UNDERSTANDING VACCINE HESITANCY

AMONG ETHNOCULTURAL COMMUNITIES IN THE CONTEXT OF THE COVID-19 PANDEMIC

INTEGRAL VERSION

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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.

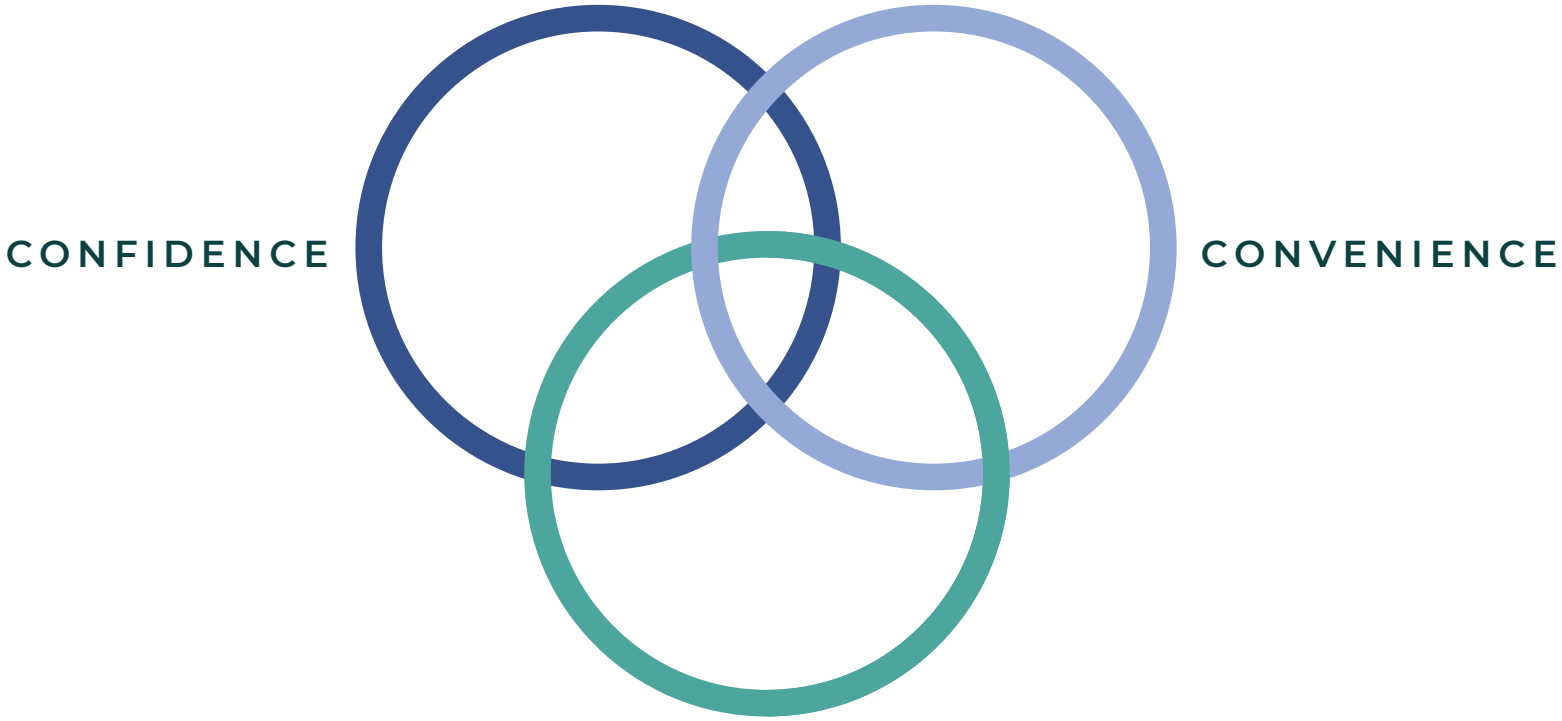
WHAT IS VACCINE HESITANCY?

Vaccine hesitancy encompasses a continuum of responses to vaccination, with one end representing a systematic and complete refusal of all vaccines and the other end constituting their total and systematic acceptance. Between these two extremes lies a multitude of social representations, attitudes and behaviours that take on different forms depending on the vaccine. Vaccine hesitancy may include not only vaccine acceptance preceded by reluctance and concern but also acceptance preceded by a period of reflection (Monnais, 2019).

Vaccine hesitancy is linked to concerns that vary greatly between different groups and regions and that can range from the political economy of the vaccine and medical mistrust from historical or even systemic racism to uncertainties related to perceived risks (of the disease or the vaccine itself). Very often, multiple factors are involved. Vaccine hesitancy may apply to vaccines in general or to specific vaccines. It may also be a "default" position or a "reactive" one, i.e. related to localized, one-time events such as intensive campaigns (e.g. polio eradication), the introduction of new vaccines (e.g. HPV, COVID-19), vaccine trials, reports of adverse events, and/or the official suspension of a vaccine, campaign, or ongoing trial.

A number of models have been developed to better understand the issues surrounding vaccine hesitancy. The "3 Cs" model (Macdonald, 2015) is one of the most common and categorizes the determinants of vaccine hesitancy, which include:

- *Confidence* which here denotes people's lack of trust in the effectiveness and safety of vaccines; in the system and the reliability of the system that delivers vaccines; and in the political motivations behind vaccination.
- *Complacency*, is when public perception about the risks of the vaccine-preventable disease(s) is low.
- *Conveniance* (i.e. accessibility) relates to cost, access to information, or physical access to the vaccine.



"3Cs" model (MacDonald, 2015)

Historically, health risks associated with the biological components or contaminants in vaccines have been cited as causes of vaccine hesitancy (Conis, 2017). Today, the causes and determinants of vaccine hesitancy are clearly complex and multiple. They relate to the context of the vaccination campaign (institutional and political context, access to care, trust in the state, etc.), to the proposed vaccines (toxicity, efficacy, relationship to the pharmaceutical industry, cost-benefit), and to individual and collective experiences with vaccination (personal or family experience, representation of risk, etc.) (Macdonald, 2015; de Figueiredo et al, 2020; Monnais, 2019).

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.

For example, the spread of negative information online as well as a lack of knowledge about vaccines are still seen as potential major causes of vaccine hesitancy (World Health Organization [WHO], 2020; Carrieri et al., 2019); however, barriers to access and confidence as described by the 3 Cs model are also common determinants.

VACCINE HESITANCY IN QUEBEC

Vaccine hesitancy has been around for as long as vaccines have existed, and Quebec is no exception to this rule (Monnais, 2019). The demonstrations and riots following the enactment of compulsory vaccinations in Montreal during the smallpox epidemic of 1885 in Quebec clearly illustrate this fact. Although the majority of demonstrators opposed what they say as authoritarian and invasive health measures (Lachaussée, 2020), there were already significant misgivings about the vaccine and a refusal to get vaccinated among the population. These misgivings stemmed from a fear of a relatively new scientific technology, from the idea that vaccine doctors were only out to get rich, and from the very high social and political tensions at the time (Bliss, 1993, p. 275). In 1885, the disproportionate impact of smallpox on French Canadians in a political and socio-economic context that favoured Anglophones, along with rumours in the press about Francophones' hygiene (or rather lack thereof) added to tensions between these two groups and fuelled beliefs that vaccination was a grasp at control by Anglophones (Farley, 1987, p. 129). Anglophones, on the other hand, pointed to the resistance of French Canadians to get vaccinated as the cause of the epidemic (Dubé, 2019). In Quebec in 1885, vaccinations were also seen as a sign of the secularization of health care (or the withdrawal of religion from the administration of hospitals and education) feared by the Francophone Catholic authorities (Bliss, 1993, p. 275).

