Trust in Public Health within Black African and Caribbean Communities: Grounded Theory as applied to the COVID-19 Vaccine Uptake

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ABSTRACT

Trust plays a critical role in public health, encouraging community unity and cooperation with health initiatives. Despite substantial research on trust, its relationship with race and power dynamics remains under-explored.

To address this research gap, the study focused on exploring the relationship between race and trust, particularly within Black African and Caribbean populations that have historically faced discrimination and exclusion in society and healthcare. The study aimed to understand the unique experiences and perspectives of these communities, especially in the context of the COVID-19 pandemic and vaccination efforts in the UK.

The study utilised a critical grounded theory methodology, influenced by Community Psychology values, to conduct interviews with 15 self-identified Black African and Caribbean individuals. The discussion explored their public health experiences and their perceptions of trust, with emphasis on the COVID-19 pandemic.

The study developed an ecological model to conceptualise the dynamic nature of trust in public health within these communities. The model highlights the influence of social power and structural societal factors, acknowledging that historical marginalisation, colonial injustices, and political distrust contribute to avoidance and scepticism towards public health measures.

It proposes that trust in public health is community-driven, highlighting the role of communities in fostering trust, improving health outcomes, and ensuring care continuity and safety. The research advocates for tailored multi-level interventions centred on community engagement and trust to effect enduring change in health outcomes for these communities.

It calls for a paradigm shift in public health to promote research, training, and clinical approaches that address systemic biases and encourage the decolonisation of health-related knowledge. The study's implications extend to public health policy, clinical practice, training, and future research.

In conclusion, the study underscores the importance of consistent, trustworthy, and transparent actions and accountable processes in public health initiatives, fostering partnerships with marginalised communities to promote equitable and inclusive health practices.

1. INTRODUCTION

1.1. Chapter Overview

Trust is a fundamental element that underpins social interactions and institutions influencing effective healthcare delivery. However, trust is a complex and multifaceted concept that is subjective and influenced by various factors.

This chapter critically examines the literature on trust and race, emphasising their distinctive properties and relationship. The analysis provided comprises a comprehensive review of power dynamics, historical events, and prevalent ideologies. Following this is a literature review investigating the significance of trust and race in public health, particularly in the context of public health emergencies. The recent COVID-19 pandemic is examined in detail, with a focus on its effects on public health, racism, and trust. The chapter concludes with a discussion of the rationale and objectives of the study, which are contextualised in relation to the study's primary theoretical approach (community psychology) and the current socio-political context.

1.2. Outlining Key Constructs and Terminologies

This research employs the term 'racialised' to characterise non-White individuals who encounter race-related impacts within society. The use of 'racialised' aims to avoid language that marginalises based on race and reinforces White supremacy. The researcher avoids using collective terms including 'Black, Asian and Minority Ethnic' (BAME) as they overlook the diversity within racialised experiences, perpetuating White power dominance (Walker et al., 2021).

Various terms, such as patients, service users, and survivors are used interchangeably based on how researchers referred to individuals accessing healthcare services, as there is no consensus on the most appropriate term (Costa et al., 2019).

1.2.1. Race and Ethnicity

Race is regarded as a social construct, implying that is a construct formed by societal beliefs rather than scientific evidence (Witzig, 1996). Physical characteristics such as hair and skin colour are commonly used to classify individuals into racial groups, despite the absence of biological justification.The concept of race also incorporates distinct sociocultural characteristics and has a substantial impact on both the life outcomes and ideological orientations of individuals in social and political domains (Wilkes & Wu, 2018).

Race and ethnicity are often used interchangeably, but they possess distinct definitions and implications. While ethnicity is associated with cultural affiliations, race has been historically used to perpetuate racial inequality and racism (Wilkes & Wu, 2018). Ethnicity refers to groups outside the dominant culture and carries value-laden connotations (Fernando, 2017). This research will focus on the concept of race and its associated phenomenon of racism, as opposed to ethnicity or culture.

1.2.2. Racism

Racism is a pervasive paradigm that underpins contemporary society, fostering the perpetuation of stereotypes, prejudice, and discrimination (Fernando, 2017). The emergence of the race has resulted in the manifestation of racism, which operates on multiple levels (Parsons, 2022). Generally, racism is conceptualised along a continuum and characterised by its overt, covert, institutional, or internalised manifestations (Fernando, 2017). Structural racism is a multidimensional phenomenon that encompasses all forms of racism in society (Mendez et al., 2021).

1.2.3. Whiteness

The term 'Whiteness' pertains to the privileges that sustain racial hierarchies and oppression (Garner & Clarke, 2010), with the aim of establishing and perpetuating the supremacy of individuals with White skin or those who can pass as White (DiAngelo, 2018). Whiteness is a powerful construct, perpetuated by individuals, institutions and systems which redirects attention away from the oppressed individuals and towards the dominant groups responsible for perpetuating systems of oppression and power that sustain racism. Additionally, it establishes norms that are challenging to discern, question, or alter due to their imperceptibility (Patel, 2021).

1.2.4. Power

Power is a multifaceted concept characterised by the capacity to exert influence over others (Kloos et al., 2020). It can take many forms, including power over, power to, and power from (Kloos et al., 2020). The existing systems of knowledge and Whiteness are intrinsically linked to the exercise of power (Bruce & Clennon, 2022).

1.2.5. Community

This study adopts McMillan and Chavis' (1986) definition of community, emphasising sense of belonging and shared commitment. According to these researchers, one's sense of community encompasses more than the territorial definition of community, considering key elements such as membership, influence, fulfilment of needs, and shared emotional connection.

The concept of community is dynamic and evolves over time due to changing values, systems, and structural forces. Studies have found that identifying with broader networks increases one's willingness to sacrifice for the group (Sarason, 1974). Understanding community from this perspective offers insights into public health behaviour, particularly in marginalised and racialised communities.

1.3. Literature Search Strategy

The study conducted literature searches on psychology, healthcare, and social science databases, including EBSCOhost, PsycINFO and Google Scholar. No results were found when using the search terms 'trust', 'public health','Black African', and 'Black Caribbean'. However, by modifying the search terms to include 'Black*', or 'Black Caribbean*', or 'Black African*', 15 results were obtained. To supplement this search, a Google Scholar search was conducted, focusing on the first 100 results out of a total of 4,117 results ranked by relevance. This was supplemented by a comprehensive examination of reference lists and the use of Google Scholar's "cited by" function.

The literature search also included reputable sources such as the Department of Health and Social Care, focusing on relevant articles and policies related to public health policies, disparities, and improvements in the UK. Only English-language studies were considered. Appendix A provides details on the search strategy, including search terms and databases used.

1.4. The Crisis of Trust

In recent years, trust has acquired prominence in public discourse, particularly in its role as a moderator of public behaviour during times of public crisis (Blair et al., 2022). However, scholarly perspectives on its precise definition and significance differ (Soderstrom, 2009). The following section elaborates on the different conceptualisations of trust and their relevance to the context of the study.

1.4.1. Conceptualisations of Trust

Trust is a prominent topic in the social sciences, attracting attention from various academic disciplines (Smith, 2010). This multidisciplinary perspective has contributed to the expansion of the trust literature, but also to the ambiguity surrounding the definition and interpretation of trust (Boulware et al., 2003).

Each model of trust proposed in the literature emphasises distinct aspects of the trusting process. For instance, Mayer et al. (1995) propose an integrative model that defines trust as a trustor's willingness to rely on a trustee's actions, considering the trustee's qualities and the trustor's inclination to trust. Trust involves anticipating specific activities carried out by the trustee.

On the other hand, Rousseau et al. (1998) defined trust as a psychological state marked by a readiness to take risks and be vulnerable, driven by optimistic expectations regarding the behaviour of the trustee.

Various models of trust, such as the psychological propensity model, cognitive model, and social learning theory, offer different perspectives on the nature and development of trust. The psychological propensity model (Glanville & Paxton, 2007) suggests that trust is a fundamental personality trait acquired in early childhood and influenced by other traits such as cooperation and optimism. It considers trust to be reasonably stable throughout adulthood, only altered by traumatic or difficult life experiences.

The cognitive model views trust as a cognitive process founded on the evaluation of the trustworthiness of an individual or system (Fiske & Taylor, 2017). As a cognitive process, trust is simultaneously automatic and deliberate, influenced by cognitive and unconscious processes resulting from previous experiences, and knowledge of the social world (Vaisey, 2009).

The social learning theory focuses on trust as an interpersonal belief in the reliability of others' commitments, influenced by social priors such as social status and ethnicity (Szcześniak et al., 2012). The influence of the trustor on the trustee in influencing an individual's perceptions of trust is central to this definition (Bellucci et al., 2017).

Trust can also be categorised based on the object of focus (Wang & Gordon, 2011), including interpersonal, institutional, political, social and epistemic. Interpersonal trust refers to trust between individuals including their willingness to be vulnerable to the unpredictable actions of others (Ma et al., 2019). Interpersonal trust plays a crucial role in shaping personality development, fostering collaboration, and influencing risk-taking behaviour (Wang & Emurian, 2005). Interpersonal trust in close relationships, those with whom we are familiar was found to be fragile due to its dependency on direct personal socialisation and reciprocity (Uslaner, 2015). However, the availability of prior knowledge was identified as influential in the development of trust and decision-making (Fouragnan et al., 2013).

Institutional trust relies on formal arrangements and organisational structures to increase the probability of reciprocal success (Bissola & Carignani, 2007). Trust based on indirect knowledge or limited personal interaction is increasingly significant as modern society frequently lacks direct personal knowledge (Ravale et al., 2022). Trust in institutions is crucial for a variety of reasons, including the operation of a democracy, the effectiveness of the judicial system and cooperation with the authorities (Liebow & Rieder, 2022).

Political trust involves confidence in the efficacy of various institutions including the executive, legislature, judiciary, bureaucracy, and police, with regards to their ability to make informed decisions, communicate information, and execute actions (Newton et al., 2018). It has significant implications for the successful implementation of initiatives and policies (Reinhardt, 2019).

