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UNDERSTANDING VACCINE HESITANCY AND SUPPORTING VACCINE DECISION-MAKING

Practical guide for professionals in contact with the public in the context of COVID-19 in Quebec.

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PURPOSE OF THIS GUIDE

This guide was produced by the CoVivre team under the direction of Dr. ***Cécile Rousseau****, Child Psychiatrist and Professor with the Division of Social and Transcultural Psychiatry at McGill University and co-lead of the CoVivre program, in collaboration with:*

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CoVivre addresses inequalities faced by marginalized groups through initiatives with key stakeholders in the community, education, and health and social services sectors. CoVivre facilitates and accelerates initiatives to reduce the socio-economic and health inequalities caused by the pandemic.

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A TOOL TO SUPPORT VACCINATION DIVERSITY

Responses to the pandemic have been developed in great haste, and this guide is no exception. This document is meant to be a tool for health care professionals working directly with the different communities in the Greater Montreal area. As an introduction to vaccine hesitancy, it aims to support interventions that respect personal and collective differences around this issue. It answers the following questions: What issues are at stake when it comes to deciding whether to get vaccinated? How can we support people's decisions about whether to get vaccinated? How can we motivate and engage people who are vaccine-hesitant?

The guide gives an overview of the vaccination issues faced by people from different ethnocultural and Indigenous minorities during the COVID-19 pandemic. Note that these issues take on particular and shifting forms in the context of a health crisis and an unprecedented mass vaccination campaign. This guide does not prescribe what to do but instead provides avenues on how to think about adapting interventions. A more detailed document about these issues is available from our website (https://sherpa-recherche.com/sherpa/projets-partenaires/covivre/#covivre-tab-3).

OVERVIEW OF THE COMMUNITIES STUDIED

A community is defined by one or more shared collective identities. These identities can be religious, ethnic, national, or racial or based in other characteristics (migratory, gender, etc.). While an identity may be assigned by the majority, it may also be appropriated by the people who identify as belonging to the group.

In the rest of this guide, we use the term "community" to refer to large groups of very heterogeneous people who experience marginalization due to prejudice or due to a past or present lack of social equity in Quebec society. However, this term does not imply that each group or individuals within that group possess homogeneous characteristics or experience single trajectories in their lives.

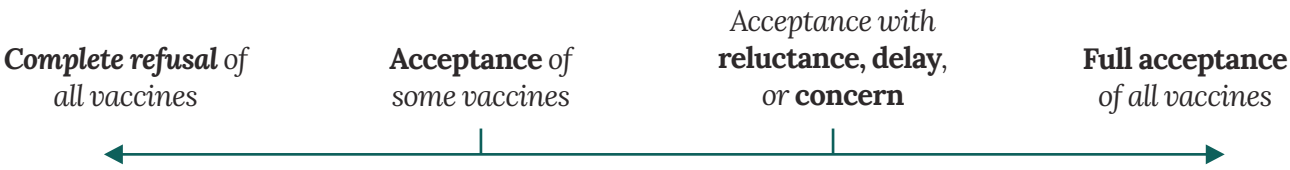
We chose the different communities mentioned here based on (1) the ethnocultural composition of the Montreal region and (2) knowledge already available about vaccine hesitancy among certain geocultural groups. This guide is therefore not exhaustive and is constantly evolving.

Each community presented illustrates the diversity of vaccine hesitancy and the factors likely to play a role in its expression and therefore serve as case studies to help us better understand the many ways that vaccine hesitancy can be expressed.

In itself, vaccine hesitancy is a historical, global, and dynamic phenomenon. There is no such thing as a "hesitant" religion, nor are some communities more hesitant than others.

WHAT IS VACCINE HESITANCY?

Vaccine hesitancy is part of a process to decide whether or not to get vaccinated. Specifically, vaccine hesitancy is part of a continuum of social representations, attitudes and behaviours around vaccination, which is a healthy and legitimate process that must be understood if we are to respectfully support a person's decision-making.



One pole of the continuum is a systematic and complete refusal of all vaccines, while the other end represents a total and systematic acceptance of all vaccines.

Between these two extremes lies a multitude of social representations, attitudes and behaviours that take on different forms depending on the vaccines and the conditions in which they are offered. For example, being open to some vaccines while refusing others or delaying getting vaccinated are both forms of vaccine hesitancy.

