, while local Muslim communities did not necessarily trust the British Islamic Medical Association for health advice. This suggests the importance of community engagement with smaller and specific groups, and that it should be adequately tailored. This can involve 'going to' residents' spaces which requires, as earlier mentioned, greater resource commitments.

People in Ealing and Marseille sites seek information from a diversity of sources. Many trusted the local news channels for health information. Those who were more sceptical made use of social media, Facebook or Instagram. Yet at the same time social media was seen as not trustworthy and required being filtered with a critical eye. Opinions on the efficacy of the government response were significantly polarised in Marseille and Ealing between people who believed the government had done their best and people who did not. Sharing a background with those who provide the vaccines was a good motivator to get vaccinated, as well as finding clinics locally for convenience in Ealing and Marseille. This created a sense of trust among those residents, and was the reason one of our interviewees got vaccinated.

Doctors and other health workers in Ealing and Marseille are reported to be trusted across the two sites, but they themselves are an heterogenous category, and some doctors have decided *not* to promote vaccination in Marseille and Ealing, even though a majority have supported vaccination. Some doctors who are anti-establishment have been mobilised by anti-vaccination movements, and have had an immense impact through global social media, many speaking from the US. Marseille has its own medical personality in Dr Raoult, who trialled experimental treatments like hydroxychloroquine in Marseille, and became an anti-establishment figure, fuelling mistrust in the COVID-19 response.

In turn, those respondents in Marseille who had a negative experience of the state, framing a gap between 'us and them', in which the state and health authorities are seen as uncaring, together with interviewees that had had a difficult time due to restrictions, were more likely to be hesitant and did not trust public health information.

Age and relative perceptions of risk played an important role amongst respondents in Marseille. Older residents had risk perceptions that convinced them more readily to get vaccinated. Younger people on the other hand were less likely to make these connections, and would focus on the experiences of migration, facing discrimination and so on.

**How have structural inequities shaped vaccine (in)equity locally?**

Broader structural inequities must be tackled while building trust in vaccination

Inequitable urban planning and transport that curtails people's mobility can contribute to vaccine inequity. In Ealing, despite good public transportation, it was found that many residents tend to stay within very small geographical areas. People in both settings benefited from pop-up or mobile vaccination opportunities (e.g. vaccination buses), and ad hoc transport opportunities. In the 'medical desert' of Marseille's northern districts, transportation to available health facilities is very poor, here also underscoring the importance of ad hoc or mobile opportunities for vaccination, or indeed other services.

In Ealing, negative experiences of health services, including due to their lack of cultural appropriateness may interact with the broader hostile policy environment to discourage many migrants from seeking needed care, even when they are entitled to it. Racism within health clinics, notably against Muslim women, has also sometimes been reported in Marseille.[94] There is a need to develop intercultural skills among health personnel, like those used by French mediators, and to ensure translation resources to improve health equity broadly.

Understanding different groups' geographical mobilities, including where people feel safe to go, is crucial in a pandemic; but problems noticed in an emergency can also signal needs for longer term change such as equitable public transport investment. Public actors should also support availability of local health infrastructure (clinics, hospitals) so people have less need to move in the first place. Lack of investment in communities can contribute to vaccine hesitancy as people may ask "why now?" about vaccination efforts, when other health and social priorities are neglected. Suspicions can be exacerbated when vaccination is made mandatory, as occurred in France, which imposed vaccine passports. In Marseille another layer of political violence involving clientelism, insufficient measures to fight against drug trafficking and a lack of state presence in certain areas has contributed to an 'us versus them' sentiment.

A disregard by the state for appropriate affordable housing has also played a major role in COVID-19 vulnerability in London and Marseille. Lack of economic opportunity and poor housing are critical drivers of deprivation within Ealing and London generally. A failure to adequately address unsafe and unaffordable housing can chip away at residents' trust in local authorities.