After the 1885 outbreak, health authorities began stressing the importance of winning over public opinion and launched health awareness campaigns (Lachaussée, 2020). Vaccinations became increasingly accepted, to the point that Montreal became the site for the first tests of the BCG tuberculosis vaccine in the 1920s (Lachaussée, 2020). However, since the 1920s, reactions and attitudes to vaccination have varied and changed in the face of different diseases, scientific advances, and vaccine events. Salient examples of these include the Wakefield controversy (MMR-autism) in the late 1990s (Monnais, 2019) and the COVID-19 pandemic, which has triggered a great deal of questioning about vaccinations on the part of the population. Recent studies show that vaccine hesitancy remains a major problem to be addressed (Dubé, 2021).

In the context of the COVID-19 pandemic, a February 2021 survey done in Quebec reported an acceptance rate for COVID-19 vaccines of 73.9%, a refusal rate of 9.2% and a hesitancy rate of 17.6% (Gamache, 2021). These responses represent a decrease in vaccine refusal compared to data collected for the same group in November 2020, when the acceptance rate was only 62% (Gamache, 2021). The same survey reported that women were more likely to be hesitant and that young people aged 18 to 34 were less likely to get vaccinated (Gamache, 2021).

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 vaccine event. Their development has been widely reported in the media and has generated a great deal of public debate about new vaccine technologies, the design of clinical trials, expedited regulatory processes, and

even supplier manufacturing capabilities. The current pandemic represents the first time in history when technology and social networks have been used on such a massive scale to keep people informed (WHO, 2020). A great deal of information and narratives, which may be incomplete and inaccurate, have circulated very quickly in Quebec. Since January 2021, the majority of social media posts about COVID-19 in Quebec have been about vaccines (Dubé, 2021). This information overload, or "infodemic" can either support critical thinking or increase confusion. It can also promote the deliberate or inadvertent dissemination of misinformation that can be harmful to physical and mental health (WHO, 2020). The efficacy, safety and even necessity of vaccines are simultaneously hammered home by governments yet questioned by multiple authorities. For example, some people fear the side effects and long-term effects of the vaccines. Others fear the new mRNA technology used by scientists and the speed at which the COVID-19 vaccines were developed, while others believe that you do not need to get vaccinated if you simply lead a healthy lifestyle. There is also a strong association between risk perception and vaccine hesitancy; people who perceive that COVID-19 does not pose a risk or poses a lower risk to themselves and to their community are less likely to get vaccinated (O'Doherty et al., 2019).

Misinformation and non-transparent institutional narratives have become fodder for conspiracy theories and are at the root of many cases of vaccine hesitancy and specifically vaccine refusal (Smith et al., 2020). These narratives spread in particular on social media, where conspiracy theories are overrepresented and where theories about vaccines outnumber those related to moral or religious issues (Smith et al., 2020). Online personalities, such as Alexis Cossette-Trudel, have seen their popularity rise significantly in Quebec and elsewhere since the start of the pandemic through the spread of conspiracy theories mainly on YouTube and Facebook (Boulanger & Tousignant, 2020). These theories are based on ideologies such as libertarianism, which in Quebec has emerged as a movement whose basic tenet is freedom and therefore emphasizes individual freedom and shows skepticism toward authority, institutions and governments. Its most extreme adherents fear that imposed health measures are just the beginning of a slippery slope toward an Orwellian future. Conspiracy theories, however, are not necessarily linked to a shared ideology; ideologically incongruous communities can also form around vaccine refusal (Smith et al., 2020). One can see QAnon, libertarian, American, Quebec, and Patriote flags (among others) flying in the midst of anti-vaccine messages at demonstrations against the government's measures.

VACCINE HESITANCY: A COMPLEX PHENOMENON

Aside from personal experience and the understanding of information, the perception of vaccines, risk, and institutional motivations are influenced by the context in which they occur and particularly by interactions between people's different personal and social spheres (Ansons et al., 2020). The desire to cement one's in-group identity has a strong influence on the emotional response to risk (Ansons et al., 2020). In a worldwide context, COVID-19-related conspiracies depend not only on individual factors (socio-demographics, personality traits, resilience, cognitive biases and intuition, etc.), but also on social factors such as group identity and social media (van Mulukom et al., 2020). Trust in authority is also an issue.

That said, it is important to view vaccine hesitancy as a legitimate decision-making process that should be supported and above all understood. In a divisive social context, it can become a symptom of people's lack

of confidence in certain institutions. This is a global reality that is expressed in different ways depending on the context (van Mulukom et al., 2020). Vaccination comes with debates about political and economic issues, such as alliances between governments and pharmaceutical companies; distrust therefore arises from the belief that government stakeholders and pharmaceutical players do not care about the public's welfare but rather about wealth and power. In Quebec, there is also a degree of rejection of any perceived authoritarianism or paternalism in government messages and actions. This skepticism is linked to imposed health measures that may be perceived as harmful, too severe, not aligned with science, or inevitably inconsistent due to the constant emergence of new data (Schellenberg & Fonberg, 2020; Drew, 2019). The discourse around mandatory vaccinations and vaccine passports has also raised a similar kind of reluctance (Comité d'éthique de santé publique, 2021; Drew, 2019). Confidence in governments fell by 4% among Quebeckers between June and September 2020 (70% to 66% for the provincial government and 60% vs. 56% for the federal government) (Institut de la confiance dans les institutions [ICS], 2020a). This drop has come with decreased satisfaction with the management of the crisis (ICS, 2020b) along with anxiety, worry, and exhaustion (ICS, 2020a). Eventually, this frustration has translated into resistance to following the rules, and a broader movement of defiance has taken shape (ICS, 2020a; Baillargeon, 2020).

UNDERSTANDING VACCINE HESITANCY IN ETHNOCULTURAL COMMUNITIES IN QUEBEC

Although a reality initially neglected due to the urgency of the pandemic, vaccine hesitancy can be seen 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 (Wilson et al., 2018; de Figueirado et al., 2020; Khan, 2021). 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 IN QUEBEC

GENERAL PROFILE

People of Afro-Caribbean descent form the largest visible minority in Quebec. According to the 2016 Canadian census (Ministère de l'Immigration, de la Francisation et de l'Intégration, 2018), nearly half of this community are of Haitian origin, who included about 143,000 people in 2016. Having arrived in Quebec in several waves since the end of the 1950s, the Haitian diaspora is marked by strong socio-economic, identity and generational differentiations. While more than half of these individuals were born in Quebec or have lived here for over twenty years, 20% are newcomers and 11% have refugee or an equivalent status. The majority of the African diaspora is first generation and arrived in Quebec in the last 10 to 20 years. The main countries of origin of these individuals are Congo/DRC (33,000), Cameroon (17,000), Ivory Coast (8,500) and Senegal (8,200). Most of this population consists of economic immigrants; however, there is a higher percentage of refugees among the Congolese, Burundians and Rwandans.

