

Mario Cardano, Dino Numerato, Luigi Gariglio, Jaroslava Hasmanová Marhánková, Alice Scavarda, Piet Bracke, Ana Patrícia Hilário, Paulina Polak

A team ethnography on vaccine hesitancy in Europe. A case study of a local truth construction

(doi: 10.1423/112399)

Rassegna Italiana di Sociologia (ISSN 0486-0349)

Fascicolo 4, ottobre-dicembre 2023

Ente di afferenza:

()

Copyright © by Società editrice il Mulino, Bologna. Tutti i diritti sono riservati.

Per altre informazioni si veda <https://www.rivisteweb.it>

Licenza d'uso

Questo articolo è reso disponibile con licenza CC BY NC ND. Per altre informazioni si veda <https://www.rivisteweb.it/>

A team ethnography on vaccine hesitancy in Europe A case study of a local truth construction

by MARIO CARDANO, DINO NUMERATO, LUIGI GARIGLIO,
JAROSLAVA HASMANOVÁ MARHÁNKOVÁ, ALICE SCAVARDA, PIET
BRACKE, ANA PATRÍCIA HILÁRIO, PAULINA POLAK

1. *Introduction*

The summarised report about a field of research always contains only a very small part of the worker's relevant experience, and not even the most important. Missing is that which makes the stylised visual perception of form possible. It is as if the words of a song were published without the tune (Fleck 1979, 96).

This essay presents a critical narrative about ethnographic section of an international research into childhood vaccine hesitancy in seven European countries: Belgium, Czechia, Finland, Italy, Poland, Portugal and the UK, financed by the European Union¹ (Vuolanto *et al. in press*). The study, planned before the Covid-19 pandemic, started immediately after its outbreak, being forced to adapt its pace to the new dramatic scenario, urging the planned ethnography to become a rapid team ethnography (Vindrola-Padros 2021). This shift contributed to defining a specific «thought style» (Fleck 1979) shared – with some nuances – by the team members. In what follows, we attempt to transmit to the reader – with Fleck's words in exergue – the missing «tune» of the research story, aware that we can offer a tame version of the decisions the research team makes, being ourselves the storytellers. Karin Knorr-Cetina, in the same line as Ludwik Fleck, maintains that our knowledge is «decision laden» (1979, 5). This paper shows the theoretical and methodological decisions that have shaped our notion of vaccine hesitancy. But

¹ This study was funded by a project from the European Union's Horizon 2020 research and innovation programme under Grant Agreement No 965280.

before starting with the story, let's say a few words on vaccine hesitancy.

Vaccine hesitancy is a long-lasting, complex societal phenomenon. Despite being recognised as the most successful public health intervention for preventing infectious diseases (Andre *et al.* 2008), vaccines are widely contested regarding their efficacy and safety (Dubé *et al.* 2013; Dubé *et al.* 2014). In Europe, vaccine hesitancy has been growing steadily in the past two decades (Larson 2018), raising concerns among policymakers since it has contributed to the drop in vaccine uptakes and the resurgence of some infectious diseases. Moreover, it is a crucial issue for healthcare professionals who face the effects of the broader phenomenon of the contestation of expertise in their everyday work situations and struggle to build a trusting relationship with patients². Vaccine decisions are portrayed as «a spectrum of behaviours and beliefs from the rejection of all vaccines to active support of immunisation recommendations» (Feemster 2013, 1752). Vaccine-hesitant individuals are usually positioned in the middle of the continuum between vaccine take-for-granted acceptance and non-negotiable refusal. The Strategic Advisory Group of Experts (SAGE) on Immunisation convened a Working Group which defines vaccine hesitancy as follows.

Vaccine hesitancy refers to delay in acceptance or refusal of vaccination despite availability of vaccination services. Vaccine hesitancy is complex and context specific, varying across time, place and vaccines. It is influenced by factors such as complacency, convenience and confidence (MacDonald, *The SAGE Working Group on Vaccine Hesitancy* 2015, 4163)³.

The international literature on vaccine hesitancy is vast but mainly based on quantitative studies that offer an undoubtedly relevant overview of the phenomenon without the essential details about the argument that sceptical people advance. Available qualitative studies – mainly based on interviews – conceal the interaction between parents and healthcare professionals, the rele-

² On the relationship between expert and popular knowledge, see the relevant contribution by Collins, Evans, Durant, Weinel (2000). Interestingly enough, in Charles Thorpe's book presentation we can read a reference to Fleck's conceptual coupling of esoteric and exoteric knowledge.

³ The complacency, convenience and confidence triade refers to vaccine-preventable disease risk perception, vaccines availability, the health system and healthcare professionals' trust.

vance of which appears when studying the topic ethnographically (for a review of qualitative studies, see Dubé *et al.* 2018; Diaz Crescitelli *et al.* 2020; Majid, Ahmad 2020). Not only parents but also healthcare professionals may entertain doubts about vaccination. A recent qualitative study (Karafillakis *et al.* 2016) of vaccine providers in Croatia, France, Greece, and Romania analysed healthcare professionals' concerns about vaccination. The research shows that healthcare professionals' vaccine hesitancy is present in all countries, and vaccine safety is the most critical concern. Healthcare professionals, as well as their patients, seem to overestimate the risk of side effects and, at the same time, underestimate the risk of infection from vaccine-preventable diseases. A recent review has discussed the role of healthcare professionals' vaccine hesitancy (Verger 2022). In our study, we observed the interaction between parents and healthcare professionals, considering this interaction and the trust emerging from it as one of the sources of vaccine hesitancy.

In this paper, we aim at to two primary interwoven targets. One is offering the scientific community the natural history of Vax Trust research, allowing the evaluation of the soundness of the research findings that will be distilled from the rich empirical material acquired. The other is to read this research's natural history as an instance of constructing a local truth (Geertz 1983) in one of the current ways of doing social research: in international teams funded by government institutions (the European Union in our case)⁴. In addition, the paper attempts to describe the emergence of a specific «thought style» (Fleck 1979) within which the notion of vaccine hesitancy is locally built. Summoning Ludwik Fleck to frame a study on vaccine hesitancy's methodological path seems particularly appropriate. The Polish scholar was a bacteriologist and microbiologist, therefore in tune with

⁴ Clifford Geertz introduces the notion of local knowledge by reflecting on law from a comparative perspective (Geertz 1983). In that context, the US anthropologist defines the scope of ethnography as follows: «Like sailing, gardening, politics, and poetry, law and ethnography are crafts of place: they work by the light of local knowledge» (Id. 167). The quotation addresses the space- and time-bound of ethnographic statements. In this paper, to the general features of the ethnographic research underlined by Geertz, we add another aspect contributing to defining the contingent nature of the proposed truth about vaccine hesitancy, the functioning of the observational tools, including in this case the team committed to the study. In other words, «local» means a «truth» conditioned either by the specificity of the studied contexts (the seven countries) or by how they are studied.

the medical aspect of our story. Fleck – although tardily – is unanimously recognised as one of the most brilliant epistemologists of the past century. In his *Genesis and Development of a Scientific Fact* – published in the original version in 600 copies in 1935 – Fleck anticipated most ideas that oriented the epistemological critical turn of the second half of the XX century. The Kuhnian notion of paradigm (Kuhn 1962) has – in our view – clear roots in the more convincing and flexible paring of «thought style» and «thought collective» (Fleck 1979, 38 ff.)⁵.