Social trust, is rooted in individuals' beliefs about the moral orientation and trustworthiness of others, including strangers (Uslaner, 2015). Social trust encourages cooperative behaviour and collaboration by enabling individuals with divergent viewpoints to partake in collective problem-solving (Uslaner, 2015).

Social trust is closely linked to institutional and political trust, impacting the wellbeing and sustainability of democracy (Newton & Zmerli, 2011). The decline in social trust is believed to contribute to decreasing support for political leaders and governmental institutions in Western society (Dalton, 2004).

Epistemic trust, particularly relevant in public health, refers to the willingness to recognise the relevance and trustworthiness of other people's knowledge (Campbell et al., 2021).

Epistemic trust is grounded in experiences during early development, and studies have found the absence of such trust may contribute to the development of psychopathology (Campbell et al., 2021). Research has suggested that individuals who have experienced trauma and marginalisation may exhibit decreased levels of epistemic trust (Kampling et al., 2022).

Although these conceptualisations of trust vary considerably, they share a few core characteristics. Trust develops in the context of uncertain outcomes (Fiske & Taylor, 2017), it involves expectations of a positive outcome (Rousseau et al., 1998), and it requires vulnerability exposing the trustor to the trustee's behaviour (Colquitt et al., 2007). This deliberate disregard of risk, which is inherent to disciplines such as public health, enhances social connection, suggesting that trust and vulnerability are inextricably entwined, (Hall et al., 2001).

Earlier theories (e.g., Mayer et al., 1995) have been criticised for prioritising a bottom-up approach to trust and failing to comprehend the characteristics of entire societies or communities within which trust is established and evolves (Uslaner, 2018). While modern approaches to trust (e.g. the social learning theory) have been criticised for failing to recognise power dynamics as a crucial contributory factor in the development of trust (Schilke et al., 2015).

The complexity of the topic of trust is reflected in the absence of a widely accepted conceptualisation (Colquitt et al., 2007) or consensus on its origins (Robbins, 2016). However, this does not imply a lack of effort, as demonstrated by the present study.

1.4.2. Trust and Power

In recent years, there have been concerns about dwindling trust in public institutions, especially among certain communities (Liebow & Rieder, 2022). Despite this, trust is one of the least observed aspects of social interaction, and its intersection with race and position of power is seldom studied in depth (Wu et al., 2022).

Empirical studies have demonstrated that trust is frequently more closely associated with social factors than with psychological or genetic ones (Jen et al., 2010; Lindstrom & Mohseni, 2009). Education, income, social class, ethnicity, religious background, and membership in a majority or minority group are among the variables that can impact an individual's experiences and opportunities. These social characteristics are frequently associated with adversity, diminished social power and social exclusion (Uslaner, 2018).

According to Catala (2015) power largely determines levels of trust. People with a greater sense of power tend to trust more because they are better equipped to deal with the negative repercussions of a disrupted trust relationship (Yamagishi, 2011). Cook et al. (2005) posit that power disparities can engender mistrust. The concept of power within the framework of racial dynamics embodies a persistent manifestation of inequity that necessitates further examination.

1.5. The Evolution of Race and its Impact on Trust

Research indicates a trust disparity between racialised individuals and White individuals, with the former showing lower levels of trust (Evangelist, 2022; Smith, 2010). This distrust seems to persist across generations, with studies suggesting that it is rooted in both historical and contemporary forms of discrimination (e.g. Paxton & Glanville, 2015). The following sections will explore how historical discrimination influences trust in interpersonal and institutional contexts.

1.5.1. Trust and Colonialism

Colonialism is a framework that encompasses socioeconomic and political aspects and utilises the ideology of White supremacy to justify the subjugation and exploitation of ethnic groups that are non-White (McGibbon et al., 2014).

The historical records of colonisation reveal a wide range of detrimental actions, including unethical medical trials, genocide, displacement, forced labour, and a purposeful endeavour to eradicate the cultural and spiritual customs of populations (Paradies, 2018).

The establishment of power by White colonisers and the oppression of Black colonised individuals were predicated on the existence of racial differences and racism (Fernando, 2017). The slave trade was marked by conflicts and invasions, fostering a culture of mistrust and insecurity (Nunn & Wantchekon, 2011). This had implications for interpersonal and social trust, eroding social bonds and fostering insecurity within communities and scepticism towards political authorities (Nunn & Wantchekon, 2011).

In 1663, Britain became officially involved in the transatlantic slave trade and the ownership of enslaved people, especially in India and Africa (Parsons, 2022). Within a span of less than 150 years, Britain enslaved millions of Africans, subjecting them to forced labour on colonies and depriving them of basic rights. This oppressive system led to the emergence of racist theories and pseudoscience as justifications. This is further discussed in Section 1.5.3.

Although the British government enacted laws to abolish the slave trade in 1807 and slavery itself in 1834, discriminatory practices persisted against the Black African and Black Caribbean communities in the UK (Parsons, 2022).These included racism, employment refusal, substandard housing, and school-based bullying (Shafiq et al., 2020), which culminated in riots in 1958.

The year 1948 witnessed a significant surge in immigration, which was predominantly ascribed to the government initiatives aimed at enlisting labourers from Commonwealth nations (Parsons, 2022). In 1948, the British Nationality Act granted “Citizens of the UK and Colonies” status to workers from the West Indies who arrived in London aboard the Windrush, along with their passports.

The effects of historical aggression can endure across generations, influencing attitudes and behaviours, including trust, towards entities such as governments, corporations, and individuals within the former aggressor community (Kobayashi et al., 2022). The enduring effects of colonisation and slavery highlight the importance of understanding historical experiences in shaping attitudes and trust in various contexts.

1.5.2. The Post-colonial Crisis

Post-colonialism emerged in the mid-20th century as former colonies gained independence from their colonisers, signifying a significant historical transition (Ashcroft et al., 2013).

The British Empire transformed into the Commonwealth, a voluntary association of independent nations, after World War II (Ashcroft et al., 2013). The aftermath of British colonialism resulted in political, economic, and social confusion, leaving the former colonies in a state of disarray (Bhambra & Holmwood, 2018).

Post-colonialism is characterised by the emergence of decolonisation, highlighting the process of liberation of native populations in former colonies (Ashcroft et al., 2013). The post-colonial theoretical framework acknowledges the enduring impact of colonialism on contemporary power dynamics, ethnic and racial relations, prejudices, and gender dynamics.

In the 1950s and 1960s, British administrations used the notion of "cultural difference" to enforce racially driven containment strategies, mainly through restrictive immigration policies (Shain, 2020). These policies perpetuated the narrative that there are "dangerous others".

The Macpherson report (Home Office, 1999), prompted by the murder of Stephen Lawrence in 1993, brought institutional racism to the forefront of societal discourse. The investigation revealed institutional racism within the police and public institutions, leading to the Race Relations Amendment Act (2000), aimed at promoting racial equality.

Institutional racism, as defined by the Home Office (1999), involves organisations' failure to provide appropriate services due to discrimination based on race, culture, or ethnicity. It is characterised by thoughtless, racist stereotyping processes, attitudes, and behaviours that disadvantage racialised individuals. While there seemed to be progress in British race relations following the Macpherson report (Shain, 2020), efforts to confront racial inequality were undermined after the September 11 attacks and subsequent conflicts, resulting in the re-emergence of colonial stereotypes and the management and containment of racialised minorities.

The public sector maintains a self-image of impartiality and scientific objectivity regardless of the impact of political and cultural environments, partly due to the unrecognised colonial legacy (Alexander & Stivers, 2020). Neglecting the enduring impact of colonialism on the nation's cultural landscape contributes to amnestic responses to past wrongdoings, influencing dominating discourses, relationships and trust.

1.5.3. Race, Colonialism and Scientific Racism

The concept of race has a complex history and has been used throughout different historical periods to justify slavery, colonisation, and acts of violence against certain racial groups (Hogarth, 2017). The term “race” was adopted by the English language in the 16th century, prior to the emergence of genetics and evolutionary biology (Mersha & Beck, 2020).

In the 18th century, scientists started categorising humans into distinct racial groups (Bhopal, 2007), a construct propagated by White Europeans to maintain Whiteness and marginalise non-white identities (Mersha & Beck, 2020). It became embedded in legal frameworks, leading to discriminatory practices, including Jim Crow laws, eugenics, scientific racism, and apartheid, resulting in systemic inequities and disparities in healthcare, legal treatment, and economic wellbeing for racialised communities (Tobbell & D’Antonio, 2022).

Eugenics, a movement which emerged in the 19th century (Galton, 1909), falsely assumed psychological and biological differences between races, promoting the idea of white superiority. This led to the pathologisation of the desire for liberation of Black communities (Ruane, 2019) and the justification of violence against them to “alleviate” the acute urge for escape by medical professionals (Lipsedge & Littlewood, 2005).

However, most anthropologists, geneticists, and biologists reject the concept of race as biologically bounded groups (Witzig, 1996), recognising race as a social construct rather than a scientific reality (Fernando, 2017).

Despite the lack of scientific validity, racial taxonomies continue to be used in various domains, including medicine, clinical practice, research, and teaching (Khan & Mian, 2020). This leads to the objectification of patients, erroneous genetic conclusions, and alienation (Khan & Mian, 2020).

The historical impact of racial classifications is exemplified by the Tuskegee Syphilis Study (Gamble, 1997), where Black participants were intentionally deceived and denied treatment. This study and other instances of racial discrimination have led to deep-rooted mistrust among black populations towards medical research and public health (Sengupta et al., 2000).

The historical impact of racial discrimination in science has led to the misconception that race determines inherent health advantages, impeding progress in addressing institutional and structural racism (Kimani, 2023). Recognising race as a social construct is essential for achieving equity and eliminating institutionalised racism. Challenging the use of racial classifications in healthcare and addressing the multifaceted socioeconomic factors contributing to poor health is crucial, moving beyond simplistic race-based explanations.