Hesitancy to get vaccinated is related to highly variable concerns depending on the era, groups and geography in which each person lives. It depends on three sets of interrelated factors:

Individual and collective:

Personal or family experiences, representation of risk.

Vaccine-specific:

Toxicity, efficacy, cost-benefit ratio (weighing the benefits of the vaccine against the risks of the disease).

Contextual:

Historical factors, access to care, trust in the state.

VACCINE HESITANCY IN QUEBEC

Vaccine hesitancy has been around for as long as vaccines have existed, and Quebec is no exception.

During a deadly smallpox epidemic that struck the province in 1885, many people did not trust the vaccine and refused to get vaccinated. The enactment of compulsory vaccinations was followed by riots in Montreal.

Although we have come a long way since the end of the 19th century, vaccine hesitancy remains a fixture of society. For example, the Quebec population showed a reluctance at getting vaccinated during the major measles epidemic in 1989, a reticence that seems to have been reinforced in the past two decades due to misinformation widely shared on social media linking vaccines with autism. Epidemics and pandemics give rise to a range of expressed concerns about vaccination, which have indeed resurfaced in the era of COVID-19.

UNDERSTANDING VACCINE HESITANCY IN QUEBEC IN THE CONTEXT OF THE COVID-19 PANDEMIC

The development and introduction of the COVID-19 vaccines have been an unprecedented global vaccine event.

During the COVID-19 pandemic, social networks have been used extensively to inform the public. A great deal of information, rumours and hearsay have spread at high speed throughout Quebec and rest of the world. This wealth of information can:

- *Support informed critical thinking about vaccinations*
- *Increase public confusion*
- *Promote the (deliberate or inadvertent) spread of false information*

At the same time, governments have been emphasizing the effectiveness, safety and necessity of vaccines, but often with poorly explained or poorly contextualized facts. Multiple authorities have also challenged these facts out of a concern about the side effects of vaccines, the speed of the vaccine development, and the use of a new type of vaccine (mRNA). This situation has led to confusion and may be responsible for increased mistrust in the government and its institutions and may, consequently, exacerbate vaccine hesitancy.

However, the rapid and confusing spread of misinformation are just two aspects that play a role in vaccine hesitancy, which is the result of multiple interrelated factors within marginalized minority communities in Quebec. This phenomenon will be described in the following pages.

UNDERSTANDING VACCINE HESITANCY IN ETHNOCULTURAL COMMUNITIES IN QUEBEC

Although a reality initially neglected due to the urgency of the pandemic, vaccine hesitancy is indeed exhibited in ethnocultural communities. The history and experiences of these Quebec communities may influence their relationship with the medical system and therefore their social representations, behaviours and attitudes when it comes to vaccination. This phenomenon in relation to COVID-19 is just starting to be documented. This new area of interest stems from:

- *The over-representation of minority communities in the number of coronavirus cases, hospitalizations and deaths.*
- *Potential problems with access (economic, geographic, cultural, etc.) to vaccines and the distrust of institutions by these same communities.*
- *Media coverage of the under-vaccination of specific communities (e.g. African Americans in the United States) or the identification of other communities as vulnerable priority groups for vaccination (e.g. Indigenous communities in Canada).*

UNDERSTANDING THE VACCINE HESITANCY OF DIFFERENT ETHNOCULTURAL COMMUNITIES

requires considering the following four aspects:

1. SOCIAL, POLITICAL AND ECONOMIC CLIMATE IN THE PERSON'S COUNTRY OF ORIGIN

There are many reasons why minority populations of Quebec immigrants decide to leave their country of origin. These reasons may include social unrest or political and economic instability from a dictatorship, military coup, abuse of power, corruption, etc. This is the case for refugees and asylum seekers, whose experiences are often associated with a loss of basic human rights and a high level of mistrust in the State and its institutions.

2. SYSTEMIC RACISM AND THE EXPERIENCE OF DISCRIMINATION IN QUEBEC

Racism and discrimination are daily issues for many visible minorities and Indigenous communities in Quebec. These phenomena affect specific individuals and can be institutional. They may be expressed as attitudes that are (often unconsciously) prejudiced and stereotyped or as policies and practices that are widely adopted without consideration of the characteristics of the target groups. Systemic racism continues to be denied or minimized by many institutional and political powers, yet this reality is at the root of community differences in terms of mortality and the consequences of the pandemic (deepening of socio-economic inequalities, stigmatization of Asian communities because of the virus, etc.). This can lead to negative experiences with the health care system and therefore to a mistrust of this system on the part of visible and language minorities.