Fleck defines the thought style as «[readiness for] directed perception, with corresponding mental and objective assimilation of what has been so perceived» (Fleck 1979, 99)⁶. The thought style can be defined as the shared Gestalt through which a scholars' group frame their research experience. Fleck offers the notion of «thought collective» to designate the social dimension of the scientific enterprise in what follows.

The communal «carrier» of the thought style is designated the thought collective. [...] A thought collective exists whenever two or more persons are actually exchanging thoughts. This type of thought collective is *transient and accidental*, forming and dissolving at any moment. But even this type induces a particular mood, which would otherwise affect none of the members and often recurs whenever these members meet again (Fleck 1979, 102-103, italics our)⁷.

The story told here can be considered the narrative of creating a specific thought style embedded – temporarily – in the European team working on the Vax Trust team ethnography. It is a story of a micro-decision sequence that clearly illustrates the «decision ladenness» (Knorr-Cetina 1981, 5) through which methods, concepts and passing theories are drafted. In the frame of the present special issue, the reflexive account (Altheide,

⁵ In the Foreword of English translation Fleck's book, Thomas Kuhn recognises his intellectual debt to *Genesis and Development of a Scientific Fact* – albeit with a certain reluctance. «I have more than once been asked what I took from Fleck and can only respond that I am almost uncertain. [...] The lines in the margin of my copy of the book suggest that I responded primarily to what had already been very much on my mind: changes in the gestalts in which nature presented itself and the resulting difficulties in rendering «facts» independent of «point of view». (Kuhn in Fleck 1979, Foreword: viii, ix).

⁶ In other words, the «thought style» is a kind of «seeing something as something» in Wittgenstein's meaning (Wittgenstein 1958, first original edition 1953).

⁷ Compared to the Kuhnian notion of paradigm, the pairing of «thought style» and «thought collective» shows a higher degree of flexibility and seems more suitable for describing the transient constitution of the research groups in our sociological community.

Johnson 1994) proposed here can be considered an instance of the collective construction of a temporarily *truth* performed in a team that, as usually occurs, is beset by conflicts, sometimes shallow, sometimes profound. The notion of local truth can again be framed in Fleck's not-fully-exploited conceptual repertoire: «Truth is not a convention, but rather (1) in historical perspective, an event in the history of thought, (2) in its contemporary context, stylised thought constraint» (Fleck 1979, 100). The team ethnography story took shape in a particularly critical moment: the pandemic crisis. We were studying the hesitation towards childhood vaccinations when society was committed to combating the Covid-19 virus, and the health institutions that made the Covid-19 vaccination mandatory.

The rest of the paper is organised as follows. Section 2 focuses on the relevance of the team-building process. Section 3 – the core of the paper – delves into the research design and describes the functioning of the «thought collective» committed to carrying out the Vax Trust study, namely the «method in process» (Davidson 2019, 72). The paper concludes with some methodological remarks.

2. *Building the team*

The team working on the Vax Trust project was gathered by the first author of this work. At the end of February 2019, the members of ESA Research Network 16, Sociology of Health and Medicine, received, from the first author, a draft of the forthcoming Horizon 2020 call «Addressing Low Vaccine Uptake», with an invitation to participate. The invitation implied the establishment of a research network which, in a second step, would have to identify the principal investigator. Thirty expressions of interest emerged in a few weeks, including those currently involved in the project and others. The first collective activity of the team was to identify the principal investigator (PI) as a scholar with a robust track record of project publications on the specific topic of vaccination. Two names emerged: this paper's second author and another colleague with a solid background in vaccinations and in CAM (Complementary and Alternative Medicines). They were asked to express their availability to lead the research group,

and a couple of months after the beginning of our adventure, we had found our PI, helped by a very efficient management staff⁸.

The network that drafted the research project was composed of scholars without previous relevant scientific relationships, very like a «blind-date approach» (Davidson 2019, 41). This particular genealogy of the group was possibly responsible for the frictions among partners.

The whole research project was collaboratively developed during three in-person meetings (in the pre-Covid era). Besides defining the content of the research proposal in these meetings, the current team was composed after careful consideration of the size (number of countries) and scale (diversity of cultural contexts) viable for a consortium. The scholars eventually on board were based in seven countries, showing considerable heterogeneity in their national healthcare systems, vaccine coverage, vaccination policies, and health cultures, making the expected comparison quite promising. As happens frequently in the European Union funding frame, the «thought collective» planning to perform comparative research emerged through only one partially-guided procedure. The promising heterogeneity of points of view that would contributed to the «thought style» of the team was a partly accidental result, although a happy one. Then Covid burst onto the scene, and the following planning activities – four meetings – were carried out online.

Vax Trust Project (see Vuolanto *et al. in press*), combines three research lines and two intervention-oriented activities. In the Vax Trust frame, we carried out a secondary analysis of the attitude toward vaccinations based on the Eurobarometer archive. Then we moved toward analysing media discourses, later starting with the rapid team ethnography (see Section 3). After the differentiated data collection procedures in all seven countries, a training intervention directed to healthcare professionals was implemented and evaluated to define a set of recommendations.

The foreseen ethnographic study was profoundly challenged by the emergence of a new social scenario. Due to Covid-19, access to paediatric structures was governed by strict sanitary rules, which were not easily manageable in an ethnographic study.

⁸ After an attentive reading of the last version of the paper, the PI decided not to sign it due to her disagreement on some relevant aspects of the reconstruction of the natural history of the research, particularly on the carrying out of the team ethnography.

These objective reasons were strengthened by the scepticism toward ethnography that some research group members showed. At that time, the research group faced a critical step when some members – the PI included – considered the possibility of excluding the ethnographic fieldwork. Luckily this did not happen, and the Vax Trust research group agreed pragmatically to perform a rapid version of the ethnographic fieldwork described in Section 3. Coming to terms with the PI on the ethnographic fieldwork was not a given. At first, the PI did not show unconditional support for the ethnographic work and criticised the possibility of an international comparison grounded on the team ethnography. We finally solved the problem unanimously.

Neither all the consortium members nor all the authors signing this paper shared or currently share the critical view expressed above. The alternative reading justifies the scepticism exhibited against ethnography based exclusively upon the critical contingent situation. From this point of view, the unexpected scenario imposed a rethinking of the original research project, including long-lasting ethnography into healthcare facilities. Furthermore, in this frame, the reservations about the ethnographic study's feasibility were magnified because of the perceived difficulty of getting ethical clearance from national ethical committees. The differences in the reading of the natural history of the study here exposed can be considered another instance of manufacturing the truth (in the meaning of Knorr-Cetina 1981) based on different views that cannot easily be framed in the worn triangulation's metaphor⁹.