Again according to the census data, while the vast majority (about 98%) of these main groups speak French, a significant minority of newcomers only speak Creole or the languages of Equatorial Africa. There is also a large English-speaking Afro-Caribbean community (30% to 40% of whom do not speak French) of Jamaican and Trinidadian origin (26,500, most of whom came before 1990 or were born in Quebec) as well as of Ghanaian and Nigerian origin (about 6,000). It is also important to note the longstanding presence in Quebec of descendants of slaves, who cannot be considered immigrants. Despite a high level of French-language proficiency and formal education (which also varies by group), Afro-Caribbean communities on average have lower incomes and higher unemployment rates than the Quebec average, even with equivalent levels of schooling, and this rate persists into the second generation. Beyond these differences, there is a shared experience of systemic racism in these communities (in terms of employment, housing and policing), while first-generation immigrants come from countries that are among the poorest in the world.

BIOMEDICINE AND VACCINATION IN HAITI

Biomedicine, including smallpox vaccination, has a very long history in Haiti (Brodwin, 1996). Despite its colonial roots, this tradition has not grown from foreign influence or the desire for modern/elite status. Biomedical care instead is seen as normal and compatible with the dominant role of the church and moral values in health care. It is also congruent with the widespread use of domestic knowledge (herbal recipes) and consultations with herbal or spiritual healers. As in Africa, the major barriers to the use of biomedical services and tools are financial: there are fees even in the public system, whose underfunding has stimulated growth of the private sector.

Vaccinations, on the other hand, which are prioritized through primary health-care policies, are free or highly subsidized and generally work well. Reported rates of partial vaccinations in children are high, suggesting that factors of convenience rather than confidence prevent children from getting their full vaccination series (Rainey et al., 2012). However, a rapid assessment from the late 1980s indicates that better knowledge of illnesses and the vaccination schedule is associated with greater likelihood of complete vaccination (Coreil et al., 1989). A recent survey to prepare for the deployment of the HPV vaccine in Haiti found that, despite a lack of information about the infection and the vaccine, almost all respondents (women aged 18–49 years) said, after getting information about the vaccine, that they would get it for themselves or their daughters (Gichane et al., 2017). A series of surveys about the HPV vaccine among Haitian women living in the United States also found that they have high confidence in vaccination in general and in Creole doctors and media as a source of information. While the newness of the HPV vaccine and its association with sexuality raised concerns, Haitian respondents did not express fears about experimentation on Black people like African American respondents did (Joseph et al., 2012; Joseph et al., 2014).

COVID-19 AND FAKE NEWS: HAITIAN NETWORKS

Morbidity and mortality due to COVID-19 are, officially, very low in Haiti. Some may even doubt the existence of the virus. There have been rumours that "lethal injections" are being carried out in health facilities to inflate the death toll—as a state strategy to attract international aid—in addition to secret vaccine experiments (Médecins sans frontières, 2020). In general, Haiti's turbulent political history and the recurrence of foreign/humanitarian intervention make Haitians likely to question the interests at stake in any major initiative (which is also the case in Africa).

Reports of deaths after a COVID-19 vaccine administered in the United States may also be circulating among family and diaspora social networks (between Haiti, New York, Florida, Boston and Montreal) (Pierre Minn, personal communication). Herbal recipes to prevent and treat COVID-19 have also been making the rounds. Although the first type of fake news warns about the risks of vaccination, the use of plants is not an obstacle to vaccine acceptance per se. The strong influence of churches—and multiple churches, given the divergent faiths within the Montreal diaspora—on all matters of health (as well as morality, sex and money) should not be overlooked in communication strategies.

BIOMEDICINE AND VACCINATION IN WEST AND CENTRAL AFRICA

From the 1920s to the 1970s, public health interventions, especially in rural areas, were carried out through mobile campaigns that gathered populations for screening and "serial" injections, which led to "accidents" (contaminated needles, side effects, etc.: see Lachenal, 2014). While these often-coercive campaigns left bitter memories, which, some would argue, have had a long-term effect on confidence in biomedicine especially in Equatorial Africa (Congo and Cameroon: see Lowes and Montero, 2018), the dramatic effect of antibiotic treatment and mass vaccination on the incidence of dreaded diseases (yaws, measles) seems to have been received positively.

Starting in the 1980s, "routine" vaccination developed to become part of primary care, whose network became increasingly dense. It is generally noted that vaccination is accepted—or at least "not resisted"—, leaving organizational and supply problems more likely to be blamed for gaps in vaccine coverage. According to a study carried out in the Gambia, vaccination (which is perceived as a tonic, prophylactic or remedy) aligns well with West African social representations of the body and the protection of babies (Leach & Fairhead, 2012). Vaccine acceptance is therefore not dependent on a biomedical understanding of immunity or vaccine-preventable diseases (although recent memory of serious diseases that are now "prevented" may also play a role). This study also indicated that social pressure and inclusion reinforce the idea of vaccinations but may also exclude mothers who are already marginalized. An analysis of African data indicates that education level and literacy are inversely associated with vaccination (Wiysonge et al., 2012). This may suggest a lack of access to information and may also be indicative of social marginalization. A recent survey in Senegal, Burkina Faso, Cameroon and Benin suggests that routine vaccination—in contrast to COVID-19 vaccines—remains widely accepted (Alice Desclaux, personal communication).

While little attention has been paid to benign "individual" hesitations about vaccination among African populations, some episodes of "collective" resistance have been a topic of interest. Two episodes of "anti-vaccine rumours" in Cameroon (1990s) and Nigeria (2000s) have become classic (Feldman-Savelsberg et al., 2000; Yahya, 2007). For social scientists, these "rumours" do not reflect ignorance or misinformation but instead should be interpreted as a form of discourse that rationally questions the interests and power relations that underlie the promotion of certain vaccines, especially in the context of intensive campaigns (also see Cole, 2016). State violence, memories of colonial coercion, and the unequal relationship between African countries and funders (particularly the mega global health alliances in which the Gates Foundation plays an important role)—which inexplicably focus on certain diseases (such as polio) while others are ignored—explain why some vaccines are represented as "weapons of control" of the African population (sterilization, deliberate infection, microchipping) rather than as tools of protection. These themes recur, for example, in the debates around the introduction of the HPV vaccine in Senegal in 2018, and again with the COVID-19 vaccines (Alice Desclaux, personal communication).

COVID-19 AND FAKE NEWS IN AFRICA

In April 2020, a French researcher's remarks on TV suggesting that vaccine trials should be conducted in Africa triggered a heated debate across both French and English African media and social networks about the remnants of colonial practices of using Africans as "guinea pigs" (Gay-Padoan, 2020). This commentary seems to have fuelled the spread of fake news about deaths resulting from secret COVID-19 vaccine experiments in Senegal.