**How do different social and moral frameworks shape social groups' vaccine engagement?**

Vaccination decisions are moral behaviours, whether we get vaccinated or not. People's vaccine attitudes are shaped by their senses of obligation – the social pressures that they experience or expect of others – in terms of defending autonomy, community or divinity. Their personal experience of an emergent situation like a pandemic, may also shape their vaccination practices. Vaccine attitudes are also shaped by who people think they are (a 'good citizen' and 'good family or community member' and so on) and who they aspire to be, in relation to an idea of the 'good'. A

---

94    At Home in Europe Project and Open Society Initiative for Europe, Les Marseillais musulmans (New York: Open Society Foundations, 2011).

majority of the evidence here emerges from the Marseille ethnographic fieldwork.

## Autonomy against the state versus autonomy to move freely

Some vaccine-hesitant interviewees emphasised autonomy in terms of information. For those mistrustful of government, doing their "own research" may lead them to misinformation, while those more trusting of formal institutions may turn to official websites (e.g., NHS). Vaccination for relatively vaccine-confident individuals, conveys the importance of bodily autonomy, particularly for those at risk or with co-morbidities. Being "healthy" or "staying safe" become reasons for vaccination. At the same time, those who saw the vaccine as potentially dangerous would voice their right to choose not to get the jab.

Those who trust the state understand vaccination and vaccine passports as enablers of freedom and normality while less trusting individuals see vaccine passports as affronts to personal autonomy and freedom. This drove further hesitance or even entrenched vaccine refusal for some, although the desire for freedom of movement did drive some to get vaccinated despite preferences not to.

## Protecting your loved ones and your communities

Some interviewees referred to familial obligations to protect family members when considering vaccination. This varied depending on the ages of household members, and interviewees' understanding of their own risks. Young people reported getting vaccinated to protect elders in their lives, including family members who themselves refused to get vaccinated. Some parents, unsure about getting their young children vaccinated, decided to get vaccinated themselves to protect them.  There were many discussions within families about vaccination, and these discussions could be gendered. For example, in Marseille, one woman pressured her husband to get vaccinated, as getting ill could jeopardise his fatherhood responsibilities toward his children.

Peer pressure and community expectations also played an important role, with respondents reporting that their community, faith, neighbourhood or university peers, expected them to get vaccinated. Some interviewees were health or social workers who got vaccinated to protect "the people I take care of". Yet a sense of community belonging and social norms can also lead to opposite results. For example, in certain Guadeloupe communities in Marseille, residents experienced pressure *not* to vaccinate. Similarly, some young people in the northern districts did not want others to know they were vaccinated. Although such feelings were reported in our research, it is important to avoid reifying communities as "hesitant" as there were many other factors at play.

## Respecting the sacredness of our lives and bodies

Some interviewees had refused vaccination or were unsure about it due to notions of the sacredness of the body. These interviewees believed in the role of the body in taking care of illness, and would not take medicines, as it would disrupt the natural healing of the body.

In a similar narrative, some hesitated on religious grounds, indicating that the vaccine was "haram". This argument was combined with strong government mistrust for one and associated with a reluctance "to bringing something not natural or foreign" inside one's body. In turn they would be less likely to believe in medical interventions.

Divinity can also play in favour of vaccination. For example, some Imams in northern districts have played an important role in advocating for the vaccine, and similarly in Ealing, faith leaders have played an important role in community engagement.

It is important to note that we cannot reify faith in a monolithic way in terms of shaping vaccination choices. First of all, there are many variations in terms of local denominations, but also faith intersects with key aspects of trust in the government and anti-establishment discourses, and with economic deprivation and other structural factors we have discussed. For example, some Roma communities' distrust in the medical establishment and vaccines is rooted in a reaction to medical violence and European discrimination, in a similar way to Nigerian mistrust of vaccines is rooted in their colonial and postcolonial context.

## The embodied experiences of trust and mistrust

Whilst the methodologies employed for this research project do not capture many aspects of phenomenological experience, there is a notion that many vaccine decisions are not made via a process of rationalising through a moral conundrum, measuring the 'pros and cons', but rather in a more reflexive and intuitive fashion that has to do with how we interact with others in the world.