As mentioned above, the definition of the research design and its implementation took place at a particularly critical moment: the pandemic emergency at the beginning of the research path and – to a different extent – the war in Ukraine during the conclusion of the empirical phase. The difficulties created by these dramatic events had two connected effects. Most group activities were carried out online. This constraint slowed down the creation of trusting relationships between the research group members. Mutual trust, as is well known, is a fundamental ingredient in organisational configurations called upon to manage

⁹ In her seminal book, *The Manufacture of Knowledge*, Karin Knorr-Cetina maintains that what we define as facts are constructed through a set of procedural decisions making truth decision-laden (Knorr-Cetina 1981, 5 ff.).

complex activities without stringent hierarchical constraints, the configurations Herry Mintzberg labels as «adhocracy» (Mintzberg 1983, Chapter 12). Access to the observation sites slowed down, and the availability of parents and healthcare professionals to be involved in an in-depth interview was obtained with difficulties. Some interviews with parents and healthcare professionals were carried out online. These unplanned changes in the societal context demanded even greater flexibility than planned in our research strategy, imposing adaptation of the original plan.

3. Team ethnography: a reorientation toward a rapid version

Established as the queen of qualitative methods since the end of the XIX century (Junker 1960), ethnography assumed a kind of mythological image based on the *tòpos* of the «Lone Ranger» (Erickson, Stull 1998, 2), who immerses him/herself alone in a challenging arena, gaining the participants' complete trust through a troubled initiation to their culture. The stereotype of the Lone Ranger was commonly inscribed in the magic methodological formula based on the 1:1:1 ratio: one researcher, one village, one year (Hackengerg 1983, 13). Over time, all the aspects of this mythological image have been challenged. The rapid ethnography approach has challenged the one-year ingredient, based on brief site visits (Vindrola-Padros 2021). Multi-sited ethnography has challenged the one-village formula's component, based on a simultaneous or sequential observation of a set of sites (Marcus 1995). The third formula's constituent, that of the solo observer, has been challenged by the team ethnography approach (Erickson, Stull 1998; Davidson 2019) – Junker called it «group ethnography» (1960) – oriented to benefit from the combination of different points of view, focusing on a set of sites that a solo researcher cannot embrace.

The ethnography on vaccine hesitancy follows this emerging stream, combining all its waves. It is team ethnography, carried out in 24 sites in 7 countries, and in a short time. Performing team ethnography in a comparative study allows the cooperation of ethnographers who master the local language. The team approach adopted allowed the combination of different points of view in a dialectical confrontation that promoted the emergence of a set of robust intersubjective findings.

The team involved in the «rapid ethnography» was led by the two first authors of this paper, with the close collaboration of the other Turin and Prague research group members. The team's management structure can be defined as mildly hierarchical (cf. Davidson 2019, 17). The two team ethnography leaders made crucial decisions on the research design, but usually after an open discussion with all the team scholars. They both were committed to the fieldwork activities, which offered them practical competencies in governing the group (cf. Mauthner, Doucet 2008, 980). The main problems impinging on the teamwork activities were the heterogeneity of the ethnographic competencies and familiarity with the research topic of the scholars enrolled for ethnographic fieldwork. We faced both challenges in organising a set of webinars – named Ethnographic Café – as tools for harmonising theoretical and methodological perspectives between (and within) groups by defining shared principles. A dialectical disposition imbued all meetings. We all gained from what Judith Davidson describes as a «circle of differences» (2019, 99) by using positionality, and theoretical and methodological differences among scholars as resources to create a critical version of intersubjectivity. Along the same line, we tried valorising interpretive and methodological conflicts to improve our statements' robustness (cf. Erickson, Stull 1998, 56; Wasser, Davidson, Bresler 1996, 19), although this was not always easy.

One example of the dialectical posture is the attempt to write a joint theoretical paper on the concept of vaccine hesitancy. Two sets of researchers started group discussions to draft the paper. Through discussion and writing, they gained a deeper understanding of their different positions without reaching a consensus, as can often happen within international and cross-cultural qualitative research groups (Bresler 2002). During multiple online meetings, the two groups' divergent views on the concept of vaccine hesitancy came to light. One group was persuaded that attitudes towards vaccination could be considered along a spectrum, where all the different categories (acceptance, refusal and hesitancy) are equally distributed among more and less reflexive perspectives. Conversely, the second group opposed equating acceptance and refusal/hesitancy because the last two attitudes consist of stances resistant to regulatory guidance, which may be subject to sanctions in both the researchers' countries. We voiced this disagreement and expressed these alternative in-

terpretations of the research results, which became even clearer while drafting the first sections of the paper. The writing attempts and the subsequent multiple group online and offline discussions were clear examples of a negotiation of values and boundaries (Wasser Davidson, Bresler 1996) among researchers, which cast into focus different cultural and epistemological backgrounds, interpretations of the researchers' roles and commitments to the research process. We ended up consensually and independently with the idea that a single text could not communicate multiple meanings and insights (Bresler 2002), and we accepted the multiplicity of our perspectives. We agreed to work on different texts. In writing our various papers we were convinced that we were taking advantage of the hours of passionate discussion we had had before reaching the decision.

We worked as a team of teams, «separately together» (Siltanen *et al.* 2008). In each country, fieldwork was carried out by a small group of scholars, different in gender, age, academic status, institutional background and experience in qualitative research. We had to plan, perform, and coordinate the seven national ethnographies quickly, framing our activities as a «rapid ethnography» (Vindrola-Padros 2021) for the reasons listed below.

Vax Trust is a study that combines research and intervention (see Vuolanto *in press*). The time scheduled for the team ethnography was twelve months, in which, in all seven countries, we had to observe the interaction between parents and healthcare professionals and carry out in-depth interviews with healthcare professionals and parents. The heterogeneity of the competencies in ethnographic research of the scholars enrolled in the study (most of them were early career) required time to define shared principles guiding data collection. Reflecting on the ethnography schedule, we think we underestimated the time requested for this study, considering the diversity of the institutional contexts, i.e., in the time required to get ethical approval. Overall, we carried out 466 observation hours, with a minimum fieldwork time of 22 hours in the UK and a maximum of 174 in Italy.

With this short time in the field, the question that immediately arises in an attentive reader's mind is: «Can such a rapid ethnography be really considered an ethnography?». Those who pose this question recognise the epistemic value of ethnographic research, committing themselves to distinguishing between real and pretended ethnography. This debate has mainly developed in

anthropology where, as maintained above, the rule of at least one year in the field defines the received view for most scholars. The anthropological community can, therefore, be properly considered a critical case (Cardano 2020, 78-83) for reflecting on the issue of the minimum time required to carry out good ethnography. What we conclude for the anthropological community can be said to be *a fortiori* for the sociological community, where the tradition of a long-lasting presence in the field isn't as rooted as in the anthropological community¹⁰. The tricky issue of defining the «appropriate amount of time» (Vindrola-Padros 2021, 18) to be spent on the field is tied up to a set of features of the «being there» experience. For instance, Cupit *et al.* (2018) maintain that gaining the participants' trust and access to their backstage activities becomes problematic if the time is not long enough. It is also difficult to listen to the «less powerful voices» (*ibidem*, 259) and meet unexpected, serendipitous events in a short time. The shortness of time can limit the possibility of recognising the complexity and nuances of the phenomenon studied. Last but not least, a rapid ethnography can be too theoretically thin and mute on the crucial issue of the researcher's positionality.