1.6. The Crises of Trust and Race in Public Health

The influence of social trust on population health and the public health system has gained recognition in recent years (Bergh & Bjørnskov, 2014). Colonialism is acknowledged as a key factor impacting the social determinants of health, resulting in unfavourable living conditions, restricted resource access, and reliance on external support (McGibbon et al., 2014).

The hierarchical social structures and structural violence of colonialism have particularly harmed racialised individuals, resulting in loss of livelihood (Jones, 2021) and long-term consequences for their public health experiences. The following section will explore the connection between trust, race, and public health.

1.6.1. Public Health in the UK

Public health is a multidisciplinary field focused on improving the health and wellbeing of communities and populations through disease prevention, life expectancy enhancement, and overall quality of life improvement (Jarvis et al., 2020).

In the UK, public health is a collaborative effort between national and local entities (Bruce & Clennon, 2022), led by the Department of Health and Social Care (DHSC) that is responsible with overseeing and devising public health policies (Iacobucci, 2020). The Office for Health Improvement and Disparities (OHID) and the UK Health Security Agency (UKHSA) assist DHSC in its endeavour to provide a unified strategy for addressing public health concerns.

OHID and the UKHSA assumed the duties of Public Health England (OHID, 2023) in October 2021. OHID, a DHSC division, developed to address health disparities, provides evidence-based guidance, and collaborates with various stakeholders to impact government policies including local authorities and the

National Health Service (NHS) (OHID, 2023). UKHSA, an executive agency, is responsible for planning and responding to infectious diseases (UKHSA, 2023).

Local public health services are delivered through partnerships between local authorities, the NHS, educational institutions, and community organisations (Bruce & Clennon, 2022). The NHS plays a crucial role in delivering healthcare, health education, prevention measures, emergency response, and research and surveillance efforts, safeguarding public health from communicable diseases and informing public health policies (Walshe, 2010).

Public health policies and practices in the UK are shaped by research and data provided by organisations such as the National Institute of Health Research, (Bruce & Clennon, 2022). These institutions contribute to the evidence base that informs decision-making.

Despite its critical role, public health in the UK has continuously faced budget cuts, particularly impacting low-income areas and undermining the effectiveness of public health efforts (Cabaj et al., 2019). The Public Health Grant, supporting preventative services, has been reduced by 26 percent per person between 2015/16 and 2023/24 (Finch & Vriend, 2023). These funding cuts limit the ability to prevent health deterioration, exacerbating health disparities, and imposing financial costs on society (Finch & Vriend, 2023). The short-sighted approach of prioritising public health only in times of emergency demonstrates a dearth of government commitment to prevention efforts (Cabaj et al., 2019).

1.6.2. Models of Health and Illness

Public health operates within a political framework, where value-based decision making is crucial (Kelly et al., 2007). Whilst prevention and the optimisation of population health are widely acknowledged as primary goals, scholars contend that the eradication of disparities and the promotion of equity should take precedence in public health, given persistent inequalities in health (Hepworth, 2004).

Numerous theories and models exist to support the application of health promotion and disease prevention techniques. The biomedical model, which dominated in the 20th century, focuses on physiological abnormalities within the body, asserting that breaking down a complex phenomenon into its fundamental physical components is the most effective way to comprehend it (Rocca & Anjum, 2020).

This approach has been heavily criticised due to its ontological reductionist views of health issues as primarily physiological, and due to its inherent asymmetric power dynamics (Rocca & Anjum, 2020). Hence, failing to address underlying causes, ignoring the social determinants of health and the patients' active role in their own wellbeing. Embracing this health approach can impact the establishment of trust between patients and healthcare providers.

In contrast, the biopsychosocial model was proposed in an effort to provide a holistic approach to health and disease by recognising the impact of psychological and social dimensions (Farre & Rapley, 2017). This model emphasises a downward causality, recognising that system-level changes can impact individual components.

Although the model aims to encompass a comprehensive view of health and illness, there exists a lack of integration between the biological, psychological, and social dimensions (Benning, 2015), influencing its ability to view health holistically. This approach has also been criticised for ignoring the political and historical contexts in which a person exists (Benning, 2015).

The emerging ecosocial theory addresses the limitations of the previous models, operating on multiple levels to explain patterns of disease distribution (Krieger, 2011). This perspective suggests that individuals embody their social, material, and ecological environments, considering power dynamics and wealth distribution across time and space. It emphasises interconnected and reciprocal pathways of embodiment across various contextual levels (Krieger, 2012).

It challenges biological essentialism, racial differences, and highlights the importance of a structural systems approach (Rosenberg et al., 2018).

The eco-social theory accounts for societal systems, such as sex/gender and race/ethnicity. However, there is a dearth of comprehensive explanations regarding the interaction of these systems, particularly regarding the simultaneous presence of power, race and privilege (Hankivsky et al., 2017).

Understanding these models and theories is essential for reducing health disparities, promoting justice, and developing effective health promotion strategies. It involves examining historical, biological, psychological, social, and dynamic factors to promote accountability and sustainability in public health.

1.6.3. Racial Relations Legislation in the UK

Over the past five decades, legislative measures have been implemented in the UK to address racial discrimination. The Race Relations Act (1965) was the first law prohibiting discriminatory practices based on race, ethnicity, and national origin.

The current legislation, the Equality Act (2010), which seeks to streamline and integrate all parts of equality legislation into a single act and aims to combat discrimination, particularly in the workplace, reducing socioeconomic inequalities.

The Equality and Human Rights Commission (EHRC) is a non-departmental public entity responsible for promoting and enforcing non-discrimination and equality laws across England, Scotland, and Wales (EHRC, 2023). The EHRC has faced criticism for being ineffective in enforcing anti-discrimination laws and addressing racial inequality, as well as for not implementing recommendations from studies on racial disparities (The Joint Committee on Human Rights (JCHR), 2020).

Racial discrimination remains prevalent in various aspects of individuals' lives, as evidenced by surveys and reports. The JCHR found that more than three-quarters of Black people in the UK perceive unequal protection of their human rights, and more than sixty percent believe that the NHS does not provide equal protection for their health compared to White people (JCHR, 2020). While the NHS acknowledges these inequalities, no specific eradication goals have been proposed (JCHR, 2020).

Despite legislative efforts and the existence of enforcement bodies, racial disparities persist in employment, healthcare, criminal justice, and education. These disparities undermine human rights protection, eroding social trust.

1.6.4. ‘Racism as a Public Health Crisis’

In the UK, the health experiences of Black people are recognised as inferior to those of White communities due to unequal access to health services and a dearth of appropriate care (Van Dyke et al., 2021).

Krieger (2020) argues that disparities in power, resources, and opportunities due to ideological weights allocated to different groups result in unequal social and physical environments, impacting health outcomes. These systemic failures are supported by a moral framework of Whiteness (Lehmiller, 2012).

Numerous studies indicate disparities in health outcomes among racial groups, with Black individuals experiencing racism and higher rates of chronic conditions (Halvorsrud et al., 2018; Paradies et al., 2015). Racial discrimination has also been associated with poverty and social isolation, influencing access to healthcare (Bruce & Clennon, 2022).

Maternal mortality rates are three times higher in impoverished areas with ethnic minorities, with Black women at a significantly higher risk (Limb, 2021). Black women are also less likely to be diagnosed with breast cancer but more likely to be diagnosed at advanced stages, leading to higher mortality rates stages (Limb, 2023).

Black individuals also face misdiagnosis and under-recognition of mental health disorders, leading to reduced access to specialised services and increased involuntary hospitalisations (Henderson et al., 2015).

Black African and Caribbean individuals in the UK are two to eight times more likely to be diagnosed with severe mental health disorders compared to those of White individuals (Grey et al., 2013). Hospitalisation rates for psychotic symptoms and schizophrenia are three times higher among Black Caribbean service users (Bignall et al., 2019). Black service users also face a heightened risk of unfavourable service trajectories, such as involvement in the criminal justice system (Halvorsrud et al., 2018).

According to Lawrence et al. (2021)’s study, Black Caribbean people often feel coerced into medication adherence and accepting their diagnosis, discouraging them from seeking treatment and reinforcing feelings of powerlessness. Young

Black Caribbean service users were also found to experience more hospitalisations and in association, higher dissatisfaction with mental health care (Kapadia et al., 2022).

Black Caribbean service users often encounter barriers when accessing healthcare services and navigating treatment options, leading to feelings of dismissal and being unheard within the system (Brown et al., 2014). Conversely, individuals with White family members have greater success challenging psychiatric decisions, highlighting power dynamics at play (Lawrence et al., 2021).

The underrepresentation of Black individuals in health research and public health decision-making has additional effects on service design and their ability to effectively serve Black service users (Bignall et al., 2019).

These inequalities persist with racialised staff in the public health facing inequalities such as limited job opportunities, patient harassment, and restricted career growth due to racism and discrimination (NHS WRES, 2023). Racialised nurses are often seen as less competent and influential compared to their White counterparts (Brathwaite, 2018), reflecting the pervasiveness of colonialism on the structures of public health institutions.

Racial discrimination has significant impacts on both mental and physical health. It is linked to higher psychological distress, decreased life satisfaction, and impaired mental function (Paradies et al., 2015). Repeated exposure to adverse circumstances, including racism, trauma, substandard housing, and financial difficulties, can further deteriorate mental health (Eliacin, 2013). Racial discrimination also affects physical health, impacting cardiovascular, neuroendocrine, and inflammatory processes (Hackett et al., 2020).

Researchers comprehend these disparities through various optics. Evans-Lacko et al. (2013) suggested that stigma surrounding mental illness within Black African and Caribbean populations can deter individuals from seeking treatment. They also identified mental health illiteracy, the incapacity to seek assistance, social stigma, religious association, and language obstacles as factors contributing to racial inequality in healthcare.

Historical patterns and the epigenetic effects of racism contribute to higher mortality and morbidity rates in Black communities, resulting in poorer health outcomes and limited access to healthcare resources (Bruce & Clennon, 2022). Solely focusing on biological or genetic explanations for health disparities overlooks the influence of racism on these inequities (Wade & Halligan, 2004).

