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Introduction/Objectives

Since 3 January 2020, France has documented some 7.219.357 confirmed cases of COVID-19 and 116.166 deaths.¹ As of late November 2021, nearly 51 million (87.9%) people over age 12 in the country have received full vaccination in France.²

France has experienced five waves of pandemic morbidity and mortality, and its government has imposed three national lockdowns since the beginning of the pandemic. During the first (17 March-11 May 2020), schools and universities were closed; non-essential travel was forbidden; non-essential sites were also shut down; social distancing and remote work were imposed, and non-essential travel forbidden. The second lockdown (28 October-1 December 2020) saw the closure of non-essential businesses, but schools and factories remained open. Masks, social distancing and remote work and instruction (where possible) were also implemented. Although limited lifting of restrictions occurred between December 2020 and April 2021, a strict curfew (18:00) remained in place throughout this period. A third lockdown was implemented between 3 April and 3 May 2021. Sites gradually opened in May, and the curfew was lifted on 30 June.³

Because France has been considerably affected by the COVID-19 pandemic, and that the burden of disease and mortality disproportionately affected those with lower income and living in intergenerational housing,⁴ our objectives in conducting this Vulnerability Assessment was to:

- Identify the health and other vulnerabilities (social, economic, cultural) resulting from the pandemic and measures imposed to control transmission;
- Examine the factors contributing to these vulnerabilities and their consequences.

Our data collection took place during periods of strict curfew, distance work, and the third lockdown.

Description of work/Methods

Study sites

We collected our data in two sites: Ile-de-France (Paris, Seine Saint-Denis), and the Communauté agglomération des Territoires Vendômois. These sites were selected for their socioeconomic and geographical characteristics to permit comparison of the Covid-19 pandemic and its consequences for urban and rural populations. Most data collection took place between March and July 2021, although we interviewed some local stakeholders between October 2020 and February 2021.

Participant recruitment

Participant recruitment took place through multiple means. Following the study protocol, the team first identified 11 groups who based on our preliminary interviews with various

¹World Health Organization, *WHO Coronavirus (COVID-19) Dashboard*, <https://covid19.who.int/region/euro/country/fr> (data last updated 24.11.2021), viewed 25.11.2021

² Gouvernement.fr, *Vaccins*, [https://www.gouvernement.fr/info-coronavirus/vaccins?xtor=SEC-3-GOO-\[-511245726400\]-S-\[%2Bvaccination%20%2Bcovid](https://www.gouvernement.fr/info-coronavirus/vaccins?xtor=SEC-3-GOO-[-511245726400]-S-[%2Bvaccination%20%2Bcovid) (data last updated: 23.11.2021), viewed 25.11.2021

³ Gouvernement.fr, *Les actions du gouvernement: chronologie des actions*, <https://www.gouvernement.fr/info-coronavirus/les-actions-du-gouvernement>, viewed 25.11.2021

⁴ drees.solidarites-sante.gouv.fr. DREES, Inserm, *Enquête EpiCov (Epidémiologie et Conditions de vie sous le Covid-19)*, <https://drees.solidarites-sante.gouv.fr/sources-outils-et-enquetes/enquete-epicov-epidemiologie-et-conditions-de-vie-sous-le-covid-19#toc-pour-en-savoir-plus>, viewed 25.11.2021

stakeholders had been particularly adversely affected by the pandemic and whose characteristics could be plausibly linked to health vulnerabilities. Through contacts with various NGOs and associations, we recruited our first set of participants among these groups. We then inquired, as part of the interview, whether they knew someone who they perceived to be especially affected, and if they could put us in contact with this person. This approach was moderately successful. Pandemic restrictions made both snowballing and direct recruitment (where participants were approached by fieldworkers without intermediary) challenging. In addition, some participants had very limited social networks and could not refer us to. The involvement of local NGOs and associations was the most effective means of recruitment.

Conduct of interviews and data analysis

Data was collected following a “global” VA protocol developed for WP7 by UCL which was implemented in all partner sites (France, Italy, Germany, Malta, and Slovenia). The protocol outlines steps to administer Vulnerability Assessments and includes a demographic questionnaire, a semi-structured interview guide, a field summary template for ethnographic observations (See appendix), as well as a code manual and guidance on analyses.

The interview guide constitutes the core of the VA data collection. In France, all questions were translated into French, Wolof, Italian, Spanish, and English, piloted, and revised where needed by the fieldworkers. Some interviews were conducted via video (Teams, Zoom, Skype, WhatsApp) or phone, which increased the difficulties of contacting certain socioeconomic groups and of collecting ethnographic observations. We mitigated these challenges by posing additional questions of participants about their experiences of the pandemic, as well as work, study, and living situations. Assessments administered in person followed a strict COVID-protocol (1.50 m distances between researcher and participant, ventilated spaces, use of clean masks supplied to researcher and participant).