The matter of the appropriate time pertains to the Sorites Paradox (Oms, Zardini 2019). The more common illustration of the Sorites Paradox is that of the bald man. Let's consider a man without hair; undoubtedly, he can be considered bald. But what about a man with only one hair on his head; can he be considered bald, too? Probably yes. Carrying on in this line, adding one hair after another, it becomes difficult to detect the exact number of hairs which allows distinction between a man who is bald and one who is not, being between them only a hair of difference¹¹. Suppose we substitute the hairs on the head with the days spent in the field, the logical difficulties of

¹⁰ A reviewer's comment forced us to reflect on this issue to avoid the representation of the sociological community as less rigorous than the anthropological one. We disagree. After the golden era of the Chicago School, sociological ethnography had to cohabit with more structured quantitative methods, presenting an idea of rigour that was the mainstream for a long time. In sociology, plastically expressed by the Grounded Theory approach, the need to defend a different idea of rigour imposed constant methodological reflection on the heterogeneous world of qualitative research, which was not requested in the anthropological field, where ethnography is the mainstream.

¹¹ In a quasi-formal way, the Sorites paradox can be expressed as follows: «For every n (n stands for a number), if a man with n hairs is bald, so is a man with $n+1$ hairs» (adapted from Oms, Zardini, 2019, 7).

distinguishing based on the duration of what is and what is not true ethnography emerges. In the philosophical literature, we find many attempts to solve the vagueness problem expressed by the Sorites Paradox (cf. Oms, Zardini 2019). The one that we consider most convincing refers to the so-called «Degree Theory», for which – in a nutshell – susceptible Sorites' arguments, baldness or sound ethnography can be better expressed through fuzzy logic (Paoli 2019)¹². In this perspective, the detection of cutting point which separates real from false ethnographies loses its relevance.

Another methodological frame seems more appropriate, borrowed from the historiography. Considering the ethnographical data as texts (cf. Davidson 2019, 25), not so different from those analysed by historians grappling with our predecessors' lives, what we should do is limit the questions for which our text can offer a plausible, evidence-based answer. Jerzy Topolski defines the capacity of a text to answer our research questions as «authenticity range» (Topolski 1977, 434; original edition 1973) framing the methodological problem at issue by drawing closer to the data profile with research questions¹³. Ethnographies with different depths – due to their duration and to the researcher's way of being in the field – are equipped with a diverse authenticity range; they can offer plausible answers to sets of questions which vary in their broadness. What really matters seems to be the appropriateness of focalisation of our vision and, thereby, of our research question (cf. Knoblauch 2005). Moving from this perspective, we calibrate the questions to be addressed with the robustness of the empirical material acquired in each local ethnography.

Returning to the natural history of our research, the primary logical and, in a way, chronological steps of the study included i) the selection of cases: the sites to be observed and the people to be interviewed; ii) the definition of grids for the observation and in-depth interviews. These two steps will be illustrated in what follows.

¹² For an informal presentation of the fuzzy sets theory, close to sociological sensitivity, see Cardano (2020, 17 ff.).

¹³ Topolski defines the range of authenticity of a historical document as «the sum of those questions (problems) to which a given source can provide true answers» (Topolski 1977, 434, original edition 1973; Cardano 2020, 74 ff.).

3.1. *Case selection*

The issue of the choice of cases must be faced from two different points of view: the definition of the set of countries involved in the study and the selection of cases to be analysed – organisations and people – in each country. The composition of countries engaged in the study is not the results of a fully deliberated choice. As usually happens in establishing an international research network, the seven partners decided to join together, attracted by the European call and paying attention to the requests for a sound comparative research design. If we must frame the countries' selection in a sampling design, it can only fit with a convenience sample. Regardless of its origins, the eloquence of the self-selected countries' array can and must be evaluated. Childhood vaccination is compulsory in four Vax Trust countries: Belgium, Italy, Poland, and the Czechia. In the UK, Finland, and Portugal, vaccines are only recommended. The seven countries offer sufficient heterogeneity of European vaccine policies' legal and organisational aspects. The practical organisation of vaccine inoculation differs significantly throughout the research consortium (see Table 1). The diversity of the seven countries also emerges from the cultural and geopolitical points of view. In addition to a Fennoscandinavian country, Finland, we have two countries in Southern Europe, Italy and Portugal, that share some cultural similarities. Poland and the Czechia have a Soviet Union legacy that still impinges on their societies to different degrees despite diverging religious attitudes. Then we have in the consortium the UK, which is outside the European Union. Overall, we can maintain that the composition of the set of countries in the consortium offers enough «potential for comparison» (Barbour 2007, 53).

From an operative point of view, in all countries the study focused on some restricted areas (target regions) that are more manageable for ethnographic study and subsequent interventions¹⁴.

The choice of cases within the consortium's seven countries implied the individuation of the organisational context to be observed and the recruitment of parents and healthcare professionals for in-depth interviews. The more appropriate and

¹⁴ The study focuses on the Helsinki, Piedmont, Nottingham/East Midlands, Flanders, Prague, Malopolska, and Lisbon regions.

accessible contexts for the field observation were identified with a short questionnaire filled in by all consortium members. The questionnaire's findings allow us to define the kind of site to observe, guaranteeing sufficient heterogeneity among contexts. Each country's site selection considered the need for evidence on discourses and vaccination practices. In some countries, namely in Finland and Belgium, these two activities are performed in the same institutional place; in the other five, the healthcare professional responsible for children's care is not the person who inoculates the vaccines. Thus we could count on more than one site in these countries, identified with some degree of freedom by the local research groups. Therefore, it was possible to observe contexts where taking note only of discourses on vaccinations – from paediatricians and GP clinics – and contexts where discourses and material practices are interwoven – hospitals, vaccination centres and specialised agencies¹⁵.

In general, each country's observation site selection was guided by the «most different system design logic» (Przeworski, Teune 1982, 31-39; original edition 1970; Cardano 2020, 83-87). The heterogeneity sources considered were suggested by the pertinent literature on vaccine hesitancy (in particular, Delaruelle *et al.* 2021; Dubé *et al.* 2014) and related to the features of the area where clinics, agencies, and centres are based: urban versus rural, big or small demographic dimensions; the socioeconomic profile of the neighbourhood: working-class versus affluent; high versus low concentration of cultural minorities – namely social groups outside mainstream religious beliefs. Where possible, in the selection of medical clinics (held by paediatricians and GPs), we consider the healthcare professional reputation with regard to childhood vaccines, distinguishing between critical and mainstream professionals. These observational sites' selection criteria were applied in a context-sensitive manner. The implementation of these general criteria was harmonised with national vaccination policies and the local organisation of childhood care and moulded by the field-access barriers which characterised each country. The final case selection design is illustrated in Table 1.

¹⁵ In some countries, this information was enriched by ethnographic data collected in different settings within different hesitant community meetings: parents' movements meetings, workshops, demonstrations.