Acknowledging racism as a public health concern is vital for addressing the structures that impede fair access to quality care and contribute to racial inequalities. The urgency to confront systemic racism in healthcare is evident, as it impacts not just health outcomes but also education, sustenance, housing, and employment prospects. However, it is only in recent times, notably with the public recognition of the Marmot review (2020), that the significance of racism in health disparities has gained traction in public discussions.

1.6.5. Racial Disparities in Public Health Trust

Trust is considered a fundamental function in medical ethics, health care law, and public policy (Hall et al., 2001). Trust arises as a crucial element in forming a therapeutic alliance between healthcare providers and patients, significantly influencing patients' propensity to adhere to medical treatment, seek medical attention, disclose confidential information, grant consent, engage in research and cultivate long-lasting relationships with their providers, expressing satisfaction (Rhodes & Strain, 2000; Westergaard et al., 2014).

The effectiveness of guidance and countermeasures disseminated by public health authorities is contingent upon the trust placed by the public in the information provided and their subsequent adherence to recommended practices (Holroyd et al., 2021). Enhanced levels of trust have been shown to yield positive outcomes, such as increased endorsement of public health initiatives and cooperative behaviour from the public (Kim et al., 2011). Notably, cooperation with public health policies appears to be intricately intertwined with public trust in the government (Blair et al., 2017).

Racism and institutional racism in healthcare have been associated with lower trust in public health officials among minority ethnic groups (Brown, 2020). For Black African and Caribbean communities, distrust of healthcare professionals and concerns about discrimination pose significant barriers to accessing services (Kapadia et al., 2022). These communities commonly report lower treatment satisfaction, increased mistrust of primary care and mental health professionals, and apprehensions regarding discrimination in healthcare settings (Kapadia et al., 2022). Marginalisation in healthcare contributes to cautious and resistant trust negotiation (Schultz, 2006).

Research Distrust and dissatisfaction contribute to a decreased likelihood of seeking care, an increased reliance on alternative remedies, and possibly higher rates of involuntary admissions through emergency pathways (Verhaeghe & Bracke, 2011). This perpetuates a cycle of mistrust known as "circles of fear," where mistrust and fear within a community reinforce avoidance and further exacerbate existing distrust (Keating & Robertson, 2004). Consequently, this leads to reduced engagement with public health interventions and services.

The persistence of institutional racism in the healthcare system has substantial implications for both psychological health and interpersonal trust. Understanding the racial disparities in trust provides valuable insights into the inequities related to race in healthcare and health outcomes.

1.6.6. The Management of Public Health Crises

Establishing trust in public health officials is crucial for promoting cooperation with policy programs, especially during public health crises (Calnan & Rowe, 2006). The credibility of official messages plays a vital role in enhancing the adoption of policies and preventive measures (Saechang et al., 2021).

Public health crises, often associated with significant hazards to large populations (Bailey et al., 2017), can erode trust in public health institutions (Mendez et al., 2021). In turn, eroded trust can exacerbate or precipitate public health emergencies (Mendez et al., 2021).

The measles-mumps-rubella (MMR) vaccine crisis in the late 1990s exemplifies the impact of trust on vaccination rates (Poltorak et al., 2005). Research found that safety concerns, controversies, and parental scepticism led to decreased trust and vaccination rates (Casiday et al., 2006). Vaccination promotion directly by the government was found to hinder clinicians' ability to counsel parents due to controversy and scepticism surrounding the government's involvement (Casiday et al., 2006).

Siegrist and Zingg (2014) discovered that the level of adherence to protective behaviours, such as vaccination uptake, was substantially related to the level of trust in medical authorities. According to Marien and Hooghe (2011), distrust may have detrimental effects on the legitimacy of public policies, which could ultimately result in a decline in public support.

Bogart and Thorburn (2005) observed that racial minorities in the USA viewed HIV/AIDS as a weapon of racial warfare, resulting in a lack of confidence in public health.

The deterioration of trust caused by one public health crisis can impact subsequent crises. For example, the loss of public confidence during the BSE (mad cow disease) outbreak in the UK affected trust in the MMR vaccine with researchers suggesting that it further contributed to vaccine hesitancy for COVID-19 (Mold et al., 2020).

Addressing mechanisms such as structural racism contributing to health disparities is essential in the effective management of public health crises (Mendez et al., 2021).

1.7. The COVID-19 Public Health Crisis

The COVID-19 pandemic has emphasised the significance of a competent and well-funded public health workforce and the need to address societal disparities. Inequality, racism, and injustice have become prominent issues during this crisis. This section explores the impact of racism and trust on managing the pandemic, focusing on social inequity and activism.

1.7.1. Racial disparities during COVID-19

The COVID-19 pandemic has had profound effects on the global economy and health systems (Büyüm et al., 2020), exposing systemic violence and inequities that disproportionately impact marginalised populations.

In the UK, individuals from ethnic minority backgrounds face a higher risk of contracting and experiencing severe outcomes, including death, from COVID-19 (Sze et al., 2020). Black African and Caribbean communities have been disproportionately affected by the virus, experiencing higher rates of infection (Sze et al., 2020) and mortality rates that are two to four times higher than White ethnic groups (Mathur et al., 2021). This disparity persists even after controlling for demographic variables such as age, gender, and socioeconomic status (Tai et al., 2021).

Factors such as residing in multigenerational households, working in essential jobs, and facing structural prejudice were found to contribute to their increased vulnerability, making it challenging for these groups to practice social distancing and putting them at a greater risk of exposure during their commute (Office for National Statistics (ONS), 2021).

The conceptualisation and racialisation of COVID-19 in media and research have perpetuated colonialist ideologies, perpetuating stereotypes and differential valuations of lives with headlines such as "What is the cause of the disease's absence in African populations?" (Hairsine, 2020) and scientists advocating for the conduct of SARS-CoV-2 vaccine trials in Africa (Busari & Wojazer, 2020).

Disparities in morbidity and mortality were initially attributed to biological factors (Martineau et al., 2017; Tillin et al., 2012), and unhealthy lifestyles, downplaying the impact of racism and colonialism as health determinants (Danso & Danso, 2021). ‘Victim-blaming' and 'race science' narratives undermine efforts for health equity and fail to address the impact of racism and discrimination within the healthcare system.

It was only following a public inquiry, Public Health England (2020) identified racism, discrimination, stigma, and mistrust as fundamental factors affecting health, exposure risk, and disease progression in COVID-19.

The COVID-19 pandemic exposed deep-rooted inequities and systemic racism. Addressing these issues is essential for promoting health equity and developing an inclusive response to public health crises.

1.7.2. Vaccine hesitancy and Trust

It is well acknowledged that vaccination plays a crucial role in the fight against pandemic-level infections. Unvaccinated people are more likely to be hospitalised and to die from COVID-19 infection (Havers et al., 2022).

MacDonald and SAGE Working Group on Vaccine Hesitancy (2015) defined vaccination hesitancy as delaying or rejecting vaccinations despite the fact they are available. This definition excludes elements such as trust, historical factors, and socio-political influences, which have been found to contribute to hesitancy (see Woolf et al., 2021). Failing to acknowledge the various factors that contribute to it may promote a tendency to assign blame to those who decline vaccination.

Numerous studies have examined the factors influencing vaccine hesitancy during the COVID-19 pandemic including mistrust, conspiracy theories, negative perceptions of medical practitioners and the government (Hussain et al., 2022). Mishra et al. (2021) identified the quality of healthcare provider relationships, intergenerational cohabitation, household decision-making as relevant factors affecting vaccine acceptance.

Chowdhury et al. (2023) additionally identified health literacy, strict appointment requirements, clinic location, inadequate information in non-English languages, and culturally dismissive public health messaging as factors exacerbating vaccine hesitancy.

Vaccine hesitancy is particularly prevalent among racialised communities, with Black or Black British communities (21 percent) exhibiting higher levels of hesitancy compared to White groups (four percent) (ONS, 2021).

Woolf et al. (2022) observed comparable patterns of vaccine hesitancy among HCWs, with White British staff reporting to be significantly less hesitant than Black Caribbean and Black African staff. The presence of hesitancy has significant implications for marginalised groups already bearing a disproportionate burden of COVID-19's impact (Mishra et al., 2021).

Kadambari and Vanderslott (2021) observed that vaccine hesitancy among racialised communities was largely driven by concerns about misinformation, inaccurate information regarding vaccine impact, rapid vaccine development, and insufficient representation in clinical trials.

Chen et al. (2022) found that trust in government and public health professionals is not only important in promoting vaccine acceptance, encouraging the adoption of COVID-19 protective measures, but also in reducing the adverse impact of misinformation on hesitancy.

Woodhead et al. (2022) proposed that acknowledging past and present instances of abuse of power is crucial in preventing the perpetuation and exacerbation of mistrust. Failure to contextualise vaccine hesitancy within the broader social processes that influence it, may undermine efforts to promote vaccine uptake.

The SAGE sub-group on ethnicity (2021) underlined the vital importance of community participation in jointly formulating vaccination distribution plans that are responsive to the community's requirements and encouraging engagement and mitigating mistrust. The role of the community in trust and public health is discussed in greater detail in Section 1.8.2.

These studies suggest that trust played an important role in mitigating vaccine hesitancy approaches during COVID-19. Approaches addressing vaccine hesitancy should therefore avoid perpetuating mistrust by isolating it from its underlying social processes and by refraining from exerting pressure, discrimination, or condemnation on marginalised communities displaying hesitancy.

1.7.3. Government Initiatives

In response to the COVID-19 pandemic's disproportionate impact on ethnic minorities, the UK Government prioritised immunisations for these groups and implemented initiatives to enhance vaccination rates (Razaq et al., 2020). Research shows no significant correlation between ethnicity and vulnerability to misinformation in the UK (Christie, 2021). Nonetheless, the government has focused on improving health literacy and combating misinformation in racialised communities.