UNDERSTANDING THE VACCINE HESITANCY OF DIFFERENT ETHNOCULTURAL COMMUNITIES

requires considering the following four aspects:

3. RUMOURS ABOUT VACCINES

The spread of false or incomplete information plays an important role in how the COVID-19 pandemic and vaccine hesitancy can be managed. Rumours about vaccines tend to spread within communities via social networks (whose members may live in Quebec or outside the province) and through everyday discussions and conversations. These rumours may affect people's perceptions about vaccination.

4. A PLURALITY OF RELATIONSHIPS WITH MEDICINE

Different communities and individuals relate to medicine—and to health more broadly—in different ways. This plurality of relationships means that biomedicine (or "Western" medicine, i.e. the conventional medicine on which the Quebec and Canadian public health system is based) can be perceived as one option among many. This does not mean that people reject or minimize the biomedical option or that people are not familiar with or do not value vaccines. However, when it comes to prevention, people weigh getting vaccinated against other preventive actions and practices, which can in turn influence their acceptance, delay or refusal of the vaccine.

1 BLACK COMMUNITIES[1] IN QUEBEC

GENERAL PROFILE

Black communities form the largest visible minority in Quebec. Their presence is linked to the period of slavery in British Canada that lasted until 1833 and to several waves of immigration, first from the Caribbean (1960s) and then from Africa (1970s).

Today, members of the Black community are mostly made up of people from:

- *Haiti (143,000 people)*
- *Congo (33,000 people)*
- *Cameroon (17,000 people)*
- *Ivory Coast (8,500 people)*
- *Senegal (8,200 people)*

RELATIONSHIP TO BIOMEDICINE AND VACCINATION

Biomedicine and vaccination have a very long history in Haiti. Both are also considered compatible with the predominant role of the Catholic Church and traditional medicine (healers, remedies, etc.). Vaccination is therefore widely accepted.

In general, routine immunizations in Africa seem readily accepted; however, vaccination campaigns, which were often forced, along with vaccine scandals have left bad memories in some communities.

[1] *We have focused on Black communities in reference to the Black Lives Matter movement and the calling-out of systemic discrimination experienced by Black people in Quebec and around the world.*

1 BLACK COMMUNITIES[1] IN QUEBEC

Black communities in Quebec may show resistance and distrust of the government and its affiliated institutions. This mistrust is reflected in attitudes towards vaccination and stems from:

- *Repeated medical experiments carried out without the consent of the population (e.g. the scandal of the Tuskegee syphilis study, vaccine experiments in colonial Africa). These experiences gave rise to collective trauma.*
- *The strength of transcontinental networks (with countries of origin), transnational networks (with the United States), and virtual networks that help spread anti-vaccine rumours (e.g. vaccines are being used as a tool of surveillance or forced sterilization).*
- *The daily experience of racism and discrimination marked by deep socio-economic inequalities.*

BLACK COMMUNITIES AND THE EFFECTS OF THE COVID-19 PANDEMIC

The COVID-19 pandemic has increased the inequalities experienced by Black communities. These inequalities relate to increased exposure to the COVID-19 virus, e.g. due to the need to take public transit, an inability to work remotely, and over-representation in the so-called "invisible" health professionals and groups most at risk.

Black communities are therefore over-represented in COVID-19 cases, hospitalizations and deaths.

The pandemic has also contributed to the stigmatization of Black communities. This is the case in neighbourhoods which have been singled out as "hot zones," such as Montréal-Nord, which is known for its seniors' residences, high rate of poverty and large Haitian population.

2 QUEBEC'S INDIGENOUS COMMUNITIES

GENERAL PROFILE

The Indigenous peoples of Quebec include the First Nations, Métis and Inuit.

In the 2016 census,

- *92,000 people in Quebec identified as Indigenous and belonging to one of the 10 First Nations of Quebec.*
- *14,000 people identified as Indigenous and belonging to the Inuit Nation.*
- *70,000 people identified as Métis.*

About half of these people live in urban areas, including 13,000 in Montreal, or 0.7% of the Montreal population.