Tab. 1. Description of countries' observation sites

Countries	Healthcare professionals' surgeries		Health organisations or health agencies		
	GP surges-ries	Paediatricians' surgeries	Hospital	Health care centres	Specialised agencies
Italy		2 sites		2 sites: Vaccination centres	
Portugal			1 site	1 site	1 site: a private clinic
Belgium					6 sites: Office de la Naissance et de l'Enfance
Finland					3 sites: Child Health Clinics
UK	2 sites				
Poland	3 sites		1		
Czech Republic		3 sites			

To enrol parents and healthcare professionals in the interviews, we combined a set of context-sensitive procedures through which the hidden population of hesitant parents (Faugier, Sargeant 1997) was targeted. The inclusion criteria adopted addressed families with children between 0 and 7 years who show hesitancy, doubts, and/or scepticism toward childhood vaccines. We adopted three main strategies, different from the wealth of information used to guide our theoretical sampling¹⁶. Through the first strategy, we tried to enrol hesitant parents in the general population of young parents, inviting them to participate in a study on childhood vaccines using different kinds of filters. In the simplest version of this strategy, the research team distributed informational flyers on the Vax Trust project in places habitually attended by parents with young children or more selectively contacted through emails or online newsletters, parent students or generic groups interested in parenting. Our most targeted procedure addressed the general population with the Prolific platform, using as a filter a Likert scale that analysed parents' attitudes toward childhood vaccines.

¹⁶ For a more analytical description of the hesitant parents' sampling, see Hilario *et al.* 2023.

Through the second sampling strategy, hesitant parents' enrolment was guided by a set of clues suggested by the pertinent scientific literature¹⁷. In this case, the invitation to participate in the study was directed to selected populations known for their possible caution or scepticism toward childhood vaccines. In line with this, the research group proposed an interview through adverts in Facebook communities of parents who declared an alternative lifestyles or by contacting the same population through informational flyers distributed where these parents usually physically met. The team members' personal knowledge was also used to contact acquaintances who could be hesitant. In the same direction, some people were directly invited to participate in the study, betting on their vaccine hesitancy for their known commitment to CAM or alternative lifestyles. Finally, we vainly contacted the managers of alternative schools inspired by Steiner's philosophy, asking them to propose, on our behalf, an interview with the pupils' parents. Applying the third strategy, we moved from attitude to behavioural information. In this case, the proposal to participate in the study was addressed to the parents who expressed caution or hesitancy during the observed inoculation procedure. The ethnographer who observed these behaviours approached the parent in the waiting room to schedule an appointment for the interview. A further recruitment strategy that can be positioned between the attitudes- and behaviour-centred procedures was adopted. Three cultural mediators working with the immigrant Muslim North African communities were enrolled. We asked them to find some hesitant parents among their reference community. Some parents of this theoretically important minority were singled out and interviewed by the researcher and the cultural mediator responsible for contacting the participants.

Independently of the recruitment strategy adopted, we requested interviewees' cooperation to help us find other candidates for the interview, employing canonical snowball procedures. Among the heterogeneity criteria adopted in the sample selection of hesitant parents, we included social class and membership of cultural minorities. From neither points of view did we reach optimal results: middle-class parents were over-represented, and cultural minorities under-represented.

¹⁷ This second strategy can be framed within the so-called «evidential paradigm» (Ginzburg 1978).

The healthcare professionals' sampling inclusion criterion was direct involvement in communication and practices concerning childhood vaccination. Among healthcare professionals satisfying this requirement, we tried to maximise heterogeneity by considering gender and age. It was impossible to fulfil the heterogeneity requisite in all seven countries due to the specificity of the local demographic structure of healthcare professions. The healthcare professionals in a broader meaning included doctors, nurses, midwives, and doulas. We adopted different strategies to contact the healthcare professionals who wanted to propose the interview. First, we involved all the healthcare professionals we met on site in observational activities, allowing us to compare what they said and did, following Deuthscer's advice to consider two dimensions as not necessarily aligned (Deutscher 1973).

Additionally, the healthcare professionals who proposed the interview were identified by considering the interviewed parents' suggestions in both directions, for better or worse. We also counted on the aid of professional orders that indicated the names of healthcare professionals more committed to childhood vaccinations through word-of-mouth and parents' websites. We again used snowball procedures from the healthcare professionals who agreed to participate in the study to enlarge the sample dimension.

The planned sample design for healthcare professionals asked all the national teams to include some vaccine-hesitant or critical healthcare professionals. Critical healthcare professionals belong to a hidden population that tries to remain in the background to avoid not only stigma but also legal persecution. For this reason, critical professionals were recruited only in a few countries (Czechia and Italy) and with few doctors, nurses and midwives. This sample outcome imposed particular caution in analysing the healthcare professionals' critical views¹⁸.

Both for the interviews with parents and with healthcare professionals, where it was possible, considering the national habits,

¹⁸ To identify the sceptical healthcare professionals, we used a set of clues. First, we considered the professional's self-presentation on the clinic's website. Secondly, we investigated the healthcare professionals' reputation based on parents' word-of-mouth, discussion forums, public Facebook groups, and their membership in associations or organisations of parents or professionals nursing critical attitudes toward child vaccinations. Thirdly, as a clue of critical dispositions, we focused on the position expressed by professionals on CAM, natural birth, and prescriptions of homoeopathic or naturopathic medication.

culture and local university ethical guidelines, participants received a symbolic remuneration. These strategies have been thoroughly assessed to avoid connotations of bribery and coercion. Table 2 describes the final composition of the sample of parents and healthcare professionals.

Tab. 2. *Number of interviews with parents and healthcare professionals*

Country	Parents' interviews	Healthcare professionals' interviews
Belgium	15	39
Czechia	33	18 (3 hesitant)
Finland	24	25
Italy	23	23 (6 hesitant)
Poland	23	22
Portugal	31	30
UK	11	14
Total	160	171

3.2. *Deciding how: observation and in-depth interview grids*

The grid for field observation and the guide for in-depth interview definition involved all the consortium members in online meetings where different methodological and theoretical orientations were confronted. For the observation grid, we agreed to consider the notion of hesitancy as a sensitising concept (Blumer 1969) meant to guide our gaze without circumscribe it¹⁹. The observation grid suggested three main thematic areas: i) the description of the observed site, ii) the interaction between parents and healthcare professionals, and iii) participant profiles.

In describing the observed site, we focused on the material culture, considering whether and how the discourses on vaccines were embodied and if they were branded with explicit reference to pharmaceutical companies. Particular attention was devoted to the site's baby-friendliness. A few short notes on the organisation of the observed site were recommended to the

¹⁹ «Whereas definitive concepts provide prescriptions of what to see, sensitizing concepts merely suggest directions along which to look» (Blumer 1969, 148).

ethnographers. We also annotated the features of the area around the observed site (e.g., in the city centre or on the outskirts of the city, predominantly inhabited by upper-class or lower-class people; whether well-run or run-down). To observe the interaction between parents and healthcare professionals, we agreed to consider each visit as an autonomous unit of analysis, focusing mainly on deviations from the detected ordinary routine. We dedicated particular attention to hesitant behaviour and what we labelled «near-miss hesitancy»: under-track hesitancy that did not emerge only for fortuitous reasons. In the description of the «actors» on stage, we considered all the framing aspects (detected inconspicuously, without an explicit request addressed to participants), such as gender, estimated age, type of clothing, linguistic register (proficiency in the national language, slang), emotional tone of the interaction.