For example, people report getting vaccinated without thinking too much about it, because they see their friends getting vaccinated, or have an embodied trust in vaccination and see very little difference between these vaccines and childhood vaccines that they routinely give their children.

On the other hand, this phenomenological experience can also be expressed in mistrust. Some interviewees in Marseille were hesitant and would struggle to put into words the reasons for this mistrust, but would make references to contradictions in care by the state. In the Marseille fieldwork, a North African woman stated: "I'm sorry but they didn't protect us, they don't want us to be here, and now they want to take care of us?"

As an embodied experience, mistrust in the colonial state may not emerge necessarily at a discursive level. When people are not able to voice what they really think, despite having a clear idea of what is morally incorrect or correct, this is called moral dumbfounding [95]: when you in your gut you know that something is right or wrong, but you can't put your words to it, and that has to that has to do with the fact that your moral thoughts are connected to your experience. And if your experience is one of precarity of violence, moral problems are not dealt in the rationalised kind of way that public health specialists think people adopt to make decisions. Ultimately mistrust emerges as a sort of bodily understanding of histories of discrimination. This is certainly an avenue for future research on health-seeking pathways in environments with structural inequities, looking at it from a phenomenological anthropology lens.

## 'Being good'

We have already mentioned instances in which notions of "being a good community member", or of being a "good family member" shaped people's vaccination practices. Notions of being a "good mother" versus a "bad mother" would drive people' decision to get vaccinated or get their children vaccinated if they are eligible.

---

95     Jonathan Haidt, 'The Emotional Dog and Its Rational Tail: A Social Intuitionist Approach to Moral Judgment.', Psychological Review 108, no. 4 (2001): 814.

Ideas of what makes a 'good citizen' of the state also play a fundamental role and show divergences between generations. In Marseille, older migrant generations would seek to be 'good citizens' striving to speak French and would choose to vaccinate as a form of allegiance. These seemed less important drivers amongst younger generations.

We also saw that gender roles can play in favour or against vaccinations. Vaccines could be framed as a form of weakness, as a 'strong man' that takes care of himself will be able to fight infection. On the other hand, as we saw above, 'being a good, strong man' is behaving as someone who protects himself to be able to procure for his family.

Virtue ethics is also about moral exemplars, those people within your 'in group' that one might want to emulate. Working with local trusted and admired people within communities has been used in the COVID-19 response across the two field sites. For example, mediators in Marseille who come from the communities are often a good example. Promoting the sharing of the experiences, and journeys that these exemplars went through in order to get vaccinated, has been useful to increase confidence and trust.

To finish, we'd like to highlight how the dynamics of trust and mistrust occur at different levels and in different spaces, and how they are inevitably all interrelated to shape vaccine confidence. Mapping these layers and interconnections is crucial for engaging in productive dialogues with communities.

# References

Al-Mohammad, Hayder, and Daniela Peluso. 'Ethics and the "Rough Ground" of the Everyday: The Overlappings of Life in Postinvasion Iraq'. HAU: Journal of Ethnographic Theory 2, no. 2 (2012): 42–58.

At Home in Europe Project, and Open Society Initiative for Europe. Les Marseillais musulmans. New York: Open Society Foundations, 2011.

Augustynowicz, Anna, Janusz Opolski, and Michał Waszkiewicz. 'Resilient Health and the Healthcare System. A Few Introductory Remarks in Times of the COVID-19 Pandemic'. International Journal of Environmental Research and Public Health 19, no. 6 (2022): 3603.

Baby-Collin, Virginie, and Stéphane Mourlane. 'Histoire et Mémoire Du Grand Saint Barthélémy à Marseille, Entre Immigration, Politique de La Ville et Engagement Associatif'. Diasporas. Circulations, Migrations, Histoire, no. 17 (2011): 26–41. https://halshs.archives-ouvertes.fr/halshs-00784522.

Bajos, Nathalie, Alexis Spire, Léna Silberzan, and EPICOV study group. 'The Social Specificities of Hostility toward Vaccination against Covid-19 in France'. PloS One 17, no. 1 (2022): e0262192. https://doi.org/10.1371/journal.pone.0262192.