The government has implemented strategies to combat vaccine misinformation, including moderation on social media platforms (Christie, 2021), accurate information dissemination, and education on addressing misinformation (SAGE, 2021). The government collaborated with the NHS to develop targeted messaging for minority ethnic groups and hard-to-reach audiences (DHSC, 2021) and initiated a social media campaign featuring racialised community leaders, celebrities, and clinicians to address vaccine misinformation among minority ethnic communities (Department for Digital, Culture, Media & Sport & Dinenage, 2021).

Councils received funding to implement various programmes to provide accurate information to the public, such as telephone helplines and workplace training courses (Christie, 2021).

These approaches can be criticised for perpetuating colonial ideologies of ‘unintelligence’ and undermining the intellectual abilities of racialised communities. The use of celebrities and members of the community also appear to be done in a deceptive ‘tokenistic’ manner. For instance, Kadambari and Vanderslott (2021) found that celebrity endorsements for COVID-19 vaccination lacked interactive communication and failed to address the concerns of racialised individuals and communities.

Tokenism in healthcare involves devaluing stakeholders' capacities and using patronising engagement methods (Howrey et al., 2015). Patient representatives from minority ethnic groups are often absent in public health decision-making and research, impacting health decision-making, trust, and the ability to address health disparities (Ocloo & Matthews, 2016).

During the H1N1 pandemic, Gilles et al.(2011) found that individuals with limited health literacy skills still followed public health recommendations. Robertson et al. (2021) suggested that targeted educational interventions may not be adequate to induce behavioural changes or increase confidence levels.

These studies suggest that approaches targeting health literacy may not only be ineffective in addressing vaccination hesitancy but may also contribute to greater marginalisation of these populations, aggravating mistrust.

In England, vaccination against COVID-19 became mandatory for social workers in November 2021 (Woolf et al., 2022). The government initially planned to extend the vaccination requirement to all HCWs by April 2022, however this decision was reversed by the DHSC in March 2022 due to concerns about its proportionality (DHSC, 2022).

The implementation of stringent measures to increase vaccination rates has sparked diverse perspectives, with some viewing them as serving the public interest (Sokol, 2021), while others express concerns that it may exacerbate vaccine hesitancy and mistrust (Kmietowicz, 2021).

Prior research has demonstrated that healthcare workers (HCWs) hold divergent opinions regarding mandatory immunisation for various diseases, (Gualano et al., 2021). Woolf et al. (2022) posited that mandating vaccines could worsen pre-existing inequalities among healthcare workers, exacerbating workforce shortages.

Similarly, the World Health Organisation advised against compulsory immunisation, highlighting the risk of aggravating social disparities in access to health and social services (WHO, 2021). HCW regulators in the UK expressed concerns that it could damage confidence, worsening current labour shortages (Woolf et al., 2022).

These studies suggest that decontextualised approaches, aimed at achieving herd immunity against COVID-19, can lead to further erosion of trust, thereby impacting the effective management of public health crises.

1.8. Community Psychology

Psychology, as a discipline, is inextricably linked with societal constructs, influencing, and being influenced by social norms and structures, including institutionalised racism and White Supremacy (Fernando, 2017).

Psychology, along with other fields in Western academia, is often portrayed as objective and unbiased, occupying a prominent role in the socio-cultural landscape of the UK (Fernando, 2017).

Psychology plays a crucial role in influencing research paradigms across diverse domains, including public policy (Fish, 2022). Contributions from psychology have enriched the study of racial history, shedding light on the lasting effects of colonialism on social institutions and academic fields (Fernando, 2017).

Clinical psychology, in particular, has originated and progressed in the backdrop of colonialism, hereby impacting its growth and approach in comprehending behaviour and psychological wellbeing (Ahsan, 2020). Psychological instruments have historically been used to perpetuate and reinforce discriminatory beliefs and stereotypes integral to colonialist ideologies (Guthrie, 2004).

The field has been criticised for its reliance on Eurocentric models, empiricism, eugenics and concepts that have been associated with cultural insensitivity, inadequate delivery of services to racialised populations, and a focus on individual pathology that neglects broader socio-political context (Wood & Patel, 2017).

The utilisation of the Diagnostic and Statistical Manual by the field, has been found to further impose Western conceptualisations of mental health upon diverse cultures (Mills, 2014). In response, there is a growing demand to decolonise clinical psychology by critically examining its foundational assumptions and promoting more culturally sensitive approaches (Bhatia, 2017).

Community psychology has emerged as an alternative that recognises the impact of societal, cultural, economic, and political elements on individuals' wellbeing (Reich et al., 2017). Unlike traditional psychology, community psychology takes an ecological perspective, recognising the interconnectedness of individuals, communities, and societies, and aiming to prevent social and psychological problems through systemic changes (Jason et al., 2019).

Community psychology prioritises social justice, and the analysis of social environments to address social and economic disparities (Jason et al., 2019), which is crucial for examining trust in public health within Black African and Caribbean Communities. It places emphasis on power, acknowledging that many social issues are sustained by the uneven distribution of resources and it primarily aims to effect social change, particularly for those with limited resources and excluded by society (Jason et al., 2019).

Kelly's Ecological Theory (1968) provides a framework for understanding how environmental attributes influence social interactions and relationships within a community, informing the design and implementation of community-based interventions (Kelly, 2006). Kelly proposes four key principles: interdependence, adaptation, resource cycling, and succession as a basis for evaluating, designing, and implementing community-based preventive interventions (Kelly, 2006)

Interdependence acknowledges that changes to one component of a system can impact others, triggering a chain reaction. Adaptation refers to the process of modification and the understanding that what may be adaptive in one setting may not be in another. Resource cycling involves recognising and utilising diverse resources within a community. Succession acknowledges the continuous transformation within communities, leading to various demands for adaptation.

While this theory has been praised for its holistic approach and emphasis on social transformation, generating testable hypotheses, it has also been criticised for lacking specificity (Jason et al., 2019).

1.9. Current Socio-political Context

Over the past decade, the political climate in the United Kingdom has significantly impacted racial dynamics. The Conservative governance from 2017 to 2022 was accompanied by a 54 percent increase in reported racial-based hate crimes (ONS, 2022), while the Brexit referendum led to a 41 percent increase in overt acts of racism (ONS, 2019). Hostile scapegoating towards immigrants and asylum seekers, coupled with the rise of right-wing nationalist organisations, contributed to anti-immigrant sentiment and increased reports of discrimination (Hackett et al., 2020).

Instances such as the unlawful deportations resulting from the Home Office's failure to maintain records of British Caribbean migrants (Griffiths & Yeo, 2021) and the Grenfell Tower tragedy highlighted the intersection of race and social inequality (Launchbury, 2021).

Despite widespread outrage, racism was not designated as the root cause of both instances of abuse of power (Quille, 2018; Danewid, 2020). The dearth of racial discussion is indicative of a larger pattern of racial erasure in society.

The traumatising murder of George Floyd and subsequent Black Lives Matter (BLM) protests drew attention to the pervasive structural and institutional racism still present in society (Weine et al., 2020). Although antiracism discussions increased in the UK following these events, racism continues to operate invisibly in the UK.

This view is confirmed by the release of the report by the Commission on Race and Ethnic Disparities (2021). The report asserts that various factors, including geography, socio-economic background and culture, exert a more significant influence on life outcomes than racism. This denial of racism in its structural manifestations and the erroneous attribution of blame to proximate determinants overlooks racism's role in perpetuating socioeconomic inequalities (Bécares et al., 2022).

The impact of the pandemic on UK’s public health system can be partially attributed to decreased national and local expenditures, especially in already impoverished and racially segregated areas, resulting in a decline in overall capacity (Finch & Vriend, 2023).

While incidents have brought racism to the forefront, institutions such as the NHS have been constrained by their impartiality, allowing established structures of Whiteness to persist unchallenged. Hence, a critical examination and active challenge of racism within these entities are necessary to address racial inequalities and foster a more inclusive society.

1.10. The Current Study

Trust is a fundamental aspect of social interactions and institutions, playing a crucial role in assuring survival and social cohesion (Wilkes & Wu, 2018). Nonetheless, the concept of trust is subjective, multifaceted, and diverse, rendering it imprecise and expansive (Colquitt et al., 2007). Although trust has been the subject of extensive research, its association with race and power dynamics has received limited scholarly scrutiny (Wu et al., 2022).

Trust is particularly crucial in the realm of public health, as it is essential for the successful provision of healthcare services and the collaboration with public health policies, ultimately leading to improved health outcomes (Blair et al., 2022). Despite existing healthcare disparities, the impact of power dynamics, colonial history, and discrimination on trust in public health is often overlooked. Scholars advocate for recognising race as a public health emergency (Jones, 2021).

Mistrust in these communities is rooted in systemic inequalities that go beyond the scope of the COVID-19 context, resulting from socioeconomic disadvantage and generations of discrimination and exclusion (Williams & Cooper, 2020).

The study aimed to address this research gap by presenting a grounded conceptualisation of trust in public health and examining its importance among Black African and Caribbean communities. This study aimed to explore the relationship between race and trust, with a focus on understanding the unique experiences and perspectives of these communities, who historically experienced discrimination and exclusion in the broader society and public health.

COVID-19 has increased awareness of the pervasive role of structural and institutional racism in perpetuating pre-existing inequalities (Danso & Danso, 2021; Sze et al., 2020). The study specifically investigates trust in the context of public health during the COVID-19 pandemic and the vaccination programme in the UK.

Community Psychology, with its moral underpinnings on social justice and comprehensive examination of interdependence, provides a helpful paradigm for the study (Evans et al., 2017).

Examining the formation and erosion of trust in these communities has potential implications for clinical practice, addressing barriers, understanding factors which might influence their "relationship to help" (Meyer & Zane, 2013), and contextualising and legitimising health-behaviours such as avoidance (Keating & Robertson, 2004).

Shifting the current paradigm is crucial to contest established systems of colonial power and ideology, recognising, and affirming the historical experiences of racialised communities. Examining trust's role in moderating public health behaviour within Black African and Caribbean communities can contribute to existing literature, inform inclusive policies, and promote community-led preventive support.