The research team defined both the interview guides as a list of potential questions in the academic lingua franca, English, to be translated into the local language with some degree of liberty to make the questions appropriate for the context of their use. We fully adopted Tim Rapley's advice on the flexible use of interview guides, for which the interviewer doesn't «have to ask the same question in the same way in each interaction» (Rapley 2004, 18).

The grid for the interviews with parents contained 17 questions through which we focused on: i) the parents' attitudes toward childhood vaccines; ii) how, in the family, they reached the position adopted; iii) the perception of social pressure toward vaccination; iv) criteria of paediatricians' choices; v) participation in the public debate on vaccines or vaccine-critical groups; vi) families' sociodemographic data. Approaching hesitant parents, we adopted an open cognitive posture by recognising Raymond Boudon's «good reasons» for parents' caution, doubts and vaccine scepticism (2003). We adopted this posture for methodological reasons – to facilitate self-disclosure (Rapley 2004, 23 ff.) and for ethical reasons – to avoid the stigmatisation of interviewees.

The grid for the healthcare professionals' interview contained 25 questions through which we focused on i) respondents' definition of not fully vaccine-compliant parents; ii) respondents' perception of the reasons for parents' hesitancy; iii) daily practice in talking about vaccines and facing parents' vaccine hesitancy; iv)

professionals' attitudes toward national vaccine policy and their degree of compulsion (asking, where vaccines are mandatory, whether the respondent agrees with this measure; and where vaccines are recommended, if they should be mandatory); v) respondents' sociodemographic data, their offspring vaccine status included. We modified this interview guide for the hesitant professional interviews, making it easier for them to express their critical views.

3.3. *The fieldwork*

In the seven countries, the fieldwork started with misalignments due to the difference in timing of getting ethical clearance and access. The people involved in the fieldwork ranged between one to four. In three out of the seven countries, Belgium, Finland and the UK, the work was organised as a «double team» (Erickson, Stull 1998, 17), with the senior scholars committed to managing activities and the early career involved in the field. In the other four countries, both senior and junior scholars were involved in the fieldwork. The involvement of the team ethnography leaders in data collection guaranteed a more attentive guide to the study (cf. Mauthner, Doucet 2008, 980). In each observed site, the ethnographers organised their presence to maximise the time devoted to observing interactions between parents, newborns, and toddlers with healthcare professionals in the least intrusive way possible. During fieldwork, we had monthly online meetings devoted to collective discussions of emerging methodological and ethical issues and the initial provisional results. For these purposes, each national team shared some translated extracts of the data collected during the meeting, triggering evidence-based discussions. In May 2022, we organised a two-day meeting in Turin, where all the national teams, except one, participated. In addition to joint online and in-presence meetings, some one-to-one meetings between the team ethnography leaders and the single national team were scheduled to face specific local methodological, ethical, or substantive issues. All the online sessions were video recorded. Videos – enriched by essential minutes – were shared among research groups.

As mentioned above, the management of the team was mildly hierarchical and committed to a dialectical posture (Wasser

Davidson, Bressler 1996, 10). Through these – sometimes challenging – discussions, we built a kind of intersubjectivity, capable of include overcoming conflicts and dissent among us caused by the plurality of voices. Close to the end of the data collection, we defined an NVivo template for data categorisation²⁰.

We carried out the interviews with parents and healthcare professionals in parallel with the field observations, gaining inspiration for the contents of our interviews from the observation activities²¹. This allowed us to enrich further the focus of interviews foreseen in the guidelines.

As we said above (see Section 3), the team ethnography carried out was compressed in time and, therefore, exposed to the criticism advanced of rapid ethnographies and effectively summarised by Cupit *et al.* (2018). As already hinted, Cupit *et al.* underlined the difficulty of gaining participants' trust in the brief time available for rapid ethnography as one of the greatest weaknesses. We understand the point but also recognise that this problem affects the seven national studies in different ways: more for the shorter ones, less for the longer ones. In the just-started data analysis, we consider the differences in the authenticity range (Topolski 1977, 434) that characterise the collected evidence and will cope with it pragmatically. However, we observed mainly routine activities, reasonably more governed by time constraints than observational perturbation (Cardano 2020, 32-33), a kind of reactivity provoked by the presence of the ethnographers in the field. Starting from the title of the study: «Addressing Vaccine Hesitancy», most of the ethnographic teams presented themselves to healthcare professionals as aligned with the mainstream approach to childhood vaccinations, depending on this for a rather large trust credit. Cupit and Colleagues maintain that, in a short time, the ethnographer cannot access the backstage activities. This was the case for most of the observational activities. Anyway, it does not jeopardise the robustness of the study, which is focused

²⁰ The template definition was designed following the indication of Nigel King (2012) in the simplified version proposed by the first author of the paper (Cardano 2020, Chapter 5).

²¹ This mutual influence was magnified in the Italian study, where the local team could recruit hesitant parents in the field and in this way, carry out ethnographic interviews, where we had the possibility to ask for the participants' views of their interaction with healthcare professionals, interactions that the interviewer-ethnographer observed too.

on the interactions between parents and healthcare professionals in the *health institutions stage*. The two pertinent last criticisms that Cupit and her colleagues advanced undermine the robustness of our rapid ethnography more deeply. It is a matter of fact that, in the sites observed, we couldn't give voice to the less powerful figures in healthcare professionals' communities. Instead, giving voice to the hesitant parents was one of the most important achievements of our study. Since observers were perceived as being pro-vax, the healthcare professionals, nurturing doubts or criticisms, could hardly have shared their views with the ethnographers. The interviews with hesitant healthcare professionals compensated for this limitation to some extent²². We also have to accept Cupit and colleagues' objection concerning the possibility – in a short time – of actually grasping the multifaceted nuances of the interactions between parents and healthcare professionals. We grasped some of them, and observed due caution in data interpretation.

The most widespread criticism toward rapid ethnographies, namely their theoretical frailty, does not apply to our study. We collected data quickly, but were slower in data analysis. During the writing of this essay, all the consortium members have been involved in a theoretically-oriented close reading of the empirical materials, spending the usual unlimited time in distilling our academic papers.

4. *Concluding remarks*

After this deep immersion in research practices delving into the complex world of childhood vaccinations, a few concluding remarks are due. We will develop our consideration in an argumentative space between a team ethnography reflexive account (Altheide, Johnson 1994) and a broader discussion of the competitive European research policies.

Starting from this last point and our experience, it emerges that the European call can trigger a «blind-date approach» (Davidson 2019, 41) to the constitution of research groups. Encouraging the constitution of this kind of research group can impose a

²² With regard to the hesitant parents' voices, we are more confident of having given them the possibility of expressing a critical view of childhood vaccines.

vast heterogeneity in newborn «thought collective» (Fleck 1979). This heterogeneity can be a resource but also a problem. The heterogeneity in national research regulations, particularly from the ethical point view, can produce misalignment among national research groups. The blind-data approach in the constitution of the research group can also produce heterogeneity in scholars' competencies and motivation. Another significant risk, in Vax Trust experience, was incomplete cooperation among national research groups: each one cultivating mainly its own back yard, that is, the topic they are most interested in. This free-riding behaviour cannot be corrected through an authoritarian approach. The hierarchy lines in a multinational group are fuzzy, and the kind of management that seems most suitable is the «adhocracy» (Mintzberg 1983), based on reciprocal trust among the organisation's members. In the Vax Trust case, the pandemic crisis, imposing a migration of the bulk of scientific activity online, slowed down trust-building among scholars. Overall, we can conclude that the European calls system can promote a kind of situationist constitution of research groups or, in Fleck's words, of «thought collectives».