Another popular piece of fake news in France that Bill Gates is behind a project to microchip and/or control the population with COVID-19 vaccines has also circulated in Francophone Africa (Smith et al., 2020). These stories take on a particular meaning in a post-colonial context in which discourses about "overpopulation" are generally perceived as inherently racist and in which populations are highly dependent on international institutions for material goods. The fake news stories circulating in Senegal also include questions about partnerships (between the state, Bill Gates, the European Union, and pharmaceutical

companies) that have formed around the "coronabusiness" (Alice Desclaux, personal communication). There have also been reports of vaccines being traded in the informal drug market, indicating that there is nevertheless demand for them. Here again, self-medication "recipes" have spread and often include chloroquine and antibiotics, which can be obtained informally without a prescription and are widely promoted as an effective treatment for COVID-19. Some fake news stories maintain that vaccination is not necessary given the effectiveness of this remedy.

A recent survey in Senegal, Burkina Faso, Benin and Cameroon (Ibid) found that only 15% of people would get vaccinated against COVID-19, about a quarter are undecided, and over 60% would refuse. The main reasons given were the risk associated with the vaccine (and the speed of research), "conspiracy theories" (population control), and the interests of the "coronabusiness."

RACISM, HEALTH, AND CARE IN NORTH AMERICA

There is comparatively little public discussion and studies of racism in Quebec, particularly of its systemic forms (Potvin, 2004). This means that there is also a lack of data about its mechanisms and effects, including on health and access to care. However, Black communities have difficulties accessing employment, housing and business credit (Ibid) and experience discrimination with youth protection services (Bernard, 2004) and police forces (racial profiling, heavy-handed tactics, over-policing). Especially for generations of Afro-Caribbeans born in Quebec, these inequalities are experienced as the effect of anti-Black racism rather than immigrant integration (Potvin, 2007). Young people of Haitian origin are more likely than their parents to identify both as "Quebeckers" and "Black," thus evoking a shared sense of exclusion and solidarity with transnational Black communities, particularly in the United States. They also advocate close relations with English-speaking Caribbean communities—who came to Montreal to work in subordinate jobs as "porters and domestics"—have a longer experience with oppression and racial discrimination (Ibid).

The study of racial inequalities in health is much more developed in the United States than in Canada (Ramraj et al., 2016). An analysis of survey data suggests, however, that Black Canadians may suffer the cumulative effects of chronic racism, leading to a higher prevalence of diabetes and hypertension as well as higher "premature" mortality from cancers and cardiovascular disease (Veenstra & Patterson, 2016).

In the United States, several mechanisms underlying health inequalities have been described and include residential segregation, overexposure to pollution, chronic stress due to economic insecurity and "microaggressions," police violence, financial exclusion from quality care, misdiagnosis and under-treatment (including for pain), medical mistrust stemming from both "everyday" discrimination and a history of violently forced and non-consensual participation in medical research (the symbols of which are the "Sims, Lacks, and Tuskegee" ethical scandals cited over and over again in the media and on social networks). These different examples of racism have been linked to a strong reluctance on the part of African Americans to get vaccinated against the flu and COVID-19 (Quinn et al., 2017; Story, 2018; Ferdinand et al., 2020) and also explain why they have been disproportionately affected and killed by the virus. While the health of Black Canadians has not been affected to the same degree, or in the same way, by the same mechanisms as those in the United States (Ramraj et al., 2016), most are nonetheless aware of the debates and tensions south of the border and may share the resulting medical distrust (e.g. Bajaj & Stanford, 2021).

In Canada, COVID-19 infection and mortality rates are not disaggregated by "ethnic group." Indirect measures, however, have shown that mortality in Montreal neighbourhoods is linearly associated with the percentage of Black residents (Subedi, Greenberg & Turcotte, 2020). Neighbourhoods such as Montréal-Nord, which is known for its combination of seniors' residences, high poverty rate and large Haitian population, have been singled out as "hot spots"; however, according to community groups such as Hoodstock, they lack the support to deal with the pandemic (Nerestant, 2021). A significant number of Haitian and some African women also work in the health system, often in subordinate positions as nurse's aides or patient care attendants. Being on the front lines, they have been highly exposed to the virus and have witnessed the ravages of the disease in their patients, which could make them persuasive spokespeople for vaccination. This exposure, which has led to demands to let asylum-seekers working on the front lines stay in Canada, could also lead to a sense of "betrayal" in the face of little societal recognition of their sacrifices. It may also be noted that the stigmatization of Haitians in both Canada and the United States as vectors of the spread of AIDS in the 1980s and their ineligibility to donate blood following the "tainted blood scandal" may have had long-term effects on relationships of trust with the medical system (Charbonneau & Tran, 2012).

2 INDIGENOUS COMMUNITIES IN QUEBEC

GENERAL PROFILE

In the Quebec territory, there are 55 communities of over 104,000 Indigenous people belonging to 11 nations. About half of these people live in urban areas. Montreal is the Quebec municipality with the largest population who identify as Indigenous. In 2016, 13,000 people in the city identified as Indigenous, representing 0.7% of the Montreal population (Landry, 2020). The majority of this population also identifies as First Nations (45%) or Métis (44%), while 5% identify as Inuit (Landry, 2020). In Montreal, the most commonly spoken Indigenous languages include Cree (28%) and Inuktitut (44%) (Landry, 2020). According to the National Household Survey, the vast majority of Indigenous people (99.2%) can express themselves in English or French (Statistics Canada, 2013). In Quebec, 13.59% reported French as their first language and 15.13% reported using this language (CERP, 2019, p. 112). A language barrier has been noted in Montreal, however, particularly for Inuit; although many speak some English, some only speak their native language (Gacon, 2019). This poses a barrier when some health services do not have internal resources who can communicate in these languages (Gacon, 2019). The level of understanding and communication ability may also be limited even among those who can speak some English and French.

There are large socio-economic gaps between Indigenous communities and all of Montreal, Quebec, and Canada. The Indigenous population is less educated, lives in poorer housing conditions, and has a lower median income and a higher unemployment rate, while over half of the Indigenous population in Montreal has a lower income (Landry, 2020). Indigenous people are also overrepresented among the homeless, as they make up 12% this population whereas they represent less than 1% of the Montreal population.

HEALTH, ACCESSIBILITY, AND PREVENTIVE PRACTICES

In Indigenous communities and villages, there is a lack of health and social services (lack of emergency outpatient services, geographic remoteness, staff shortages, etc.) (CERP, 2019). It is particularly difficult for rural, remote and northern communities to make up for the shortage in medical staff (Oosterveer & Young, 2015). They are therefore dependent on non-resident professionals who come for a short period of time but who are not able to build long-term trusting relationships with their host communities (Burnett, 2020).

During the public inquiry commission on relations between Indigenous peoples and certain public services in Quebec (CERP, 2019), many Indigenous people testified that they have a difficult relationship with the health system and that the health care services offered do not meet their needs. Their difficulties relate to problems accessing health services and to cultural barriers, prejudices and discriminatory practices within the health care system.