We carried out most interviews in two-person teams, consisting of a senior or post-doctoral researcher and a junior researcher. The lead researcher would ask questions from the questionnaire and interview guide, and a secondary researcher took notes and supplied prompts where needed. Exceptionally, one expert researcher would carry out the interview, notably when participants requested that only one person be present.

We made every effort to avoid making participants feel stigmatized for being selected for the study. For example, we adjusted and refined questions in the initial stages of research and accounted for participant responses to our terminology. Because the term “vulnerable” is considered problematic in French, we avoided using it in connection with participants, instead replacing it with terms such as “marginalized”, “excluded”, “weakened”, “at risk”. We also invited participants to share their pandemic *experiences*, rather than their *troubles* or *difficulties*.

All interviews were transcribed verbatim. We adapted the codebook suggested by UCL to convene better to data collected. All interviews and supplemental notes from meetings with authorities and leaders of nongovernmental organizations and associations were coded by two experienced researchers in NVivo. From these codes, we used Thematic Analysis to identify broader, cross-cutting themes.

Summary of major findings, policy recommendations, and concluding remarks

Summary of major findings

The study was conducted in Ile-de-France and the Communauté d'agglomération Territoires Vendômois between February and July 2021, collecting 149 vulnerability assessments and 20 supplemental interviews with field actors. Of our 149 VA interviews, 106 (71%) took place in Ile-de-France and 43 (29%) occurred in the Vendôme region. Participants' median age was 43 (IQR 31,55) years old and ranged between 21 and 95 years. There were 56 (38%) men, 89 (60%) women, and 4 (2.7%) non-binary participants. Ninety-four (63%) of participants were born in Europe and eighty (53.7%) in France. Thirty-eight (26%) participants were born in Africa, 9 (6.0%) in the Americas, 6 (4.0%) in the Eastern Mediterranean; one participant in South-East Asia and one in the Western Pacific. Fifty-eight (38.9%) participants said they had a chronic disease when questioned. Further discussion, however, yielded ninety-two (61.7%) participants describing chronic conditions that met Haut Conseil de la Santé Publique (HCSP) criteria for chronic disease.

The VA protocol and data collection generated important, actionable insights that can both inform policy-making at the local and national level and that can potentially shape social sciences discourse on COVID-19 vulnerabilities.

We have identified the following key findings:

1. Institutional constraints rendered participants vulnerable to adverse health consequences (health vulnerability). Institutions, tasked with assisting people, put severe constraints on their agency (capacity to make their actions felt in their worlds) during the pandemic and as a result, exacerbated their sense of isolation, incertitude and powerlessness in the short term and may be contributing to reducing their wellbeing and overall health in the longer term. We found that residents and workers within nursing homes, asylum seekers in reception centers, those seeking housing assistance in emergency shelters, hospital workers, and students in universities shared this sense of constraint on their capacity to act.

These constraints socially isolating beneficiaries and workers and exacerbated uncertainty among these populations. Students, for instance, experienced serious social isolation and lost their sense of purpose in their studies and internships. Uncertainty about when in-person classes would recommence and about their prospects in job markets, students recounted that they experienced major mental health problems. This immediate situation combined with ruptures in training can have potential longer-term consequences on the economic, social and broader health of this generation.

2. Eroded trust in various institutions and professions could also exacerbate health vulnerability during the pandemic. Most participants contended that their trust in (national, not local) government, certain medical practitioners, and the mainstream media had been eroded. In some cases, this erosion had predated the pandemic, and in others, the pandemic itself had contributed.

Many respondents argued that their trust in government had declined significantly, exacerbated by an incoherence in public health policy and restriction measures (on transportation, work, PPE, public spaces openings, etc.) during the pandemic.

Medical practitioners were also the subject of criticisms. A substantial number of participants indicated that they resorted to biomedical diagnosis and treatment only as a last resort, when alternative remedies and treatments (homeopathy, naturopathy, acupuncture, etc.) did not resolve their suffering. Several women recounted that their doctors did not listen to their

concerns, particularly related to chronic pain or gynecological issues. Doctors, the indicated, would downplay the gravity of symptoms or give palliative remedies, rather than providing an exhaustive and informed investigation and diagnosis of the causes. The consequence was that these patients would conduct “their own research” online to identify alternative explanations and treatments for their health problems. Other participants expressed lack of trust of “celebrity” scientists and doctors, who gave contradictory speeches and participated in endless debates online and on television.

The media (online, offline) and its role in facilitating an “infodemic” (onslaught of information, often contradictory and sometimes misleading or untruthful) came in for significant criticism by most participants. Frequent media reports of epidemiological statistics (deaths, hospitalizations, intensive care saturation, etc.) cultivated a sense of continuous urgency, rendering viewers anxious. Some participants responded by triaging the information that they received, whereas others simply tuned out, recentering on their family, friends, and personal physicians.