To the best of the researcher’s knowledge, this study represents a pioneering effort in exploring the significance of trust in public health specifically within these racialised communities, aiming to develop a conceptual framework for understanding the trust process.

1.10.1. Research Questions

The following research questions have been proposed to address the study aims:

1. How is trust conceptualised in Black communities?
2. What is the role of trust in public health for Black African and Caribbean communities?

2. METHODOLOGY

2.1. Chapter Overview

This chapter begins with a description and summary of the researcher's position, followed by an exploration of the study's epistemological orientation, and a comprehensive justification for the chosen design and methodology. Subsequently, a thorough examination is conducted on the study's recruitment, interview, transcription, and analysis processes. Finally, the chapter concludes by carefully considering and evaluating ethical considerations and the overall quality of the research.

2.2. The Researcher's Position

Reflexivity is essential in maintaining the quality of qualitative research. It involves self-reflection and acknowledging the researcher's biases, assumptions, opinions, and interests (Haynes, 2012). This process allows researchers to systematically evaluate their methodologies, enhancing transparency and overall research quality.

In this study, the researcher is an able-bodied Black African woman with extensive experience in public health, both as a clinician and service user, shaping her perspectives. The views of her family, friends, and community, most of whom are racialised, have also influenced her perspectives.

The COVID-19 pandemic and the differing opinions surrounding it have further impacted the researcher's professional life, interest and opinions. Despite attempts to remain impartial, the researcher acknowledges that her preconceptions, prejudices, and experiences may have influenced data collection, analysis, and interpretation.

The use of a reflective diary has helped minimise this influence (Engward & Davis, 2015), providing insights into the researcher's emotions during interviews and their impact on analysis and the construction of the theoretical model. Appendix B contains examples of diary entries.

2.3. Epistemological Stance

Epistemology focuses on the reliability and validity of real-world knowledge (Willig, 2012), while ontology explores the fundamental origins of reality and its underlying mechanisms (Thompson & Harper, 2012). Ontological realism posits an objective, measurable outer reality, while relativism suggests that reality is subjective and subject to interpretation (Henwood & Pidgeon, 1993).

2.3.1. Critical Realism

Critical realism posits that there is a genuine external world, however it is challenging to objectively analyse it (Archer et al., 2013). It embraces subjectivity, understanding that evidence is influenced by interpretation and subjective judgments.

This approach recognises the subjectivity of research, as the researcher's personal, social, political, and historical background cannot be separated (Oliver, 2012). Unlike naive realism, critical realism acknowledges that reality and research data are mediated (Willig, 2013).

This study applies critical realism, recognising that racism and Whiteness structures have tangible effects on individuals in public health (Willig, 2013). It also acknowledges that concepts such as race, racism, and whiteness are socially constructed and influenced by cultural and temporal contexts.

The critical realist, phenomenological perspective accepts the existence of Whiteness and racism while acknowledging the variation in individuals' lived experiences and interpretations.

In adopting this approach, the researcher values the viewpoints of participants, considering them valid and factual within the context of their experiences. Critical realism is well-suited for investigating societal issues due to its ability to engage in reasoning and its contextual awareness (Fletcher, 2017).

2.4. The Appropriateness of the Chosen Methodology

Quantitative methods involve operationalising variables for testing, while qualitative methods focus on exploring experiences without operationalising concepts. The study utilised a qualitative approach to gain deeper insights into concepts and narratives related to policies and guidelines (Thompson & Harper, 2012).

Grounded theory (GT) is a well-regarded methodology used to understand social behaviour, attitudes, and experiences, involving the systematic identification and integration of meaningful data categories (Willig, 2013). Descriptive coding is used to categorise and comprehend the data, with initial codes generated based on relevance and essential aspects of participant accounts. These codes are then organised into higher-level groups to develop more abstract concepts and theory (Charmaz, 2006). The researcher's ability to reconsider facts in light of new categories and ideas is known as theoretical sensitivity. The process helps identify data that do not conform to important patterns, allowing for reconsideration. There are three primary versions of GT: traditional, structured, and constructivist (Charmaz, 2006; Glaser & Strauss, 1967; Strauss & Corbin, 1994), exploring the applicability in various epistemological frameworks.

GT methods have an abstract theory of action, interaction, and processes developed by the researcher based on participant viewpoints (Oliver, 2012), from which a new theoretical framework is produced to assure coherence (Oliver, 2012). Due to its data-driven methodology, GT is suitable for studying phenomena without a pre-determined theoretical foundation, making it well-suited to investigate this study's aims.

2.5. Critical Grounded Theory (CGT)

This research employs a CGT approach (Belfrage & Hauf, 2017). Although CGT may seem contradictory, it reconciles GT’s promotion of naive realism with critical realism's critique and techniques such as retroduction. Retroduction initiates with an inductive phase, wherein the researcher actively engages in the field, followed by constructing empirical data and conceptualisations. This method encourages researchers to analyse, update, and apply theory to real-world circumstances (Belfrage & Hauf, 2017).

CGT researchers begin by reviewing the literature to form preliminary conceptualisations and understand prevailing social discourses on the social problem. Unlike more objective grounded theory approaches, CGT cannot claim neutrality, and the researcher initially favours familiar theories.

Through multiple fieldwork cycles, researchers gently guide participants in ethnographic fieldwork, such as semi-structured interviews, using preliminary conceptualisations. These ethnographic methods generate rich qualitative data for grounded theory analysis. Finally, empirical findings are used to update, reconstruct, or develop preliminary conceptualisations. Reflexivity is essential during the analysis stages, following a similar pattern to the constructivist grounded theory approach (Charmaz, 2006).

CGT involves continuously comparing interpretations to refine, develop, and expand fundamental ideas. As a result, CGTs are always subject to revision, making saturation unachievable. CGT is not objective but theoretically anchored in prior and current knowledge, capable of developing substantive knowledge, creating new conceptual linkages, improving or rebuilding theory, and challenging existing ideas. Its objective is moral and social emancipation, with the researcher being self-reflective and recognising their social location within a society marked by oppression, power, and exclusion. They critically observe or experience a social problem or process, aiming to explain and ultimately change it (Delbridge, 2014).

This study utilises CGT due to its emphasis on induction and theory formation. Considering that "trust" and "racialised experiences" are social constructs, CGT offers a critical framework for understanding the experiences of Black African and Caribbean individuals within the public health system, while adopting principles of social liberation (Prilleltensky, 2008). This decision aligns with the increasing adoption of critical realism epistemology in public health research (e.g. Price, 2017), and the researcher’s adoption of community psychology values and principles (Jason et al., 2016).

2.6. Recruitment Strategy

To enhance recruitment and interest in the research, various strategies were implemented. Recruitment materials, including a poster (Appendix C) and participant information sheet (Appendix D) were sent to UK-based organisations focusing on social inequalities affecting Black African and Black Caribbean communities.

The aim was to establish relationships with these organisations and leverage their networks for recruitment. The materials were shared through these networks, as well as the researcher's social media and internal networks, over a two-month period. Potential participants contacted the researcher via email to express interest and schedule interviews.

A total of 15 participants were recruited and interviewed through videoconferencing (Microsoft Teams) at their convenience. The interviews averaged 50 minutes, ranging from 45 minutes to 60 minutes.

2.6.1. Inclusion/Exclusion Criteria

The inclusion/exclusion criteria stated participants should:

- be over 18 years old
- be able to communicate in spoken English
- be ordinarily resident in the UK and eligible to use the NHS
- self-identify as being from Black African or Caribbean background including mixed and biracial ethnic backgrounds

The researcher verified that participants met the inclusion criterion upon their first meeting, even though they were requested to self-select.

2.6.2. Participants Profile

Participants were asked initial questions pertaining to demographic information. Participants were not required to provide this information and were not constrained by predetermined categories. Table 1 displays the demographic information and pseudonyms of participants to protect their anonymity.

Table 1

Participants Profile and Demographics

Pseudonym	**Gender**	**Age**	**Ethnicity**	**Level of Education**	**Vaccination Status (COVID-19)**
Patricia	Female	24-30 years	Black African	Bachelor's degree	2 or more
Crystal	Female	24-30 years	British African-Caribbean	Doctorate	2 or more
Charlie	Female	40+ years	British African-Caribbean	Master's degree	1 vaccine
Grace	Female	40+ years	Black African	GCSE	1 vaccine
Ruth	Female	40+ years	British African	Bachelor's degree	Unvaccinated

Amanda	Female	40+ years	Black African	GCSE	1 vaccine
Becky	Female	24-30 years	British African-Caribbean	Doctorate	2 or more
Tyler	Male	24-30 years	Mixed heritage - Black African Caribbean and White British	Master's degree	2 or more
Tom	Male	24-30 years	Black African	Bachelor's degree	2 or more
Cleo	Female	40+ years	British African-Caribbean	A Level	2 or more
Diana	Female	24-30 years	Mixed heritage - Black African and White European	Bachelor's degree	2 or more
Shirley	Female	31-40 years	Black African	Master's degree	1 vaccine

Iro	Male	31-40 years	British African-Caribbean	Bachelor's Degree	2 or more
SAZ	Female	31-40 years	British African	Bachelor's Degree	Unvaccinated
Sabrina	Female	31-40 years	British African-Caribbean	Doctorate	Unvaccinated

This study utilised the COVID-19 pandemic vaccination drive to examine trust in public health. Thus, each interview also collected COVID-19 vaccination status (Table 2).

Table 2

Participant Descriptive Statistics

Sample size	*N = 15*
Age mean (min, max)	36 (24, 58)
Age categories	24–30 years old = 6 (40%) 31–40 years old = 4 (27%) 40+ years old = 5 (33%)

Gender Identity	Male/Man = 12 (80%) Female/Woman = 3 (20%)
Ethnicity	Black African = 5 (33%) British African-Caribbean = 6 (40%) British African = 2 (13%) Mixed heritage = 2 (13%)
Level of **Education**	GCSE or equivalent = 2 (13%) A Levels = 1 (7%) Bachelor's degree = 6 (40%) Master's degree = 3 (20%) Doctorate = 3 (20%)
COVID-19 Vaccination Status	Unvaccinated = 3 (20%) 1 vaccine = 4 (27%) 2 or more vaccines = 8 (53%)

The study collected data on participants' level of education to explore its influence on vaccine uptake, considering the impact of health literacy may have on cooperation with public health guidelines (Kricorian et al., 2020).