Focusing on ethnographic work, it emerges quite clearly that, besides the constant invitation to mix methods in order to combine quantitative with qualitative approaches, ethnography carried out at a European level is particularly challenging. Linguistic heterogeneity represents the greatest obstacle. Turning to English as a lingua franca only partially solves the problem. Fieldnotes deeply underpin ethnography, and some of the local cultural nuances are inevitably lost in translation. In our team ethnography, we did not invest enough time and resources to acquire a sufficiently large volume of translated ethnographic extracts. In a way, the heterogeneity of perspectives among the small ethnographic patrol committed to fieldwork was positive. As already said, we benefitted from the «circle of differences» (Davidson 2019, 99), trying to build a intersubjective reading of the social interactions observed in a dialectical way. In this way we created – not without difficulty – the «thought style» of the team. All in all, external and internal constraints influenced the pace of ethnography in the Vax Trust project. Either the pandemic crisis or the scepticism toward ethnography emerging on and off in the research group moved our fieldwork toward

the rapid version of ethnography (Vindrola-Padros 2021)²³. Remarkably, the pandemic crisis imposed the renunciation of the planned visits to the observed sites. The team ethnography leaders had no opportunity to visit the other colleagues' fields, which weakened the study's «potential for comparison» (Barbour 2007, 53) while not eradicating it. These practical conditions contributed to manufacturing our «truth» on vaccine hesitancy.

On our «truth» about vaccine hesitancy, since this paper is a methodological one, we can anticipate only a few issues here. The first and most important relates to the dependence of vaccine hesitancy on the interactive context with healthcare professionals. Vaccine hesitancy is not a steady personal trait but a disposition that can be triggered or defused in interactions with healthcare professionals.

We start from this point in the production of further local truths. Learning from the circle of differences within our group, we hope that many different papers – compared with the few already existing – will be published.

REFERENCES

- Altheide, D.L., J.M. Johnson (1994) *Criteria for Assessing Interpretive Validity in Qualitative Research*, in N.K. Denzin, Y.S. Lincoln (eds.), *Handbook of Qualitative Research*, Thousand Oaks and London, Sage Publications, pp. 485-499.
- Andre, F.E., R. Booy, H.L. Bock, J. Clemens, S.K. Datta, T.J. John, *et al.* (2008) *Vaccination greatly reduces disease, disability, death and inequity worldwide*. Bulletin of the World health organisation, 86, pp. 140-146.
- Barbour, R. (2007) *Introducing Qualitative Research: A Student's Guide to the Craft of Doing Qualitative Research*, London, Sage Publications.
- Blumer, H. (1969) *Symbolic interactionism*, Englewood Cliffs, NJ, Prentice-Hall.
- Boudon, R. (2003) *Raisons, bonnes raisons*, Paris, Presses Universitaires de France.
- Bresler, L. (2002). *The interpretive zone in international qualitative research*, in «Counterpoints, Research in International Education: Experience, Theory & Practice», 180, pp. 39-81.
- Cardano M. (2020) *Defending Qualitative Research. Design, Analysis, Textualisation*, Abingdon and New York, Routledge.

²³ As mentioned above (Section 2), not all the consortium members shared the view expressed in the text, framing the difficulty of doing the planned ethnography only as a matter of feasibility.

- Cupit, C., N. Mackintosh, N. Armstrong (2018) *Using ethnography to study improving healthcare: reflections on the 'ethnographic' label*, in «BMJ Qual Saf», 27, pp. 258-260.
- Davidson, J. (2019) *Qualitative Research and Complex Teams*, Oxford, Oxford University Press.
- Delaruelle, K., M. Bockstal, M. Ceuterick, P. Bracke (2021) *Vax Trust project 2.1 deliverable, A review report of existing data*, European Commission.
- Deutscher, I. (1973), *What We Say/What We Do*, Glenview, Ill., Scott Foresman & Company.
- Diaz Crescitelli, M.E., L.Ghirotto, H. Sisson, L. Sarli, G. Artioli, M.C. Bassi, G. Appicciutoli, M. Hayter (2020) *A meta-synthesis study of the key elements involved in childhood vaccine hesitancy*, in «Public Health», 180, pp. 38-45.
- Dubé, E., D. Gagnon, E. Nickels, S. Jeram, M. Schuster (2014) *Mapping vaccine hesitancy. Country-specific characteristics of a global phenomenon*, in «Vaccine», 32, 49, pp. 6649-6654.
- Dubé, E., D. Gagnon, N. MacDonald, A. Bocquier, P. Peretti-Watel, P. Verger (2018) *Underlying factors impacting vaccine hesitancy in high income countries: a review of qualitative studies*, in «Expert Review of Vaccines», 17, 11, pp. 989-1004.
- Dubé, E., C.Laberge, M. Guay, P. Bramadat, R. Roy, J.A. Bettinger (2013) *Vaccine hesitancy: an overview*, in «Human Vaccines & Immunotherapeutics», 9, 8, pp. 1763-1773.
- Erickson, K., D. Stull (1998) *Doing Team Ethnography. Warnings and Advice*, London, Sage.
- Faugier, J., M. Sargeant (1997) *Sampling hard to reach populations*, in «Journal of Advanced Nursing», 26, pp. 790-797.
- Feemster, K. A. (2013) *Overview: Special focus on vaccine acceptance*, in «Human Vaccines & Immunotherapeutics», 9, pp. 1752-1754.
- Fleck L. (1979) *Genesis and Development of a Scientific Fact*, Chicago, The University of Chicago Press (ed. or. 1935).
- Geertz C. (1983) *Local Knowledge: Further Essays in Interpretive Anthropology*, New York, Basic Books.
- Ginzburg, C. (2013) *Clues, Myths, and the Historical Method*, Baltimore, The Johns Hopkins University Press (or. ed. 1978).
- Hackenberg R.A. (1983) *Reflections on the death of Tonto and the new ethnographic enterprise*, in «High Plains Applied Anthropologist», 13, 115-122.
- Hilário, A.P., A. Scavarda, D. Numerato, J. Mendonça, M. Cardano, J. Marhankova, G. Gariglio, P. Vuolanto, A. Anderson, P. Auvinen, P. Bracke, T. Douglass, P. Hobson-West, E. Lermytte, .P. Polak, T. Rudek (2023) *Recruiting a hard-to-reach, hidden and vulnerable population: the methodological and practical pitfalls of researching vaccine-hesitant parents*, in «Qualitative Health Research», <https://doi.org/10.1177/104973232311964>.
- Junker B.H. (1960) *Field Work. An Introduction to the Social Sciences*, Chicago, IL, The University of Chicago Press.
- Karafillakis, E., I. Dinca, F. Apfel, S. Cecconi, A. W rz, J. Takacs, J. Suk, L. Pastore Celentano, P. Kramarz, H.J. Larson, (2016) *Vaccine hesitancy among healthcare workers in Europe: A qualitative study*, in «Vaccine», 34, 41, pp. 5013-5020.