The Indigenous peoples of Quebec have a vision of and relationship with health and biomedicine rooted in Indigenous religions and spiritualities that differ from the Western vision conveyed by the current Quebec health system. In urban centres, access to traditional healing practices is limited or non-existent (Landry, 2020). Although the health of Indigenous people living in urban areas is better than elsewhere in Quebec, it remains worse than that of the non-Indigenous population in urban areas (Landry, 2020). Moreover, the percentage of Indigenous people who have a positive perception of their health (44%) is lower than for non-Indigenous Montrealers (59%) (Landry, 2020). The public health care and social services system is based on biomedical norms and a strong reliance on individual pathways, whereas Indigenous people focus more on achieving a state of health balance and well-being. This state is supported and reinforced by family, friends, community, and more broadly, the Nation (CERP, 2019). It is based on a set of very diverse customs and rituals (medicine wheel, Indigenous remedies, etc.).

Beyond issues with access, Indigenous communities face prejudice and discriminatory practices within the health care system. In urban areas, discrimination and fear of experiencing racism are perceived by Indigenous people as the two main barriers to health care (Landry, 2020). A recent example is the mistreatment of Joyce Echaquan, whose case may have reinforced the criticism of and/or lack of confidence in the system in the context of COVID-19.

Currently, Joyce Echaquan's death is an emblematic traumatic event that has retriggered a long history of Indigenous communities' distrust in the government and its institutions stemming from the colonialist period during which Indigenous peoples were subjected to many abuses (assimilation policy, children taken from their families, the administration of unconsented-to medical tests and treatments, etc.). "Joyce's Principle" was created as a call to action and a commitment by governments to end this situation and uphold the right to equitable access to health and social services without discrimination (Atikamekw Nehirowisiw, 2020). However, the failure to adopt the principle and a refusal to acknowledge the existence of systemic racism continue to fuel tensions (Sioui & Boutros, 2021). These tensions have persisted and echo the health inequalities and discriminatory practices that remain very widespread in interactions between caregivers and patients. Health inequalities are rooted in historical and political determinants, including trauma and inaccessibility of care as noted above. Diseases, conditions or behaviours that are identifiable within Indigenous communities (alcohol use, diabetes, depression and suicide, as well as infectious diseases such as tuberculosis, etc.) are themselves vectors of unequal treatment and discrimination. In this regard, the First Nations Health Authority of British Columbia has stated that "racism in health care results in inferior care, unequal access, stigma and harm, and in some cases, death" (Lasalle, 2020).

THE PANDEMIC, VACCINATION AND INDIGENOUS COMMUNITIES

Indigenous communities have been particularly affected by the COVID-19 pandemic. As of February 23, 2021, the Canadian government reported that the percentage of First Nations people living on-reserve who have tested positive for COVID-19 is 74% higher than the general Canadian population (Gouvernement du Canada, 2021a). In Montreal, the disproportionate consequences of health measures on Indigenous communities 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.

Despite good vaccination coverage in Indigenous communities in Canada, many Indigenous people have expressed reluctance to get vaccinated against COVID-19. Their reticence stems partly from the lack of inclusive messages tailored to Indigenous communities during vaccine roll-out plans as well as from the fact that they are a prioritized group. Recent statements about the failure to end boil-water advisories by March 2021 due to COVID-19, whereas vaccine deployments were quick, have fed into the current narrative that Indigenous peoples are being used to test vaccine safety and effectiveness (Mosby & Swidrovich, 2021). Prioritizing these communities also puts them into an inferior status by indirectly assigning them a "biological vulnerability." This also feeds the idea that the government is willing to vaccinate the community at the drop of a hat but that it does not care about their quality of life or the long-term impacts and inequities that are created. This argument arises from their distrust and poor relationship with the government and health services, which has been exacerbated by the deaths of Joyce Echaquan and Raphael Napa Andre and also by public health messages and actions in Canada.

Because Indigenous communities are a priority group, their vaccination coverage is currently the highest in Canada. As of March 25, the adult vaccination rate is six times higher in Indigenous communities compared to the Canadian average (Gouvernement du Canada, 2021b). As non-Quebec examples, in Saskatchewan the average rate is 75% in most communities, while in Ontario, almost 70% of northern Indigenous communities have received their first vaccine dose (Gouvernement du Canada, 2021b).

On virtual platforms, not much misinformation related to the COVID-19 pandemic has been documented among Indigenous communities. Women's College Hospital launched a project called "Sharing Medicine" which aims to provide accurate, trauma-informed, and culturally relevant information regarding medical information related to COVID-19 vaccinations (Women's College Hospital [WCH], 2020). The goal is to promote informed consent and decision-making in Indigenous communities through storytelling. Some objects used in Indigenous rituals, such as the medicine wheel, have been adapted by some communities to the current pandemic. This practice, among others, promotes tolerance of uncertainty, holistic practices, community protection, and preventive actions such as hand-washing and physical distancing (WCH, 2020). It should be noted that the phenomenon of vaccine hesitancy and the specific context of COVID-19 is constantly changing. These are evolving concepts that must be considered as such when put into practice.

3 EAST ASIAN COMMUNITIES IN QUEBEC

GENERAL PROFILE

East Asian communities come from a region also known as the "Sinosphere" (or the area of the world where people "eat with chopsticks"), where China's cultural, religious and political influence has been fundamental (Vietnam was colonized by China for no fewer than a thousand years). The elements shared by these communities include the imprint of Confucianism on social relations (the family hierarchy reproduced in the state, respect for elders and intellectuals, the valuing of education), Taoist philosophy and especially Buddhism, which branched off into different disciplines in contact with Indigenous societies, leading to the emergence of Zen or Tibetan Buddhism.

These communities are all represented in Quebec and Montreal, but their statistical numbers are divergent. For example, the net Chinese predominance is relatively recent (120,000 individuals primarily from mainland China who speak Mandarin, but also from Hong Kong, who mostly speak Cantonese, as well as 2,000 Taiwanese and about a hundred Tibetan refugees), coupled with a strong and longer-standing Vietnamese presence (about 43,000 individuals, many of whom are of Chinese-Vietnamese origin, who arrived in the late 1970s and 1980s: Quebec therefore is already home to a third generation of Vietnamese). People of Korean (fewer than 9,000) and Japanese (just over 6,000) descent therefore make up relatively smaller communities. Other forms of diversity are linked both to the recent history of East Asia and to migratory waves in Quebec: the Vietnamese and Chinese communities are more likely to report being Francophone than other Asian communities, and while socio-economic level varies between and within communities, each one has a high rate of university graduates. The majority of Koreans in Quebec are Christians (Protestants) and not Buddhists.

HEALTH, ACCESSIBILITY, PREVENTIVE PRACTICES

East Asian communities generally show great respect for health care professionals (who are overrepresented in the Vietnamese community compared to Quebec's native-born population: 10.4% of Vietnamese workers in Montreal are in the health sector compared to 5.5% of the Quebec-born workforce in 2003: Blanc & Monnais, 2007) and a historical familiarity with biomedicine and a biomedical health system. This does not mean that immigrants have no problems accessing health services in their host country, as language barriers in particular are correlated with the aging of these populations.