Bertrand, Olivier. 'Dans les quartiers nord de Marseille, «le confinement est une gageure»'. Mediapart, 31 March 2020. https://www.mediapart.fr/journal/france/300320/dans-les-quartiers-nord-de-marseille-le-confinement-est-une-gageure.

Bonnefois, Coralie. 'Trois personnes meurent dans l'incendie des immeubles squattés des Flamants'. Marsactu (blog), 17 July 2021. https://marsactu.fr/trois-personnes-meurent-dans-lincendie-des-immeubles-squattes-des-flamants/.

Bradby, Hannah, Antje Lindenmeyer, Jenny Phillimore, Beatriz Padilla, and Tilman Brand. '"If There Were Doctors Who Could Understand Our Problems, I Would Already Be Better": Dissatisfactory Health Care and Marginalisation in Superdiverse Neighbourhoods.' Sociology of Health & Illness 42, no. 4 (May 2020): 739–57. https://doi.org/10.1111/1467-9566.13061.

Bradley, Gracie Mae. 'Care Don't Share: Hostile Environment Data-Sharing - Why We Need a Firewall between Essential Public Services and Immigration Enforcement'. Liberty, 2018. https://www.libertyhumanrights.org.uk/issue/care-dont-share/.

Burgess, Rochelle Ann, Richard H. Osborne, Kenneth A. Yongabi, Trisha Greenhalgh, Deepti Gurdasani, Gagandeep Kang, Adegoke G. Falade, et al. 'The COVID-19 Vaccines Rush: Participatory Community Engagement Matters More than Ever'. The Lancet 397, no. 10268 (2 January 2021): 8–10. https://doi.org/10.1016/S0140-6736(20)32642-8.

Carle, Zoé, and Élise Olmedo. 'Marseille est trop grande pour Marseille. Avant-propos'. Vacarme 89, no. 4 (2019): 3–11. https://doi.org/10.3917/vaca.089.0003.

Dean, Jennifer, Kristen Regier, Asiya Patel, Kathi Wilson, and Effat Ghassemi. 'Beyond the Cosmopolis: Sustaining Hyper-Diversity in the Suburbs of Peel Region, Ontario'. Urban Planning 3, no. 4 (2018): 38.

Diriye, Sharmarke. 'The Impact of COVID-19 on Ealing's BAME Communities'. GOSAD, September 2020. https://www.gosad.org.uk/sites/gosad.hocext.co.uk/files/2020-09/THE%20IMPACT%20OF%20COVID-19%20ON%20EALING%27S%20BAME%20COMMUNITIES.pdf.

Doctors of the World. 'Deterrence, Delay and Distress: The Impact of Charging in NHS Hospitals on Migrants in Vulnerable Circumstances'. Research Briefing. Doctors of the World, 2017. http://www.doctorsoftheworld.org.uk/wp-content/uploads/import-from-old-site/files/Research_brief_KCL_upfront_charging_research_2310.pdf.

Dumesnil, Hélène. 'Les Arrondissements Nord de Marseille - Etat Des Lieux Socio-Sanitaire et Environemental'. Observatoire Régional de la Santé Provence-Alpes-Cote d'Azur, October 2021. http://www.orspaca.org/sites/default/files/Diagnostic_Arrondissements_Nord_Marseille_2021_ORS_PACA_version_longue.pdf.

Eagan, Jennifer L. 'Multiculturalism'. In Encyclopedia Britannica, 2022. https://www.britannica.com/topic/multiculturalism.

Ealing Council. 'Equalities Needs Assessment'. Ealing 1.12 WISP Migration, August 2020. UK. https://www.ealing.gov.uk/downloads/download/2043/equalities_needs_assessment.

Enria, Luisa, Shelley Lees, Elizabeth Smout, Thomas Mooney, Angus F. Tengbeh, Bailah Leigh, Brian Greenwood, Deborah Watson-Jones, and Heidi Larson. 'Power, Fairness and Trust: Understanding and Engaging with Vaccine Trial Participants and Communities in the Setting up the EBOVAC-Salone Vaccine Trial in Sierra Leone'. BMC Public Health 16, no. 1 (8 November 2016): 1140. https://doi.org/10.1186/s12889-016-3799-x.