RELATIONSHIP TO BIOMEDICINE AND VACCINATION

Indigenous communities in Quebec can have a mistrustful relationship with the health care and social services system. This mistrust is related to:

- *Inequalities and problems with access to services:*
  - *Historical: The colonial past (attempts to assimilate and eradicate Indigenous culture, abuse) that triggers collective and intergenerational trauma.*
  - *Structural: A lack of services both in Indigenous communities and villages (e.g. lack of access to drinking water) and in urban centres.*
- *Racism and discriminatory practices in the health care system. Quebec's Indigenous communities face:*
  - *Cultural barriers: Indigenous communities have a different relationship to health compared to the one promoted by Quebec's current health care system. The goal is to achieve a balanced state of health and wellness that (1) is supported by the family and community and (2) involves a variety of customs and rituals (medicine wheel, remedies, etc.).*

2 QUEBEC'S INDIGENOUS COMMUNITIES

- *A disregard for their needs and realities in terms of their relationship with medicine.*
- *Prejudice and discriminatory practices (e.g. the death of Joyce Echaquan).*

This reality reinforces problems of building trust between Indigenous people and health care providers and may play a role in vaccine hesitancy.

INDIGENOUS COMMUNITIES AND THE EFFECTS OF THE COVID-19 PANDEMIC

Indigenous communities have been particularly affected by the COVID-19 pandemic. Across Canada, as of April 6, 2021, the rate of First Nations people living on a reserve who have been infected with COVID-19 was 77% higher than the general Canadian population.

In Montreal, health measures have had a disproportionate impact on Indigenous communities. These measures have sparked strong reactions, particularly following the death of Raphael Napa Andre, an Innu man who died in a chemical toilet near a shelter that was closed because of government directives.

3 QUEBEC'S EAST/ SOUTHEAST ASIAN COMMUNITIES

GENERAL PROFILE

East and Southeast Asia is a region characterized by extreme ethnic, language, cultural, religious and socio-economic diversity.

In Quebec and Montreal, Southeast Asian communities are statistically less represented than East Asian communities. The three main communities are:

- *Tagalog (from the Philippines, 38,000 individuals)*
- *Khmer (from Cambodia, 43,000 individuals)*
- *Lao (from Laos, 8000 individuals)*

These East Asian communities come from a region also known as the "Sinosphere," which culturally, religiously and politically has been influenced by China in a fundamental way.

In Quebec, East Asian communities are represented by people from:

- *China (120,000 individuals)*
- *Vietnam (43,000 individuals)*
- *Japan and Korea (9,000 and 6,000 individuals)*

RELATIONSHIP TO BIOMEDICINE AND VACCINATION

East/Southeast Asian communities generally have a very high regard for health care professionals and a long-standing familiarity with biomedicine and the biomedical health system, two realities reflected by the over-representation of health professionals who come from the Vietnamese community compared to the Quebec-born population, for example, as well as large numbers of Filipino nurses in Quebec and Canada.

East and Southeast Asian communities have not only a long history of vaccination but also a familiarity with respiratory epidemics (SARS, avian flu) that have contributed to:

- *The development of an often robust and responsive public health infrastructure in countries in this region.*
- *Awareness of the importance of infection prevention measures (e.g. collective prevention education, mask wearing).*

3 QUEBEC'S EAST/ SOUTHEAST ASIAN COMMUNITIES

- *The implementation of highly developed and effective vaccination policies.*

However, vaccine hesitancy is nevertheless present and growing, particularly in large Chinese and Indonesian cities. This has occurred due to:

- *Recent vaccine scandals and public health issues hidden by governments.*
- *The colonial past of Southeast Asia marked by imposed vaccinations and scientific and vaccine experiments (e.g. smallpox vaccine, the BCG tuberculosis vaccine).*
- *The strength of transcontinental ties (between East and Southeast Asia and North America) among communities that contribute to the spread of anti-vaccine rumours.*
- *Vaccination-related concerns that spread within dense social networks that support these transcontinental ties.*

EAST/SOUTHEAST ASIAN COMMUNITIES AND THE EFFECTS OF THE COVID-19 PANDEMIC

The pandemic has triggered long-standing prejudices about Asia as the "cradle" of infectious diseases. For example, COVID-19 has been called the "Chinese virus." As a result, East/Southeast Asian communities have been the victims of many violent, racist and discriminatory incidents in Canada during the COVID-19 pandemic.

Discrimination seems to have impacted the likelihood of these communities to get tested for COVID-19 or to seek medical attention if they have symptoms. This could play a role in people's reluctance, for example, to go to large centres for vaccination.