Preventing disease and other health risks, both individually and collectively, is a systematic priority for harmony between the individual and society, the micro and the macro, nature and man, as well as longevity, as advocated by Confucianism, Taoism and Buddhism. Prevention is expressed through Buddhists' tendency

to practice regular physical exercise (e.g. qi gong) and meditation and to use talismans (Salguero, 2020) as well as through practices of pluralistic therapy, i.e. combining biomedicine with age-old traditional medicines. While these medical traditions have been integrated for some time in the health systems of these countries of origin (referred to as "integrative health systems"), we must not forget that the Quebec public health system is also relatively open to these practices (i.e. through access to Natural Health Products Regulations or to acupuncture: Blanc & Monnais, 2007) and therefore may have the potential to reinforce effective medical and health practices. It should be noted that, although this has not actually been documented in their host countries, East Asian communities' focus on preventing infectious (or even pandemic) risks may have increased in recent decades due to direct or indirect experiences with serious epidemic threats (SARS, avian flu, H1N1) in their countries of origin (especially in China and Vietnam), i.e. by family who stayed in these countries.

VACCINATIONS AND EAST ASIAN COMMUNITIES

Vaccinations, the first being against smallpox, were introduced very early in East Asia in the 19th century. They were quite widely accepted as an extension of the smallpox vaccination campaign, although, in the case of Vietnam, which was colonized by France, compulsory vaccinations did give rise to violent reactions that were more political than health-related. China, Vietnam, Japan and Korea have had highly developed and effective vaccination policies since World War II as well as a high level of vaccine production capacity.

This is not to say that vaccine hesitancy is not present in these societies, as low vaccine confidence has been present for a long time in Japan and is still strong in that country (de Figueiredo et al., 2020), particularly due to a series of accidents and vaccine safety scares (MMR vaccine, whooping cough and HPV), all of which eroded trust in the state's concern for collective health starting in the 1960s and 1970s. Skepticism about vaccination is also growing in the major Chinese cities, fuelled by an authoritarian state that has attempted to hide scandals such as the hepatitis-B vaccine scare, the contaminated baby formula scandal, and quality defects in vaccine production at the Changchun Changsheng Biotechnology company in 2018 (Hu et al., 2020). This phenomenon has also appeared in Korea (where the "anti-vax" group ANAKI is reportedly particularly active: Chang & Lee, 2019) and with individuals who report to be practising Buddhists (Larson et al., 2016).

Some studies have also shown that in some East Asian communities, reluctance to get vaccinated is likely to increase with longer-term residence abroad (Truman et al., 2020) and that vaccine decision-making related more strongly to certain products for cultural reasons (linked to social representations of female sexuality in the case of HPV) or due to ignorance of the risk posed by a vaccine-preventable disease (hepatitis B, influenza) (Wilson et al., 2018; Jorgensen et al., 2016; Kowal, 2014).

EAST ASIAN COMMUNITIES, THE PANDEMIC AND FAKE NEWS

The Chinese community in Quebec and elsewhere has been subject to racist incidents and discrimination given that the pandemic originated in China and that the virus has been described by many, including world leaders, as the "Chinese virus" (Pâquet, 2020). This stigmatization—which other Asians also experience

through an ignorant lumping together of people from different communities—has reactivated deeply rooted social representations, i.e. of a "dirty" society that is too close to animals and wet markets that are particularly prone to spreading pandemics (Pâquet, 2020). It is therefore easy to imagine that this racism has had harmful effects on the daily lives of these same communities and their ability to adapt to the health situation, for example, when it comes to getting tested or seeking medical attention for symptoms. It is also known that COVID-19 has resulted in excess morbidity and mortality among visible minorities, including Asians (Subedi, Greenberg, & Turcotte, 2020).

Under these conditions of stigma, a reluctance to get vaccinated is also likely to increase; the excess morbidity/mortality experienced by these communities could at the same time convince people to get vaccinated if, of course, the vaccine is geographically and culturally accessible. In this case, it is important to emphasize the strong determining factor of links maintained with the country of origin, including over extremely popular national social networks (such as Weibo: Hu et al., 2020) and international platforms (What's App) as well as with East Asian communities in other countries (particularly in the U.S.) that could tip the balance in all sorts of directions: from high confidence in a domestic "made in China" vaccine (Lin et al., 2020) for the Chinese community to skepticism fuelled by the failures of the flu vaccination campaign conducted in South Korea in fall 2020 for Koreans (Yang, 2020), or even increased belief in conspiracy theories among the Vietnamese community, which is largely anti-communist and mostly in favour of Trump.

4 SOUTHEAST ASIAN COMMUNITIES IN QUEBEC

GENERAL PROFILE

As a region, Southeast Asia is often known for its extreme ethnic, linguistic, cultural, religious, and socio-economic heterogeneity. Comprising ten countries from India to Oceania (Brunei, Cambodia, Indonesia, Laos, Malaysia, Myanmar [Burma], the Philippines, Singapore, Thailand, East Timor) with 600 million people, this region is home to both the world's largest Muslim community (over 200 million Indonesians) and Asia's largest Catholic community (75 million Filipinos, or 80% of the country's population). Socio-economic disparities are high in this area both between countries—Singapore has the 4th highest GDP in the world while East Timor is the poorest country in Asia—and within countries, with tensions between urban and rural areas. The issue of ethnic minorities, and their place in state/civil society relationships, is crucial, particularly in terms of mainland Southeast Asia (which has no fewer than 160 minorities in Laos and 130 in Myanmar) and the Chinese diaspora, which is very old and very dynamic and has mixed with Indigenous populations everywhere. As their only historical commonality (with the exception of Thailand), Southeast Asia experienced Western colonization at the end of the 19th century (including U.S. colonization of the Philippines after many centuries of Spanish domination) and Japanese occupation during World War II, a double imperialist experience that marked this society including in terms of the political construction of nation states, a number of which have become authoritarian regimes.

While these realities, and particularly ethnic and religious diversity, must be taken into account to avoid assuming that all Filipinos are Catholic or that all refugees from Laos are from the Lao ethnic group and speak Lao, it must be noted that Southeast Asian communities in Quebec and Montreal are statistically less represented than East Asian communities, with the breakdown as follows: mainly Filipino (38,000, most of whom are Tagalogs from an immigration wave since the 1980s primarily driven by economics), Khmer (15,000, from Cambodia, mostly refugees from the 1975-1979 Khmer Rouge genocide) and Lao (just under 8,000), compared to 2,700 Thai, fewer than 1,000 Muslim Malays from Malaysia or Indonesia and fewer than 100 Burmese, Karen and Hmong, the last semi-nomadic mountain-dwelling minority in mainland Southeast Asia that fled primarily to California after the Vietnam War (1963-1975). Mainly Catholic and Buddhist, Southeast Asian communities have a variable education level (the percentage of post-secondary education is higher among Filipinos than among Khmer) but one that is lower overall than that of East Asian communities. The same is true of their socio-economic status, although again this varies between and within communities.