Fassin, Didier. 7. Du déni à la dénégation. Psychologie politique de la représentation des discriminations. La Découverte, 2006. https://www.cairn.info/de-la-question-sociale-a-la-question-raciale--9782707158512-page-131.htm.

Financial Times. 'Covid-19 Vaccine Tracker: The Global Race to Vaccinate', 2022. https://ig.ft.com/coronavirus-vaccine-tracker/.

Fisher, Harriet, Suzanne Audrey, Julie A. Mytton, Matthew Hickman, and Caroline Trotter. 'Examining Inequalities in the Uptake of the School-Based HPV Vaccination Programme in England: A Retrospective Cohort Study'. Journal of Public Health 36, no. 1 (1 March 2014): 36–45. https://doi.org/10.1093/pubmed/fdt042.

Fujiwara, Hiroyuki, Yuji Takei, Yoshiki Ishikawa, Yasushi Saga, Shizuo Machida, Akiyo Taneichi, and Mitsuaki Suzuki. 'Community-Based Interventions to Improve HPV Vaccination Coverage among 13- to 15-Year-Old Females: Measures Implemented by Local Governments in Japan'. PLOS ONE 8, no. 12 (16 December 2013): e84126. https://doi.org/10.1371/journal.pone.0084126.

GMB. 'Insecure: Tackling Precarious Work and the Gig Economy', 2017. https://gmb.org.uk/sites/default/files/GMB17-InsecureWork.pdf.

Graham, Jesse, Jonathan Haidt, and Brian A Nosek. 'Liberals and Conservatives Rely on Different Sets of Moral Foundations.' Journal of Personality and Social Psychology 96, no. 5 (2009): 1029.

Hachour, Myriam. 'Etude Des Connaissances, Attitudes et Pratiques et Des Facteurs de Susceptibilité Socio-Comportementale à La COVID-19 Dans Une Population Socio-Économiquement Vulnérable Des Quartiers Nord de Marseille : Parcours NORCOVID'. Faculte de Sciences Medicales et Paramedicales de Marseille, 2020.

Haidt, Jonathan. 'The Emotional Dog and Its Rational Tail: A Social Intuitionist Approach to Moral Judgment.' Psychological Review 108, no. 4 (2001): 814.

Haidt, Jonathan. The Righteous Mind: Why Good People Are Divided by Politics and Religion. London: Penguin UK, 2013.

Hélène Dumesnil. 'Les Arrondissements Nord de Marseille - Etat Des Lieux Socio-Sanitaire et Environemental'. Observatoire Régional de la Santé Provence-Alpes-Cote d'Azur, October 2021.

Hossein-Pour, Anahita. 'Ealing Council Accused of Ignoring BAME Residents over "Mounting Cancer Cases"'. MyLondon, 18 June 2020, sec. West London News. https://www.mylondon.news/news/west-london-news/we-cant-breathe-southall-waterside-18446411.

Hrynick, Tabitha, and Santiago Ripoll. 'Evidence Review: Achieving COVID-19 Vaccine Equity in Ealing and North West London'. Social Science in Humanitarian Action Platform, 2021. https://www.socialscienceinaction.org/resources/evidence-review-achieving-covid-19-vaccine-equity-in-ealing-and-north-west-london/.

Insee. 'À Marseille, Le Regain Démographique Modifie Peu Les Disparités Spatiales - Insee Analyses Provence-Alpes-Côte d'Azur - 74', 9 November 2019. https://www.insee.fr/fr/statistiques/4211491.

Insee. 'Décès En 2020 : Hausse plus Forte Pour Les Personnes Nées à l'étranger Que Pour Celles Nées En France, Surtout En Mars-Avril - Insee Focus - 231', 2021. https://www.insee.fr/fr/statistiques/5353976.