While participants' current occupation was not explicitly collected, it was noted that some were current or former NHS employees. This is not an exclusion criterion as public health officials are entitled to access public health institutions. This data may, however, influence the analysis and theoretical framework, highlighting the need for careful consideration of its potential impact on the findings.

2.7. Semi-structured Interview

2.7.1. Interview Schedule

Semi-structured interviews were the primary source of information, allowing for in-depth exploration while maintaining confidentiality. The interview schedule was divided into three sections with 12 questions, covering personal perceptions, experiences with public health service and their influence on trust, and social, cultural, and political factors influencing trust in public health, with a particular exploration of the UK COVID-19 vaccination effort (Appendix E).

Participants provided electronic consent using Microsoft Forms (Appendix F) prior to the interview and chose pseudonyms at the start of the interview for anonymity. Throughout the researcher used prompts to encourage participants to share their views and provided concise summaries and reflections. Participants had the opportunity to address concerns, ask questions, and provide feedback. They all opted to receive a summary of the findings, demonstrating their active engagement. No monetary incentives were given during the research process.

2.8. Process of Interviewing

The researcher used interpersonal therapeutic techniques to build trust and establish a safe environment for disclosure. Given the context and topic of the research, this is essential for facilitating disclosure in qualitative data (Charmaz, 2006).

2.9. Pilot Interview

A pilot interview was conducted in order to optimise the interview schedule and process, address concerns, and ensure a seamless implementation (Charmaz, 2006). In response to pilot interview feedback, the researcher adapted the interview schedule, reflecting and summarising on a regular basis to demonstrate empathy and comprehension.

2.10. Transcription

Interviews conducted via Microsoft Teams were automatically transcribed, with the researcher editing the transcriptions to correct errors, protect participant anonymity, and remove non-linguistic traits.

The transcriptions of previous interviews were reviewed before conducting subsequent interviews to facilitate the exploration of new concepts and ideas (Starks & Trinidad, 2007). While time constraints and participant availability sometimes required simultaneous editing of multiple interviews, the researcher used automatic transcriptions and a reflective notebook to identify emergent ideas.

2.11. Data Analysis

Charmaz (2014) principles were followed throughout data analysis. Due to time constraints and limited analysis time between interviews, CGT was used in an abbreviated form (Willig, 2013). The participant-researcher interaction process is called ‘data generation’ in GT (Charmaz, 2006). Data generation and analysis continue until "conceptual depth sufficiency" is reached.

2.11.1. Systematic Coding

The coding process was divided into four stages: initial, focused, theoretical and diagramming.

2.11.1.1. *Initial Coding:* Initial coding is a systematic process where the researcher closely examines the data to identify processes, actions, and meanings. It allows for inductive analysis and comparisons by assigning descriptive labels and interpretations to each line of the data.

2.11.1.2. *Focused Coding:* In the second coding stage, the researcher prioritised salient data points and developed initial categories by comparing data for similarities and variations. The transcript was carefully reviewed to ensure that the codes were firmly based on the data.

2.11.1.3. *Tentative Categories or Theoretical coding:* The focused coding stage helped establish clear relationships between the generated categories. Theoretical coding then conceptualised these relationships by developing theory-driven categories, enhancing precision and clarity in the analysis.

2.11.1.4. *Diagramming:* Diagrams were employed to visualise categories and their connections during data generation and analysis. This facilitated linking earlier coding stages with subsequent data analysis. An example of such diagramming can be found in Appendix G.

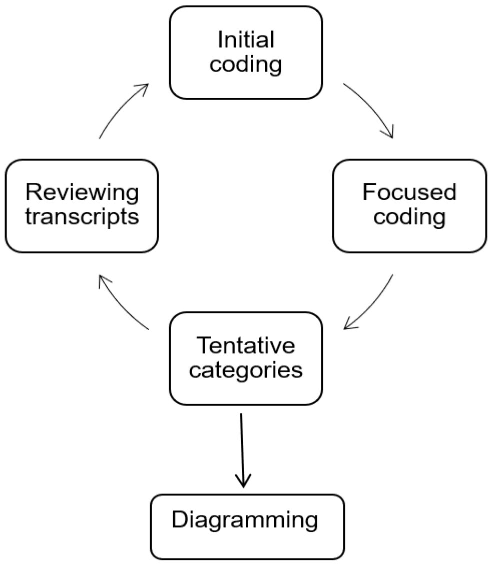


Figure 1. The coding process used in data analysis

2.11.2. Constant Comparison

Constant comparisons were employed to identify differences and similarities within and between transcripts, as well as to connect them to the evolving theory (Charmaz, 2006). The researcher analysed new data in relation to existing codes and categories, allowing for movement between coding phases, category refinement, and validation of the theory based on participants' accounts (J. Mills et al., 2006).

2.11.3. Theoretical Sampling, Conceptual Depth Sufficiency, and Theoretical Integration

Theoretical sampling aims to identify all data variations in comprehensive research (Willig, 2008). In GT theoretical sampling continues until theoretical saturation is achieved (Charmaz, 2006). However, theoretical saturation is challenging in CGT due to constantly evolving theories (Belfrage & Hauf, 2017).

To address this, the researcher chose "conceptual depth sufficiency" to assess analytical and theoretical readiness based on various factors (Nelson, 2017). This decision was made due to time constraints and concerns about oversimplification, ensuring the research's quality and transparency (Nelson, 2017).

Conceptual depth sufficiency assesses analytical and theory creation readiness based on range, complexity, subtlety, resonance, and validity. Each condition is briefly outlined below:

- A diverse range of evidence must be presented to support the theorised concepts in a number of ways.
- These ideas must be intricately linked to a complex data network of codes and themes.
- Subtlety emerges from the comparative technique, aiding in the distinction of meanings and the identification of ambiguities.
- The concepts developed must be consistent with previously published literature in the research topic.

- External validity highlights the importance of research findings being applicable not only to researchers but also to individuals familiar with the social context, encompassing broader themes (Corbin & Strauss, 2008).
- The final stage of analysis involved theoretical integration, which helped create a cohesive and meaningful narrative that delved into the participants' experiences with depth and explanatory power.

2.12. Memos

Memos were used to document the researcher's thoughts, opinions, and decisions throughout the analysis process (Tweed & Charmaz, 2011). They facilitated analytical thinking and served as a record of the analysis stages. Some memos contributed to the analysis, while others served as ideas for future exploration in different areas (see Appendix H).

2.13. Ethical Considerations

2.13.1. Ethical Approval

Ethical approval was granted by the University of East London Ethics Committee (Appendix I and J). The research was registered with the University’s Research Board and approved and conducted in line with the British Psychological Society Code of Human Research Ethics (2021).

2.13.2. Informed Consent

Participants provided informed consent by reviewing the information sheet and electronically signing a consent form. The forms were securely stored and will be deleted after the thesis examination. Participants were reminded of their right to withdraw before the interview to reconfirm their consent.

2.13.3. Confidentiality

Participants were assured of confidentiality before and after giving consent. Microsoft Teams was used for audio and video recording, with data securely stored on UEL OneDrive and deleted after transcription.

Microsoft Teams was used to record interviews, which were then securely uploaded to UEL OneDrive and deleted after transcription. Transcripts were saved separately, and the research Director of Studies (DoS) will save transcripts on UEL's OneDrive for three years before destroying them.

After the thesis examination, transcripts may be retained for publishing purposes. Participants were informed about these data storage plans. Contact information was kept securely on the researcher's UEL OneDrive and will be erased after participants receive a summary of the findings.

Pseudonyms were used to protect identities, and any identifying details were removed from the transcripts. The transcripts are accessible only to the researcher and the research DoS, with potential examiners granted access via encrypted UEL OneDrive links if necessary. The research data management officer at UEL granted approval for a data management plan, as evidenced in Appendix K.

2.13.4. Risk

As part of the application for ethical approval, a general risk assessment form was completed (see Appendix J). The researcher determined that there was no deceit in the study and that there was a minor risk that participants would experience distress as a result of their participation. Due to the delicate nature of the topic, some people spontaneously shared their experiences with prejudice and racism. The researcher used clinical therapy skills to alleviate emotional distress such as reflective and empathetic listening, reassurance and validation (Vyskocilova et al., 2011). Participants also received a list of free emotional support services and resources in the debrief form (Appendix L).

Participants were informed about the possibility of breaching confidentiality if someone's safety was at risk. The researcher established a safety plan by asking participants how they would indicate if they wanted to end the interview, decline a question, or if they needed help or a break due to distress and what support she could offer in relation to this. All participants stated their ability to communicate any concerns. Confidentiality was maintained throughout the research process.

The risk assessment indicated a minimal risk of the researcher experiencing distress from participant narratives. These were discussed with the DoS and a plan was made involving the researcher debriefing with DoS following interviews or if necessary due to risk managing emotional responses effectively.

2.14. Evaluating the Quality of the Research

The study’s sensitivity to context, commitment, rigour, transparency; and impact and importance of the research were the main guiding factors used to assess its quality (Yardley, 2000). The discussion section (Section 4.3.1) of the thesis will describe this in more detail.

3. ANALYSIS AND FINDINGS

3.1. Chapter Overview

This chapter provides a summary of the analysis's findings. It begins with a summary of the findings and an overview of the developed grounded theory model. Subsequently, an explanation and description of each category and subcategory are provided, along with pertinent participant quotations underscoring the relationships between the categories and the interdependence of the model. The chapter concludes with an illustration and summary of the model applied to the COVID-19 vaccination drive in the UK.