- Knorr-Cetina, K. (1981) *The Manufacture of Knowledge. An Essay on the Constructivist and Contextual Nature of Science*, Oxford, New York, Toronto, Sydney, Paris, Frankfurt, Pergamon Press.
- Kuhn, T. (1962) *The structure of scientific revolutions*, Chicago, University of Chicago Press.
- Knoblauch H. (2005) *Focused Ethnography*, in «Qualitative Social Research», 6, 3, 44.
- Larson, H.J. (2018) *Politics and public trust shape vaccine risk perceptions*, in «Nature Human Behaviour», 2, 5, pp. 316 ss.
- Majid, U., M. Ahmad (2020) *The Factors That Promote Vaccine Hesitancy, Rejection, or Delay in Parents*, in «Qualitative Health Research», 30, 11, pp. 1762-1776.
- Marcus, G.E. (1995) *Ethnography in/of the world system: The emergence of multi-sited ethnography*, in «Annual Review of Anthropology», 24, 1, pp. 95-117.
- Mauthner, N.S., A. Doucet (2008) *'Knowledge Once Divided Can Be Hard to Put Together Again': An Epistemological Critique of Collaborative and Team-Based Research Practices*, in «Sociology», 42, 5, pp. 971-985.
- Mintzberg, H. (1983) *Structure in five. Designing Effective Organisations*, Englewood Cliffs NJ, Prentice Hall.
- Oms, S., E. Zardini, eds. (2019) *The Sorites Paradox*, Cambridge, Cambridge University Press.
- Paoli, F. (2019) *Degree Theory and the Sorites Paradox*, in Oms, S., Zardini, E. eds (2019), *The Sorites Paradox*, Cambridge, Cambridge University Press, pp. 151-167.
- Przeworski, A., H. Teune (1982) *The Logic of Comparative Social Inquiry*, Malabar and Florida, Krieger Publishing Company (or. ed. 1970).
- Rapley, T. (2004) *Interviews*, in C. Seale, G. Gobo, J.F. Gubrium, D. Silverman (eds.), *Qualitative Research Practice*, London, Sage Publications, pp. 15–33.
- Siltanen, J., A. Willis, W. Scobie (2008) *Separately Together: Working Reflexively as a Team*, in «International Journal of Social Research Methodology», 11, 1, pp. 45-61.
- Topolski, J. (1977) *Methodology of History*, Dordrecht and Boston, D. Reidel Publishing Company (or. Ed. 1973).
- Verger, P., E. Botelho-Nevers, A. Garrison, D. Gagnon, A. Gagneur, A. Gagneux-Brunon, E. Dubé(2022). *Vaccine hesitancy in healthcare providers in Western countries: a narrative review*, in «Expert Review of Vaccines», 21, 7, pp. 909-927.
- Vindrola-Padros C. (2021) *Rapid Ethnographies: A Practical Guide*, Cambridge, Cambridge University Press.
- Vuolanto, P., A.N.Almeida, A. Anderson, P.B.A. Auvinen, P. Bracke, M. Cardano, M. Ceuterick, T. Correi, E. De Vito, K. Delaruelle, A. Delicado, M. Esposito, M. Ferrara, L. Gariglio, C. Guerreiro, M.J. Hasmanová, A.P. Hilário, P. Hobson-West, J. Iorio, K.M. Järvinen, A. Koivu, Z. Kotherová, A. Kuusipalo, E. Lermytte, J.M.R. Mendonça, D. Numerato, P. Polak., T. Rudek, S. Sbaragli, A. Scavarda, K. Silva, P.A. Silva, J. Sivelä, M.E. Soares, M. Świątkiewicz-Mośny, G. Tipaldo, A. Wagner (in press), *Trust matters. The Addressing Vaccine Hesitancy in Europe Study*, in «Scandinavian Journal of Public Health».

- Wasser Davidson, J., L. Bresler (1996) *Working in the Interpretive Zone: Conceptualizing Collaboration in Qualitative Research Teams*, in «Educational Research», 25, 5, pp. 5-15.
- Wittgenstein, L. (1958) *Philosophical Investigations*, Oxford, Basil Blackwell (or. ed. 1953).

A team ethnography on vaccine hesitancy in Europe. A case study of a local truth construction

This paper focuses on the methodological conundrum of doing quick team ethnography in complex teams in a clinical setting studying childhood vaccine hesitancy. It describes how and to what extent a particular «thought style» (in Ludwik Fleck's meaning) has developed through decisions, negotiations and disputes, producing a dialogical «local truth». It also shows how ethnographers can adapt their practice, considering day-to-day endogenous changes in fieldwork and public debate as well as exogenous ones, such as pandemics and wars. Following a compact exploration of a few sensitising concepts, referring in particular to Ludwik Fleck, Knorr-Cetina and Clifford Geertz, it explores how the complex team had worked in practice effectively while unpacking vaccine hesitancy. The paper describes three fundamental steps of this group endeavour: i) the genealogy of the birth of the team and the subsequent team-building process; ii) the illustration of how the group's «thought collective» and interactions have produced in practice a «local truth»; iii) a reflexive stance on this particular empirical case of «method in process». The paper concludes with methodological remarks.

Keywords: vaccine hesitancy, rapid team ethnography, vaccination, childhood vaccine, qualitative health research, thought style, reflexive account, EU research policies.

Mario Cardano, Department of Cultures, Politics and Society, University of Torino, Lungo Dora Siena 62, I-10153 Torino, Italy. E-mail: mario.cardano@unito.it
<https://orcid.org/0000-0003-0268-3020>

Dino Numerato, Faculty of Social Sciences, Charles University, Ovocný trh 5, Prague 1116 36, Czech Republic. E-mail: dino.numerato@fsv.cuni.cz
<https://orcid.org/0000-0002-4821-6471>

Luigi Gariglio, Department of Cultures, Politics and Society, University of Torino, Lungo Dora Siena 62, I-10153 Torino, Italy. E-mail: luigi.gariglio@unito.it
<https://orcid.org/0000-0002-6970-3885>

Jaroslava Hasmanová Marhánková, Faculty of Social Sciences, Charles University, Ovocný trh 5, Prague 1116 36, Czech Republic. E-mail: jaroslava.marhankova@fsv.cuni.cz
<https://orcid.org/0000-0003-4823-8934>

Alice Scavarda, Department of Cultures, Politics and Society, University of Torino, Lungo Dora Siena 62, I-10153 Torino, Italy. E-mail: alice.scavarda@unito.it
<https://orcid.org/0000-0002-0972-318X>

Piet Bracke, Department of Sociology, Health and Demographic Research Group, Sint-Pietersnieuwstraat 41, 9000 Gent, Belgium.
<https://orcid.org/0000-0002-9477-3236>

Ana Patrícia Hilário, Institute of Social Sciences, University of Lisbon, Av. Prof. Aníbal Bettencourt 9, 1600-189 Lisbon, Portugal.
<https://orcid.org/0000-0001-7396-5127>

Paulina Polak, Institute of Sociology, Jagiellonian University, Krakow, Gołębia 24, 31-007 Kraków, Poland.
<https://orcid.org/0000-0002-9724-0486>