Insee. 'Quartiers de La Politique de La Ville – Ceux Qui s'installent Sont plus Pauvres Que Ceux Qui Partent - Insee Analyses Provence-Alpes-Côte d'Azur - 96', 21 October 2021. https://www.insee.fr/fr/statistiques/5544563.

Institute of Community Studies. 'Understanding Vaccine Hesitancy through Communities of Place'. ICS, 2021. https://icstudies.org.uk/repository/understanding-vaccine-hesitancy-through-communities-place.

Keppeler, Florian, Martin Sievert, and Sebastian Jilke. 'Increasing COVID-19 Vaccination Intentions Through a Local Government Vaccination Campaign: A Field Experiment on Psychological Ownership'. SSRN Scholarly Paper. Rochester, NY: Social Science Research Network, 17 September 2021. https://doi.org/10.2139/ssrn.3905470.

Kontopantelis, Evangelos, Mamas A. Mamas, Roger T. Webb, Ana Castro, Martin K. Rutter, Chris P. Gale, Darren M. Ashcroft, et al. 'Excess Deaths from COVID-19 and Other Causes by Region, Neighbourhood Deprivation Level and Place of Death during the First 30 Weeks of the Pandemic in England and Wales: A Retrospective Registry Study'. The Lancet Regional Health – Europe 0, no. 0 (7 June 2021). https://doi.org/10.1016/j.lanepe.2021.100144.

Laidlaw, James. The Subject of Virtue: An Anthropology of Ethics and Freedom. Cambridge University Press, 2013.

Larkin, Gregory Luke. 'Caring in a Time of COVID: The Vaccine of Virtue'. European Journal of Emergency Medicine : Official Journal of the European Society for Emergency Medicine 28, no. 2 (1 April 2021): 88–89. https://doi.org/10.1097/MEJ.0000000000000805.

L'Assurance Maladie. 'Les Données de La Vaccination Contre La Covid-19', 22 May 2022. https://datavaccin-covid.ameli.fr/pages/type-vaccins/.

Lees, Johanna. 'Ethnographier La Précarité Énergétique : Au-Delà de l'action Publique, Des Mises à l'épreuve de l'habiter', 2014. https://halshs.archives-ouvertes.fr/tel-01117039/document.

Liu, Wenlin, and Yan Huang. 'Does Relationship Matter during a Health Crisis: Examining the Role of Local Government- Public Relationship in the Public Acceptance of COVID-19 Vaccines'. Health Communication 0, no. 0 (28 October 2021): 1–11. https://doi.org/10.1080/10410236.2021.1993586.

Local Government Association. 'COVID-19: Vaccination Case Studies'. Accessed 17 January 2022. https://www.local.gov.uk/our-support/coronavirus-council-information-and-support/covid-19-good-council-practice/covid-19-0.

Marmot, Michael. 'Health Equity in England: The Marmot Review 10 Years On'. BMJ 368 (25 February 2020): m693. https://doi.org/10.1136/bmj.m693.

Mattingly, Cheryl, Rasmus Dyring, Maria Louw, and Thomas Schwarz Wentzer. Moral Engines: Exploring the Ethical Drives in Human Life. Vol. 5. Berghahn Books, 2017.

MedAct, Migrants Organise, and New Economics Foundation. 'Patients Not Passports: Migrants' Access to Healthcare during the Coronavirus Crisis', June 2020. https://www.medact.org/wp-content/uploads/2020/06/Patients-Not-Passports-Migrants-Access-to-Healthcare-During-the-Coronavirus-Crisis.pdf.

Mortazavi, Forough, and Fatemeh Ghardashi. 'The Lived Experiences of Pregnant Women during COVID-19 Pandemic: A Descriptive Phenomenological Study'. BMC Pregnancy and Childbirth 21, no. 1 (8 March 2021): 193. https://doi.org/10.1186/s12884-021-03691-y.

Ng, Roxana. 'Immigrant Women: The Construction of a Labour Market Category'. Can. J. Women & L. 4 (1990): 96.