4 LATIN AMERICAN COMMUNITIES IN QUEBEC

GENERAL PROFILE

Quebec's Latin American communities formed during several waves of immigration beginning in the 1970s. Today, about 50% of immigrants from these countries have refugee status.

In Quebec, these Latin American communities are mainly represented by people from:

- *Colombia (34,000 individuals)*
- *Central America (36,000 individuals)*
- *Mexico (27,000 individuals)*
- *Peru (20,000 individuals)*

RELATIONSHIP TO BIOMEDICINE AND VACCINATION

Latin American communities can generally be distrustful of governments and the biomedical health system in their countries of origin.

This mistrust is related to:

- *Significant inequalities in terms of access to health care as well as problems of exclusion and discrimination in their home countries.*
- *Secret experiments carried out by the U.S. government without public consent (e.g. experiments in Guatemala during the 1940s involving injections of sexually transmitted diseases).*
- *Rumours fed by social networks and the Catholic Church, which is very influential in Latin America (e.g. "divine remedies" versus vaccines that are deemed ineffective).*

Although the region has long been targeted by vaccination campaigns, vaccination coverage is variable and people exhibit vaccine hesitancy.

4 LATIN AMERICAN COMMUNITIES IN QUEBEC

LATIN AMERICAN COMMUNITIES AND THE EFFECTS OF THE COVID-19 PANDEMIC

Latin American countries, particularly Mexico and Brazil, which already suffer from deep inequalities and weaknesses in their existing health systems, have been hit hard by the pandemic. Populism and religion also feed an official denial of the severity of the situation.

In Canada, many members of Latin American communities have experienced job losses or reduced work hours, which means they have had more trouble meeting their basic financial commitments during the pandemic. In August 2020, the unemployment rate was much higher for a number of visible minority groups, including Latin American communities, compared to the national rate. This is partly due to the over-representation of this population in hard-hit areas. The mortality rate has also been higher in racially diverse neighbourhoods in Quebec, including Latin American communities.

5 ARAB COMMUNITIES IN QUEBEC

GENERAL PROFILE

In Quebec, nearly 400,000 people identify as being of Arab origin. The Arab-Quebec population has been growing steadily since the 1990s. They represent the second largest "ethnic minority" in Quebec, behind the African and Caribbean communities. Although the Arab world is very heterogeneous and stretches from Morocco to Yemen, over 90% of Arab Quebeckers are fluent in French, as they mainly come from French-speaking countries.

The main countries of origin for these communities are:

- *Morocco (86,000 individuals)*
- *Lebanon (78,000 individuals)*
- *Algeria (60,000 individuals)*
- *Syria (27,000 individuals)*
- *Tunisia (21,000 individuals)*

RELATIONSHIP TO BIOMEDICINE AND VACCINATION

Medicine and science have a rich history in the Arab world, which explains the trust that members of this community have in biomedicine, health professionals, and other scientific experts. Countries in North Africa and the Middle East have made considerable progress in developing their health care systems and improving the health status of their populations. Vaccination is therefore widely accepted despite:

- *Racism and discrimination experienced by Arab communities in Quebec.*
- *Questions about the relationship between vaccines and fertility and how vaccines impact the practice of religious faith (e.g. fasting during Ramadan).*
- *Health care systems in some Arab countries that are threatened by political and economic issues.*

5 ARAB COMMUNITIES IN QUEBEC

- *The spread of false information in community networks, despite measures taken by authorities of some Arab countries to counter disinformation.*
- *A historically fragile trust in government.*

ARAB COMMUNITIES AND THE EFFECTS OF THE COVID-19 PANDEMIC

Arab communities experience direct, indirect and systemic forms of discrimination, such as police profiling and hiring discrimination. In 2020, in the context of the pandemic in Quebec, people identifying as belonging to Arab communities reported the poorest mental health indicators. This psychological distress is linked to exposure to the virus, discrimination related to COVID-19, and stigma.

HOW CAN WE SUPPORT PEOPLE'S DECISIONS ABOUT GETTING VACCINATED AGAINST COVID-19?

Making decisions is an important task that we do every day and involves considering the benefits and risks or drawbacks associated with a specific course of action. In this sense, vaccine hesitancy is a healthy and legitimate part of the decision-making process. Health care professionals must respect the agency of the hesitant person or group and guide their decision about getting vaccinated by providing information and emotional support.