The consequences of declining trust are crucial, but further analysis and investigation (linkage with other datasets, for instance) are necessary. Erosion of trust in physicians encouraged lay publics to seek out alternative explanations and treatments for their ailments, but at times channeled them toward online health workers (formal and informal) opposing COVID-19 vaccination. We encountered multiple informants who knew that their physicians wanted them to receive the vaccine, but who were more substantially influenced by online “experts”. Higher vaccine hesitancy and refusal among young women and those of child-bearing age (identified in other studies), for instance, may thus be linked to chronic pain not being taken seriously by their physicians, although this question requires further investigation.

This search for alternatives was compounded by eroded trust in government and the media, which may have lent additional strength to vaccine hesitancy and refusal, as well as protests against other government measures to control the pandemic.

3. **Barriers to accessing aid and public services were another factor contributing to health vulnerability.** Despite the existence of aid and assistance at multiple levels, many participants either did not know or did not use available assistance (COVID or more general), even if they had the right to do so.
 1. Some **lacked trust** in the structures and organizations providing aid and assistance, contending that they had been disappointed by a lack of help in the past or because they did not believe in the structural efficacy of associational or public aid.
 2. Still others experienced **extreme social isolation**, most frequently new arrivals to France and those who were homeless. Some participants explained they had been introduced in the system thanks to chance encounters on the street with individuals who had shared information with them.
 3. Several **structural problems** obstructed access to aid and assistance.
 - a. The **opacity of administrative procedures** (for instance, for health care or housing) forced aid-seekers into bureaucratic loopholes, as well as the scarcity of resources in the public or associational aid domain (e.g. lack of public housing).
 - b. The **penury of public and emergency housing** in the Paris region made it difficult for the most economically vulnerable to have stable housing. In addition, proximity of Vendôme to Paris attracted wealthier Parisians to this rural area (particularly after multiple confinements). But it also increased housing prices in the Vendôme region,

making it difficult for long-time and economically more vulnerable inhabitants of the region to afford housing.

- c. The **price of medical consultations and treatments** could be very high for those without good supplemental medical insurance.
 - d. The Agglomeration des Territoires Vendomois was a **medical desert**, where general practitioners and specialists were few, distant from some villages, and overwhelmed by patients. Patients also expressed mistrust in the quality of care that they received.
 - e. **Mental health care** could be very difficult to access or afford in both sites. Several participants explained they had to stop, reduce, or could not initiate psychological consultations because of high treatment costs of private practitioners and long waiting lists for public ones.
 - f. The **closure** of public spaces, associations' centers, soup kitchens, legal help desks disproportionately affected many groups -- the homeless, those needing food assistance, residents of public housing and reception centers.
4. **Difficulty asking for help** constituted a type of **cultural vulnerability**, which also contributed to health vulnerability. This difficulty was reflected in some participants' convictions that they "did not have the right" to request help, that they were not suffering "enough" or came from too privileged a background (notably among women coping with domestic violence and students). Migrants residing in France without residence papers feared that seeking assistance could potentially lead to surveillance and eventual deportation by immigration authorities.
4. The **relative absence of solidarity in both rural and urban sites contributed to health and social vulnerability on the community level**. Many of our participants in both urban and rural sites contended that their buildings, neighborhoods and villages lacked solidarity during the pandemic. Those coming from Paris complained, too, that they were profoundly socially isolated. Most of our Ile-de-France participants described relying on family and friends (if they had them) to assist, but in many cases could not describe building or neighborhood actions of solidarity and assistance.

Policy recommendations

- Make housing more available for those needing it in Paris region
- Some efforts to manage the exodus of high-income people from Paris to rural zones, which can drive up housing prices for those who need housing in these zones.
- Invest in promoting inclusivity and revitalizing communities, through the promotion of social and cultural activities and economic investments that promote spatially-based (neighborhood, village) solidarities
- Build bridges across socially isolated populations (elderly, students, asylum seekers, cultural workers), using skills and experiences of individuals
- Promote existing aid/assistance structures and availability, by ensuring that publics understand what is available, where, and for whom; by reducing doubts, fears, stigma around use; and by underscoring the distinctions between equity and equality
- Simplify procedures for access to assistance and aid
- Develop emergency communications protocols for institutions (EHPADs, CADA, hospitals etc.) which are flexible and account for beneficiaries' differential capacities to understand and act upon information provided.

- In rural zones, explore solutions that can increase availability of GPs and specialists and address the difficulties of public transportation services to and from hospitals and medical hubs
- Increase funding for insurance coverage for mental health care

Conclusion

Our next steps are three-fold. First, we will continue to supplement our evidentiary base with additional interviews that enable us to reach factory workers, sex workers, and restaurant/bar/nightclub workers. Second, we will pursue deeper analyses of our collected data and examine possibilities for linking any results to larger databases. Third, we are preparing to meet with our Advisory and Action Committee (the fourth meeting that we will have had with this group) so that committee members can work collaboratively to identify the most feasible and productive policy interventions and future steps.

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