NHS Race and Health Observatory. 'Ethnic Inequalities in Healthcare: A Rapid Evidence Review'. London: NHS Race and Health Observatory, 14 February 2022. https://www.nhsrho.org/publications/ethnic-inequalities-in-healthcare-a-rapid-evidence-review/.

NWL Health and Care Partnership. 'Towards Vaccine Equity - through Reducing Variation in NWL CoViD-19 Vaccination Uptake', March 2021. https://www.nwlondonccg.nhs.uk/application/files/5516/1770/2590/NWL_ICS_CoViD_Towards_Vaccine_Equity_Huddles_30.3_synthesis.pdf.

Osborne, Caroline, Liam Mayo, and Marcus Bussey. 'New Frontiers in Local Government Community Engagement: Towards Transformative Place-Based Futures'. Futures 131 (1 August 2021): 102768. https://doi.org/10.1016/j.futures.2021.102768.

Oyserman, Daphna, Heather M Coon, and Markus Kemmelmeier. 'Rethinking Individualism and Collectivism: Evaluation of Theoretical Assumptions and Meta-Analyses.' Psychological Bulletin 128, no. 1 (2002): 3.

Papageorgiou, Vasiliki, Alexandra Wharton-Smith, Ines Campos-Matos, and Helen Ward. 'Patient Data-Sharing for Immigration Enforcement: A Qualitative Study of Healthcare Providers in England'. BMJ Open 10, no. 2 (1 February 2020): e033202. https://doi.org/10.1136/bmjopen-2019-033202.

Patel, Daksha, Helen Baker, and Ian Murdoch. 'Barriers to Uptake of Eye Care Services by the Indian Population Living in Ealing, West London'. Health Education Journal 65, no. 3 (1 September 2006): 267–76. https://doi.org/10.1177/0017896906067777.

PHE. 'Beyond the Data: Understanding the Impact of COVID-19 on BAME Communities', June 2020.

PHE. 'Ealing - Local Authority Health Profile 2019', 2019. https://fingertips.phe.org.uk/static-reports/health-profiles/2019/E09000009.html?area-name=Ealing.

PHE. 'Overcrowded Households - Ealing'. Public Health England. Accessed 10 June 2021. https://fingertips.phe.org.uk/search/overcrowding#page/4/gid/1/pat/6/ati/101/are/E09000009/iid/90416/age/-1/sex/4/cid/4/tbm/1.

Phillimore, Jenny. 'Approaches to Health Provision in the Age of Super-Diversity: Accessing the NHS in Britain's Most Diverse City'. Critical Social Policy 31, no. 1 (1 February 2011): 5–29. https://doi.org/10.1177/0261018310385437.

Razai, Mohammad S., Tasnime Osama, Douglas G. J. McKechnie, and Azeem Majeed. 'Covid-19 Vaccine Hesitancy among Ethnic Minority Groups'. BMJ 372 (26 February 2021): n513. https://doi.org/10.1136/bmj.n513.

Roudil, Nadine. 'De l'indifférence à La Différence : La Relation Entre Le Centre Social de La Castellane et La Population d'origine Étrangère Dans Les Quartiers Nordde Marseille.' Ethnographiques.Org, no. 12 (February 2007). https://halshs.archives-ouvertes.fr/halshs-01321080.

Safi, Mirna. 'The Immigrant Integration Process in France: Inequalities and Segmentation'. Revue française de sociologie 49, no. 5 (2008): 3–44. https://doi.org/10.3917/rfs.495.0003.

Schernhammer, Eva, Jakob Weitzer, Manfred D Laubichler, Brenda M Birmann, Martin Bertau, Lukas Zenk, Guido Caniglia, Carlo C Jäger, and Gerald Steiner. 'Correlates of COVID-19 Vaccine Hesitancy in Austria: Trust and the Government'. Journal of Public Health, 5 May 2021, fdab122. https://doi.org/10.1093/pubmed/fdab122.

Shweder, Richard A, Nancy C Much, Manamohan Mahapatra, and Lawrence Park. 'The" Big Three" of Morality (Autonomy, Community, Divinity) and the" Big Three" Explanations of Suffering.', 1997.