RECOGNIZE POWER RELATIONSHIPS AND THE LEGITIMACY OF DISTRUST

To support the decision to get vaccinated, it is important to build a relationship with the hesitant person based on respect, dialogue, empathy and inclusion.

This means reflecting on and identifying the conditions of the encounter that will make the person:

- *Feel welcome*
- *Not fearful of experiencing discrimination*

This means making the person feel safe to talk about these issues.

WAYS TO BUILD A RELATIONSHIP BASED ON RESPECT AND INCLUSION

Get to know yourself as a cultural being—who has blind spots:

- *What do I represent individually and collectively?*
- *How do I define myself personally and in relation to others?*
- *How can my non-verbal communication help or hinder the creation of a safe space?*

Tolerate uncertainty:

- *You can't know everything all the time!*
- *Adopt an attitude of continuous learning*
- *Adopt a sense of humility and an instinct to reflect on your knowledge of the person's experiences and difficulties*

Recognize relationships of power:

- *Be sensitive to the experiential reality of members of minority groups*
- *Recognize systemic discrimination*

Recognize the legitimacy of distrust:

- *"I understand that it's difficult to talk to me."*

RECOGNIZE THE ROLE OF FACTS AND EMOTIONS

Communicating scientific facts is one of the main tools used by vaccine providers, health care professionals, and governments to prevent disease and encourage people to get vaccinated. However, this communication method can be problematic because:

- *Facts are not always absolute.*

Some facts can turn out to be wrong, or they can be overgeneralized. Providing evidence of vaccine effectiveness to hesitant individuals does not always limit false beliefs and fears about vaccination. Information overload in itself can generate hesitation.

- *Emotions trump facts.*

Decision-making in this case will come more from people's emotions about vaccines, such as a fear of the

virus and its side effects, conflicts at work or in the family, or anger at governments and the pharmaceutical industry.

However, scientific facts can be our allies when used as part of a personalized intervention approach. Inspired by motivational interviewing, this type of intervention consists of:

- *Building trust with people who are hesitant about getting vaccinated.*
- *Respecting their beliefs about vaccines and vaccination.*
- *Targeting their concerns.*

USE THE PRINCIPLES OF MOTIVATIONAL INTERVIEWING

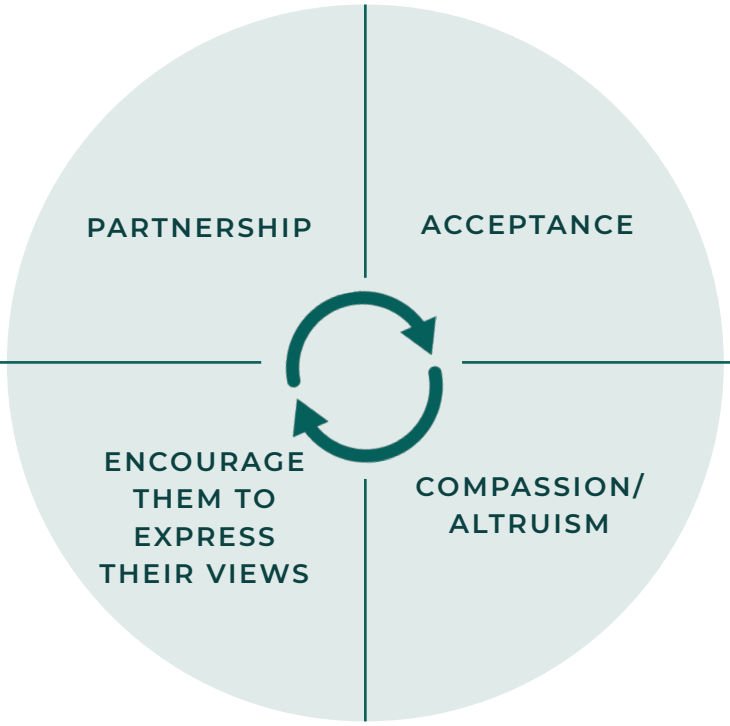
MI is a communication style based on empathy and collaboration in order to guide individuals toward changing their behaviour. MI helps reinforce the person's motivation to resolve their ambivalence.

With this communication method, health professionals do not play the role of expert. They work with individuals to establish a partnership and relationship of trust.

The MI approach has been used to promote vaccinations and has been shown to be effective at increasing people's intention to get vaccinated and ultimately increasing vaccine coverage.