HEALTH, ACCESSIBILITY, PREVENTIVE PRACTICES

As with other ethno-cultural communities, a number of barriers to accessing health services in the host country have been documented (in addition to those mentioned for East Asian communities, there may be a heightened distrust of the state on the part of Khmer and Lao refugees and ethnic minorities). However, Southeast Asian communities, and particularly Buddhist communities, are also known for their adherence to pluralistic, sustainable and effective preventive practices (Salguero, 2020). Previous immigration experience may impact their willingness to follow public health guidelines in their host country. People who lived through the Khmer genocide, for example, did not become familiar with biomedical care under the anti-Western and anti-intellectual Khmer Rouge regime (fewer than half a dozen doctors were left in Cambodia when the Khmer Rouge were ousted in 1979: Guillou, 2009); this shortage may also have been coupled with mistrust in an overly intrusive state. The same is true for some ethnic minorities who were persecuted in their countries of origin and who were accustomed to non-biomedical prevention and treatment practices given the extreme shortage of care and limited contact with a health system that was primarily intended for the ethnic majority in these countries. The resulting culture shock among the Hmong minority was documented in anthropologist Anne Fadiman's well-known 1997 book The Spirit Catches You and You Fall Down.

VACCINATIONS AND SOUTHEAST ASIAN COMMUNITIES

Familiarity with vaccination in Southeast Asian communities came with Western colonization in the 19th century, and from the very beginning of the 19th century in the case of the Spanish Philippines with the Balmis expedition (1803-1806). This familiarization is longstanding but a double-edged sword, in that colonial states often imposed this preventive practice as a tool of social control and experimented with vaccines on local populations without their consent (e.g. the BCG tuberculosis vaccine during the inter-war period). The Japanese occupation during World War II also left deep scars, for example, due to abuses, including scientific experiments, that the government committed in the region.

The construction of Southeast Asian nation states post-1945 also gave rise to very fragmented public health policies, including the vaccination policy: many countries must still rely on the generosity of NGOs and WHO-supported programs (e.g. the Expanded Programme on Immunization, 1977-) to provide mass vaccinations for the main childhood diseases. While vaccination rates against these same diseases have increased at an impressive rate in the past two decades, reaching some rural areas in the Philippines or Cambodia remains difficult. The highly mobile ethnic minorities in Laos or the Muslim minority in southern Thailand (the Jawi) are often considered particularly resistant to state intervention when it comes to their health and vaccination, which is seen as a way to monitor them. The lack of education in their own language based on their own cultural references has been used to counter the argument of "ethnic resistance" often put forward by the states themselves (Anonh et al., 2017).

SOUTHEAST ASIAN COMMUNITIES, THE PANDEMIC AND FAKE NEWS

Southeast Asian communities have also experienced discrimination and even stigmatization with the COVID-19 pandemic; they are among the visible minorities who have experienced excess morbidity and mortality from the disease since the first wave, a reality that may impact prevention practices for the disease, including vaccination. Possible mistrust of, and even frustration with, the state may be reinforced in some communities by what is going on in their countries of origin, in terms of both the pandemic and vaccination, as well as by affairs and scandals from previous vaccination campaigns. Contrary to popular belief, vaccine hesitancy is not limited to developed countries. This phenomenon is found in many Southeast Asian countries and is likely to spread through immigrant communities known to maintain very close ties with their countries of origin or who travel there regularly. While vaccine hesitancy is reportedly increasing in many major Malaysian and Indonesian cities (Wong et al., 2020; de Figueiredo et al., 2020), driven by the power of social networks (in the case of Indonesia, in connection with radical Islamist movements who consider vaccines as haram: Yufika et al., 2020), the case of the Filipino community deserves special attention. Vaccine hesitancy or even a refusal to get vaccinated in the archipelago has reportedly increased considerably since 2017 in the wake of a vaccine scandal (involving Sanofi-Pasteur's Dengvaxia® dengue fever vaccine that was the probable cause of a series of deaths in children), which was covered extensively by the media and directly linked to a major measles outbreak in 2018 (Migriño et al., 2020).

5 LATIN AMERICAN COMMUNITIES IN QUEBEC

GENERAL PROFILE

According to the 2016 census data (Gouvernement du Québec, 2016), Montreal's Latin American communities make up about 4% of the city's total population and formed through several waves of immigration, with large flows of refugees fleeing Chile starting in the 1970s, then Central America (Guatemala, El Salvador, Honduras, Nicaragua) and, more recently (after 2000), Colombia and Mexico. About half of immigrants from these countries have a refugee or equivalent status, and a significant number were born in Quebec or have been here for over 20 years. The most numerous are of Colombian (34,000), Mexican (27,000) and Central American (about 36,000) origin. There is also a large Peruvian population (20,000), a quarter of whom have refugee status. French-language proficiency rates are high in these groups, with an average of around 90%.

BIOMEDICINE AND VACCINATION IN LATIN AMERICA

Latin America was an early target of continent-wide elimination/eradication projects (measles, polio) through vaccination. Vaccination coverage rates in this region are very high on the whole but may vary in time and place. Distrust of governments, the strong influence of the Catholic Church, and health inequalities may be barriers to vaccine confidence (Guzman-Holst et al., 2020).

In general, Indigenous and Afro-Latino populations face problems of exclusion and discrimination in health care systems. Indigenous groups in the Amazon basin and along the Caribbean coast are relatively less vaccinated in part due to problems with civil registration and thus "visibility" in the eyes of these states (McSweeney & Pearson, 2013). Private services and insurance often play an important role in delivering health care in some countries, which limits access for the poorest people.

For a long time in Guatemala, family planning and vaccination campaigns have often been met with distrust, particularly from the fear around hidden intentions to forcibly sterilize rural populations (Clouser, 2018). In 2009-2010, a historian revealed that secret experiments had been conducted in Guatemala in the late 1940s in collaboration with American researchers and institutions (Reverby, 2016). The subjects—sex workers, prisoners, soldiers and mental health patients—were deliberately inoculated with STDs (syphilis, gonorrhea, and chancroid); some were then treated with trial antibiotics and others were left untreated. The uncovering of this program led to an official apology from the U.S. government, denunciations from human rights groups, and a presidential commission in Guatemala (Comisión presidencial, 2011).

Mexico and Nicaragua were among the countries where religious influence and distrust in the state have given "traction" to a rumour spread by an international Catholic group in the mid-1990s that the tetanus vaccine had sterilizing effects (Larson et al., 2011). In 2014, an HPV prevention campaign in Colombia was accompanied by reports of diffuse symptoms—headaches, limb pain, fainting—in hundreds of vaccinated adolescent girls. A controversy ensued about the cause of the symptoms. Although the official conclusion was a psychogenic phenomenon ("collective hysteria"), the debates raised concerns about the risks associated with vaccination (Téllez Pedroza, 2018).

COVID-19, VACCINES AND FAKE NEWS IN LATIN AMERICA

Latin American countries, and particularly their Indigenous populations, especially in Mexico and Brazil, have been hit hard by the pandemic (de Léon-Martinez et al., 2020). Populism and religion have also fed an official denial of the severity of the situation in these countries. Almost all fake news in Spanish identified through social media monitoring come from Latin America (Smith et al., 2020). The same dominant themes can be seen as for other languages; however, relatively more messages about morality and religion are conveyed. Some speak about a divine power guiding scientific discoveries, while others preach that divine remedies ("the blood of Christ") are more powerful compared to the vaccines, which are deemed ineffective. Much discussion has been had about the Russian vaccine, which is used to either celebrate or criticize capitalism (reflecting the political tensions that run through the continent) as well as the incompetence and corruption of governments (Ibid).

Surveys indicate that Latinx communities living in the United States have concerns about COVID-19 vaccines but are not as hesitant as African Americans and have more confidence in political and scientific institutions (COVID Collaborative, 2020).