Skills for Care. 'A Summary of the Adult Social Care Sector and Workforce in Ealing 2020/21'. Ealing: Skills for Care, 2021

Sköld, Peter. 'The Key to Success: The Role of Local Government in the Organization of Smallpox Vaccination in Sweden'. Medical History 44, no. 2 (April 2000): 201–26. https://doi.org/10.1017/S0025727300066400.

Stoop, Nik, Kalle Hirvonen, and Jean-Francois Maystadt. 'Institutional Mistrust and Child Vaccination Coverage in Africa'. BMJ Global Health 6, no. 4 (1 April 2021): e004595. https://doi.org/10.1136/bmjgh-2020-004595.

Tadros, Mariz, and Claire Thomas. 'Evidence Review: Religious Marginalities and COVID Vaccination-Access and Hesitancy'. SSHAP, 2021. https://www.socialscienceinaction.org/resources/evidence-review-religious-marginality-and-covid-19-vaccination-access-hesitancy/.

Ueda, Yutaka, Asami Yagi, Hazuki Abe, Satoshi Nakagawa, Ryoko Minekawa, Haruo Kuroki, Ayako Miwa, and Tadashi Kimura. 'The Last Strategy for Re-Dissemination of HPV Vaccination in Japan While Still under the Suspension of the Governmental Recommendation'. Scientific Reports 10, no. 1 (30 September 2020): 16091. https://doi.org/10.1038/s41598-020-73120-1.

UK Government. 'Vaccinations in the UK'. Vaccinations in the UK, 18 May 2022. https://coronavirus.data.gov.uk/details/vaccinations.

Vigh, Henrik. 'Motion Squared: A Second Look at the Concept of Social Navigation'. Anthropological Theory 9, no. 4 (1 December 2009): 419–38. https://doi.org/10.1177/1463499609356044.

Wardle, Huon, and Laura Obermuller. '"Windrush Generation" and "Hostile Environment": Symbols and Lived Experiences in Caribbean Migration to the UK'. Migration and Society 2, no. 1 (1 June 2019): 81–89. https://doi.

org/10.3167/arms.2019.020108.

West, Robert, Susan Michie, G. James Rubin, and Richard Amlôt. 'Applying Principles of Behaviour Change to Reduce SARS-CoV-2 Transmission'. Nature Human Behaviour 4, no. 5 (1 May 2020): 451–59. https://doi.org/10.1038/s41562-020-0887-9.

World Health Organization. Behavioural Considerations for Acceptance and Uptake of COVID-19 Vaccines: WHO Technical Advisory Group on Behavioural Insights and Sciences for Health, Meeting Report, 15 October 2020. Geneva: World Health Organization, 2020. https://apps.who.int/iris/handle/10665/337335.

Zigon, Jarrett. 'Moral Breakdown and the Ethical Demand: A Theoretical Framework for an Anthropology of Moralities'. Anthropological Theory 7, no. 2 (2007): 131–50.

# About the Academy

The British Academy is an independent, self-governing corporation, composed of almost 1,000 UK Fellows and 300 overseas Fellows elected in recognition of their distinction as scholars and researchers. Its objectives, powers and framework of governance are set out in the Charter and its supporting Bye-Laws, as approved by the Privy Council. The Academy receives public funding from the Science and Research budget allocated by a grant from the Department for Business, Energy and Industrial Strategy (BEIS). It also receives support from private sources and draws on its own funds. The views and conclusions expressed here are not necessarily endorsed by individual Fellows but are commended as contributing to public debate.

The British Academy is the UK's national academy for the humanities and social sciences. We mobilise these disciplines to understand the world and shape a brighter future.

From artificial intelligence to climate change, from building prosperity to improving well-being – today's complex challenges can only be resolved by deepening our insight into people, cultures and societies.

We invest in researchers and projects across the UK and overseas, engage the public with fresh thinking and debates, and bring together scholars, government, business and civil society to influence policy for the benefit of everyone.

The
British
Academy