4 COMPONENTS OF MI

- *Work with the individual and do not impose your knowledge about vaccinations.*
- *MI is done for and with the person.*



- *Be open and empathetic.*
- *Respect the person's autonomy in deciding whether to get vaccinated.*

- *Encourage them to move toward vaccination.*
- *The person has the resources to resolve their ambivalence. The goal is to help them use these resources.*

- *Be kind to the person.*
- *The person's well-being is important and must be respected.*

PRINCIPLES OF MI

1. ***Avoid correcting:*** *the reflex of correcting (telling the client how to act; arguing or blaming; wanting to convince at all costs) can cause resistance. This approach also does not create an opportunity for an open dialogue about vaccinations.*
2. ***Listen with empathy:*** *make a conscious and active effort to understand the individual's personal thinking process.*
3. ***Explore the person's ambivalences and motivations:*** *understand the important information to convey to move the person toward getting vaccinated.*
4. ***Encourage:*** *reinforce the person's autonomy.*

MI TOOLS

SKILLS	DEFINITION	EXAMPLES
OPEN QUESTIONS	*Ask open-ended questions that get the person to* ***give a detailed response****. Avoid closed yes/no questions.*	*- What do you think about vaccination?* *- Why do you think it is important?*
REFLECTIVE LISTENING/ SUMMARIES	***Rephrase and synthesize*** *what the person has just said or what they mean.*	*- You're concerned about the safety of the COVID-19 vaccines since they were developed so quickly, but you are also in favour of vaccines in general.* *- You need reassurance about the safety of these vaccines.*
AFFIRMATION	*Remarks to* ***encourage*** *the person,* ***recognize their abilities*** *and* ***emphasize their strengths****.*	*- Your loved ones' health and safety is important to you.* *- Thank you for taking the time to talk about vaccinations.* *- You already know a lot about the topic.*
ASK SHARE ASK	*1.* ***Ask*** *what the person* ***knows****.* *2.* ***Ask permission*** *to provide information.* *3.* ***Share the information*** *the person needs.* *4.* ***Ask*** *what the person* ***thinks*** *of this information.*	*1. What do you know about how COVID-19 vaccines work?* *2. Could I give you some information to build on what you already know?* *3. (Share information)* *4. What do you think of this information?*

THE FIRST QUESTIONS TO ASK AFTER INITIATING A DIALOGUE

- *What do you think about the COVID-19 vaccines?*
- *What is your position on the COVID-19 vaccines?*
- *What would motivate you to get vaccinated against COVID-19?*
- *What do you know about the COVID-19 vaccines?*
- *What are your questions or concerns about the COVID-19 vaccines?*

These questions help initiate the relationship with the person and establish openness and trust. They also help to pinpoint the individual's concerns.

MOTIVATIONAL INTERVIEWING IN THE FIELD

The following examples compare the traditional approach of convincing people to get vaccinated with the motivational interviewing approach, which tries to motivate individuals by providing information about COVID-19 vaccines.

WHAT TO AVOID: CONVINCING

Health professional: *It's important that you get vaccinated against COVID-19. Otherwise, you are putting yourself and others at risk.* ***[Confrontational attitude that puts the client on the defensive]*** *Did you know that there are still many cases of COVID-19 and that the disease can be very dangerous? Even if you don't die or become hospitalized, you may end up with long-term health problems if you contract the illness.* ***[One-way communication without asking the person's opinion]***

Client: *I don't see the urgency in getting vaccinated. And the unknown effects of this new vaccine could be worse than COVID! I heard that some people didn't even know they had COVID or that it was like the flu. It's hard to believe that the vaccine is safe when it was developed so quickly! Where I live, people say that these vaccines can even kill people.*

Health professional: *Studies have shown no significant adverse effects. I can assure you that the vaccine is safe.* ***[Does not explain why the health professional is convinced of the safety of the vaccine]*** *You should be wary of information you find on the Internet and what people are saying.* ***[Doesn't respectfully address concerns: Why do people think that? What were their experiences?]***

Client: *I've heard other things and not just from the Internet. I've read a lot about it, and vaccinations aren't mandatory. I can do what I want.*

Health professional: *Yes, you're right, getting vaccinated is not mandatory, but you are putting yourself and others at risk.* ***[Guilt]*** *The risks of COVID-19 are much higher than the risks of the vaccine. I'm taking the time to talk to you about this because it's very important.*