6 ARAB COMMUNITIES IN QUEBEC

GENERAL PROFILE

The Arab world is vast and far from homogeneous. Stretching from Morocco to Yemen, this part of the world is home to approximately 450 million people who speak dozens of languages and dialects, although Arabic is the main idiom. Jews, Christians, agnostics and atheists are found in this part of the world, even though Islam is the dominant religion. Given the complexity and richness of this civilization, it is difficult to boil it down to a few representative aspects. This fact sheet will therefore focus more on the main countries of origin of Quebec's "Arab community," including Northwest African countries (Algeria, Morocco, and Tunisia) and Lebanon (Ministère de l'Immigration, de la Francisation et de l'Intégration, 2016).

In Quebec, nearly 400,000 people identify as being of Arab origin (Ibid). In terms of population, they represent the second largest "ethnic minority" in Quebec behind the African and Afro-Caribbean communities. According to the 2016 census (Ibid), nearly 88% of people of Arab origin live in the Montreal metropolitan area. These individuals mainly come from Algeria, Morocco, Lebanon and, more recently, Tunisia and Syria (Ville de Montréal, 2017). In Quebec, the Arab population has been growing steadily since the 1990s. Nearly 60% of Quebeckers of Arab descent are first-generation immigrants. The percentage of Arab immigrants who come to Quebec for economic reasons is 70%. For the rest, nearly 22% come to join family members, while nearly 8% leave their countries due to humanitarian crises (Ministère de l'Immigration, de la Francisation et de l'Intégration, 2016).

Over 90% of Arab Quebeckers are fluent in French, as the majority come from French-speaking regions, such as Northwest Africa and Lebanon (Ibid). Although a large majority of Arab Quebeckers are Muslim, a sizeable minority are Christians and Sephardic Jews (Institut du monde arabe, 2019).

BIOMEDICINE AND VACCINATION IN THE ARAB WORLD

The Arab world has placed special importance on both scholarly and popular medicine particularly since the advent of Islam in the seventh century. The work of renowned physicians such as Rhazes (9th to 10th centuries) or Avicenna (10th to 11th centuries) were taught at leading European universities until the 19th century (Jacquart and Michaud, 1990; Mekki-Berrada, 2013) before being replaced with biomedicine and microbiology as these traditions developed.

In recent decades, 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: life expectancy is increasing, and maternal and child mortality are rapidly declining (Nations Unies, 2019). However, these countries continue to face political, social, and economic challenges that have strained their health systems and threatened access to care (SHOPS Plus, 2019). In 2010-2011, high rates of unemployment and poverty as well as political repression triggered a major wave of protests and revolts known as the Arab Spring. This led to violent conflicts in countries such as Iraq, Libya, Syria, and Yemen, which gave rise to new problems and slowed advancements in health care (SHOPS Plus, 2019). The COVID-19 pandemic has therefore been a critical test for these countries that are either war-torn or redeveloping their economies, such as Lebanon, which became paralyzed from events such as the explosion in the main port of Beirut in August 2020. According to the Organisation for Economic Co-operation and Development (OECD), the pandemic has also laid bare major underlying structural problems. Issues such as the alarming shortage of hospital beds and the lack of testing capacity during the first wave of the pandemic were among the factors that had a strong impact on public trust in the credibility of leaders and their management of the health crisis (OECD, 2020). However, the rapid and strict strategies of health care systems in other countries, such as Morocco, were effective at limiting the spread of the virus thanks to the production of masks and the acceleration of at-home testing (Ibid). Administrations in many countries such as Tunisia and Saudi Arabia eventually showed that they had a strong capacity to mobilize and implement preventive measures while providing economic stimulus to support households and businesses (Ibid).

Vaccinations were deployed in many Arab countries during the French colonial period, particularly after the creation of the Pasteur institutes at the very end of the 19th century and with the organization of massive campaigns against smallpox, diphtheria and tuberculosis before those against polio and measles (Bouazzaoui, 2006). Today, vaccination is generally accepted, with campaigns against COVID-19 in full swing throughout Northwest Africa (TV5 Monde, 2021). However, Muslims have shown increased demand for information about the impact of vaccines on fasting and the practise of one's faith during highly sacred times, such as the collective fasting month of Ramadan (Canadian Muslim Covid-19 Task Force, 2021). Some strict Muslims in Northwest Africa (Dahmani, 2020) as well as Quebec exhibited initial resistance to the vaccine and attempted to promote traditional ethnobotanical recipes (Clément, 2020). Nevertheless, the urgency of vaccination quickly became apparent to populations who chose to trust the state. In some countries, such as Algeria, Lebanon and Iraq, the difficulty of deploying a vaccination campaign has driven political opposition, which has occasionally been fuelled by restrictive measures imposed without regard to people's socioeconomic conditions (Sly, 2020).

RACISM, HEALTH, AND CARE IN QUEBEC

Relations between Arab and Muslim communities and other majority and minority communities in Quebec have been severely tested over the past two decades. These communities have felt tensions from prejudices stemming from the "war on terror," questions about their Quebec identity, and debates over diversity management that have led to hostile positions regarding accommodations requested by

minority religious groups (Commission des droits de la personne et de droits de la jeunesse du Québec, 2019; Létourneau-Desjardins, 2020). The visible and religious minorities most targeted by hate crimes in 2017 were by far those who identified as Muslim and/or Arab (Commission des droits de la personne et de droits de la jeunesse du Québec, 2019). In 2020, people who identified as being part of Arab communities reported the poorest mental health indicators in the context of discrimination related to the COVID-19 pandemic in Quebec (Miconi et al., 2020).

Arab communities are also not immune to other forms of direct, indirect or systemic discrimination, including racial profiling, which has led to differential treatment by police (Schué, 2020). While 60% of the members of Arab communities in Quebec hold a college diploma or university degree (Statistique Canada, 2016), they face employment challenges, such as the ineligibility of international degrees or hiring discrimination (Beauregard et al., 2019, p. 35). While the average unemployment rate in Quebec for those aged 15 and over is 8.9%, this rate rises to 12.5% for citizens who identify as Arab (Statistique Canada, 2016). In light of these conditions, these communities have been more affected by the pandemic and its adverse impacts. In concrete terms, many people from these communities have come up against barriers to accessing health care services or have experienced discrimination that has increased their chances of contracting COVID-19 (Direction régionale de santé publique de Montréal, 2020).

COVID-19 AND FAKE NEWS IN THE ARAB WORLD

Like the rest of the world, Arab countries have had to cope with the spread of unsubstantiated information about the pandemic and vaccinations on social networks. In Northwest Africa, "fake news," particularly about the AstraZeneca vaccine, has affected the vaccination campaign (Dari, 2021). The Moroccan, Algerian and Tunisian authorities chose to take a firm stance against this phenomenon and even resorted to laws—considered as curtailing freedoms by some—to punish anyone who spreads false information about the pandemic (Dahmani, 2020). Tools were also created to fight disinformation among refugees in Lebanon and Jordan (UNHCR, 2021), and the Lebanese authorities launched measures to counter fake news by creating an information verification page on the National News Agency website (Libanews, 2020).

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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