Client: *But what if I have a bad reaction? I would rather rely on my own natural immune system, if I can, than be injected with who-knows-what kind of chemicals. I'm worried about the risks of this new vaccine that we don't fully understand, and you don't seem to be concerned about the possible impacts on my health. I'm afraid for my family and relatives; we've been deceived so often!*

Health professional: *Of course I'm concerned! I'm also concerned that you may get COVID-19 when this vaccine could prevent it.* ***[Does not address client's concerns about the products used in vaccines and other risks and negates the valid mistrust that the person has expressed]***

Client: *I don't think we see eye to eye. Let's talk about this some other time.*

Health professional: *Of course I'm concerned! I'm also concerned that you may get COVID-19 when this vaccine could prevent it.* ***[Does not address client's concerns about the chemicals used in vaccines and other risks and negates the valid mistrust that the person has expressed]***

Client: *I don't think we understand each other. Let's talk about this some other time.*

Overall: The health professional adopted the role of an expert and used a prescriptive approach to argue and correct. The professional also failed to acknowledge the lack of cultural safety. This approach led to resistance.

WHAT TO DO INSTEAD: MOTIVATE

Health professional: *What do you think the benefits and disadvantages of the COVID-19 vaccine are?* ***[Open question]***

Client: *Well, I know the goal is to protect us from the virus and to help us get back to normal. My father was vaccinated, but I'm afraid he got it too quickly and it's not clear that the product is completely safe. I don't have the same doubts about other vaccines because they have been tested more and we have had more time to see whether they work, but this one makes me nervous.*

Health professional: *As you said, the goal is to protect us from the virus and help us get back to normal. If I understand what you are saying, other vaccines seem safe to you, but you are hesitant about this one because it is new and was developed quickly.* ***[Reflections, addressing concerns]***

Client: *Yes, I know it's a good thing to get protected against COVID, and I want to live a normal life again, but I have mixed feelings. I've read a lot of articles and comments online. A lot of people are concerned about how quickly the vaccine was deployed, and we don't know what the long-term effects will be and whether it is really safe. That's what my family members think about our position in this country; that we're guinea pigs.*

Health professional: *So you think it's important to protect yourself when vaccines are safe, but you're concerned about what you've read about the unknown possible effects of the COVID-19 vaccine.* ***[Summary of client's position and recognition of lack of cultural safety]***

I understand that you've done a lot of research and thought about the subject. ***[Affirmation]***

I have a fact sheet here about studies done on the vaccine's safety. Can we look at it together? ***[Ask permission]***

Client: *Okay. I want to know exactly what I am risking and talk about it with my family.*

Health professional: *Great. In one clinical trial alone, over 40,000 people received this vaccine under study conditions, i.e. with very strict monitoring and follow-up over several months. Although many people reported mild reactions such as pain at the injection site, fatigue and headaches, only four people experienced more serious side effects. Your arm may hurt and you may feel unwell for a day.* ***[Acknowledging the side effects but stressing their benign nature]*** *But you'll also be protected against COVID-19, which means you'll have more peace of mind to attend the family event you told me about.* ***[Share]*** *What do you think?* ***[Ask their opinion]***

Client: *Well, it was useful to know about the safety protocols. Thank you for taking the time to listen to my concerns. I think things are a little clearer now.*

Summary: The MI approach let the client express their concerns and ambivalence without judgment and acknowledged the lack of cultural safety. With the "ask-share-ask" method, the health professional provided information that the client was open to hearing.

A CONSTANTLY EVOLVING GUIDE

As mentioned in the introduction, this guide is a first step to understanding the complexity of the historical and social realities that influence vaccine hesitancy in the Greater Montreal area.

It was urgently produced by the CoVivre team based on the limited knowledge available to meet the needs of health care professionals. It is not exhaustive and will be added to and improved over time.

This guide is the result of a collaboration with multiple experts on the issues of vaccine hesitancy. However, we did not have the time or opportunity to include the opinions of key stakeholders in the field or ensure a true representation of voices, including those from affected communities, or from health care professionals themselves.

We therefore invite you to reflect on this document with us, provide feedback about its contents, and make suggestions so that we can enhance this document to promote a shared reflection on the issues of socio-economic and health inequalities caused by the pandemic. This process will help us further improve practices and adopt the necessary nuances in a context in which we constantly risk oversimplifying and stereotyping. As this guide is intended to be a collective tool, we would very much like to hear about your experiences. All comments, suggestions and criticisms are welcome.

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