3.2. The Ecological Model of Trust in Public Health: An Overview

In this chapter, the 'Ecological Model of Trust in Public Health' is presented as a representation of the participants' perspectives. This model is rooted in empirical data, derived solely from the analysis of the data, without drawing upon pre-existing models. The Ecological Model of Trust in Public Health seeks to depict the complex relational aspects of trust in public health within Black African and Caribbean communities. Nonetheless, the researcher recognises that no single model can entirely characterise the experiences of all participants.

Data was used to construct three core categories: "Distal influences", “Proximal influences”, and “Individual influences and implications”. These categories comprise 11 subcategories, which are further outlined in Table 3. Figure 2 provides a visual representation of the model, including the categories, subcategories, and relational processes.

Table 3

Factors Influencing Trust in Public Health within Black African and Caribbean Communities

Category	**Sub-category**
Distal Influences	Historical and structural influences
	Political and institutional influences
Proximal Influences	Community influences
	Immediate surrounding influences
Individual Trust Influences and Implications	Intuition
	Actions fostering trust
	Higher trust profile
	Implications of higher trust
	Actions hindering trust
	Lower trust profile
	Implications of lower trust

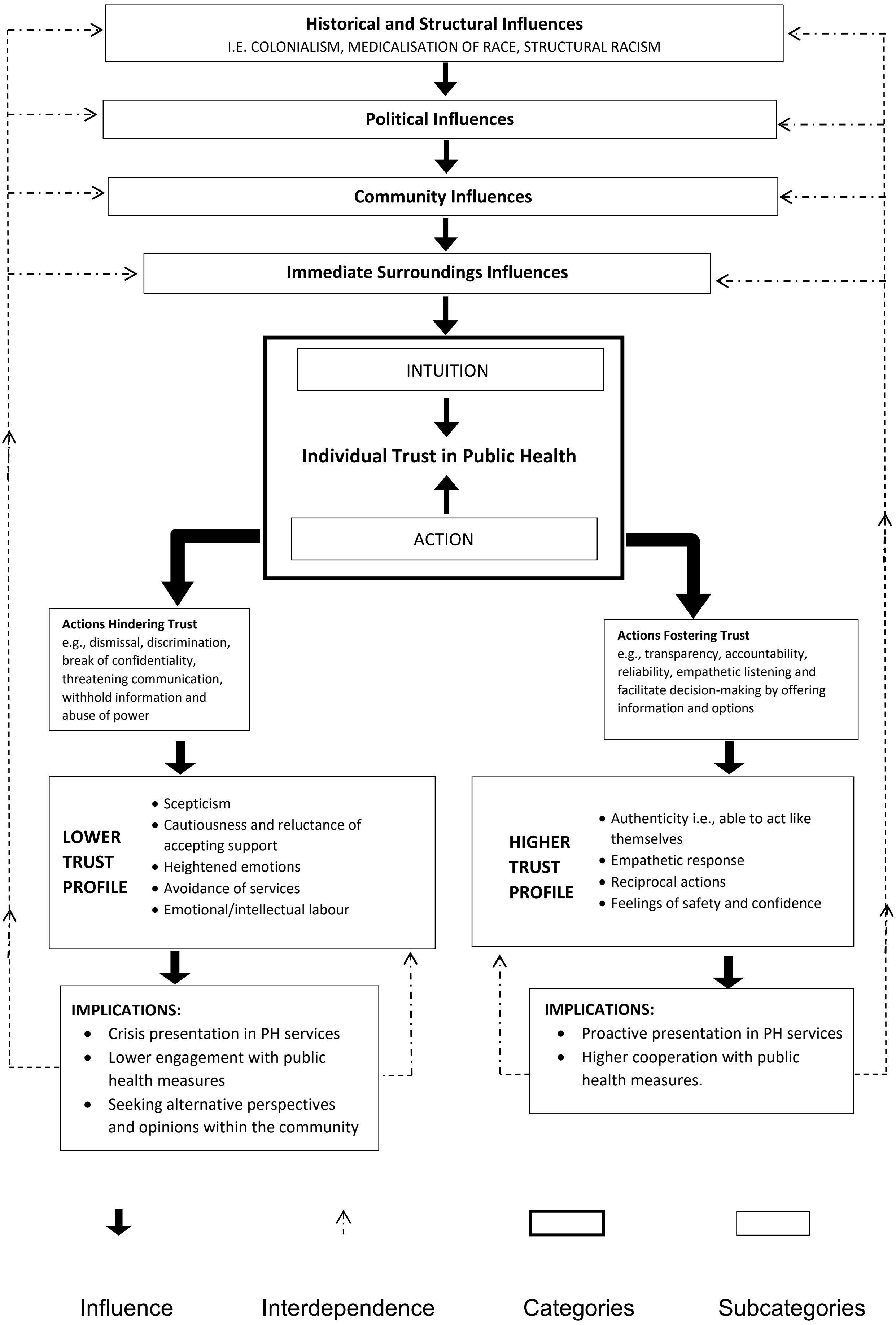

Historical and Structural Influences
I.E. COLONIALISM, MEDICALISATION OF RACE, STRUCTURAL RACISM
Political Influences
Community Influences
Immediate Surroundings Influences
INTUITION
Individual Trust in Public Health
ACTION
Actions Hindering Trust
e.g., dismissal, discrimination, break of confidentiality, threatening communication, withhold information and abuse of power
Actions Fostering Trust
e.g., transparency, accountability, reliability, empathetic listening and facilitate decision-making by offering information and options
LOWER TRUST PROFILE
Scepticism
Cautiousness and reluctance of accepting support
Heightened emotions
Avoidance of services
Emotional/intellectual labour
HIGHER TRUST PROFILE
Authenticity i.e., able to act like themselves
Empathetic response
Reciprocal actions
Feelings of safety and confidence
IMPLICATIONS:
Crisis presentation in PH services
Lower engagement with public health measures
Seeking alternative perspectives and opinions within the community
IMPLICATIONS:
Proactive presentation in PH services
Higher cooperation with public health measures.
Influence
Interdependence
Categories
Subcategories

Figure 2. The Ecological Model of Trust in Public Health within Black African and Caribbean Communities.

The ecological model of trust in public health addresses the formation of trust in public health within Black African and Caribbean communities. It conceptualises that trust in public health is a dynamic process influenced by social and environmental factors. The model adopts an ecological perspective, highlighting the role of social power in perpetuating oppression and eroding trust in public health entities.

To understand trust development, the model suggests considering distal and proximal factors. Distal influences encompass the larger context in which individuals and communities exist, including historical events such as colonialism and political factors such as government policies. Power manifests at structural levels of society, influencing resources, belief systems, and collective experiences, all of which can affect trust individual conceptualisation of trust in public health.

Proximal factors refer to the influence exerted through close relationships within the community, such as family and friends, and the collective understanding of shared experiences with public health. Communities are viewed as agentic units that facilitate the interaction of systems, challenging power structures, and resisting oppression. Proximal factors explore how social power is interpreted and exercised in these relationships, affecting individual interactions at both the individual and contextual levels.

Proximal factors refer to the influence exerted through close relationships and shared experiences within the community e.g., church community. This includes interactions with family and friends, as well as the collective understanding of the community's experiences with public health. The model recognises communities as active agents that facilitate understanding and resistance against oppressive structures, interpreting and exercising social power in proximal interactions.

Although the model portrays a sequential influence of power, it acknowledges that distal and proximal influences coexist and simultaneously shape an individual's trust in public health, resulting in individual intuitive assessments of trust. These are unconscious evaluations of trust of public health, influenced by the understanding and processing of the interaction of proximal and distal factors, resulting in a feeling of trust or distrust.

The model also recognises that trust evaluation is not solely based on intuition but is also influenced by personal encounters and perceptions of public health services and professionals. Positive actions from public health, demonstrating a commitment to individuals' best interests, foster greater trust, while negative actions that contradict individual interests lead to decreased trust and potential fear and resistance.

The model highlights the dynamic and complex nature of trust, viewing it as a relational process with the dotted arrows in the model indicating the interdependence of elements and emphasising how factors at one level influence higher levels.

The model emphasises that trust is a dynamic, relational, and complex process, and it highlights the interdependence of elements through dotted arrows, indicating how factors at one level influence those at higher levels. It argues that discrete interventions targeting single issues may strengthen individual trust but are insufficient to resolve trust issues that exist across multiple levels. Therefore, changes need to be implemented at various levels to address power dynamics and promote individual and community trust in public health.

While the model primarily focuses and represents the influence of racial identities on trust formation, it acknowledges the significance of intersectionality and the joint influence of social identities on outcomes. These factors are further discussed in section 4.2.2.

In summary, the ecological model of trust in public health provides a comprehensive framework for understanding the trust process in Black African and Caribbean communities. By examining social and environmental factors, acknowledging the role of power, and considering both distal and proximal influences, the model offers insights into the complexity of trust dynamics and the implications of such dynamics for individual and collective relationships with public health.

> Tyler: *"I think I haven't had necessarily like overly negative experiences […] Again, but I think there's probably factors involved around that. I'm a lighter skinned black man, so I think maybe Colourism has an impact on that potentially. I'm kind of able bodied. I have, like an English sounding name […] My mom is also white, so if I've been younger and you know she's taking me to appointments, I don't know whether that's had an impact."*

3.3. Distal Influences

Distal influences refer to contextual factors that indirectly influence how trust in public health develops. These factors encompass socio-economic and historical elements that shape the perception of public health organisations among Black African and Caribbean populations. Examples of the initial coding under this category can be found in Appendix M.

Participants in the study acknowledged that trust is influenced by their relationships with governmental bodies and their understanding of the ongoing structural inequalities affecting their communities. They recognised the lasting impact of historical events, which continue to hinder their relationships with the government and public health institutions.

This category is divided in two subcategories: historical and structural factors which influence trust in public health and political factors which influence trust in public health.

3.3.1. Historical and Structural Influences

This subcategory examines the influence of historical events, notably colonialism, on the experiences and perceptions of Black African and Caribbean people in public health. It highlights participants' awareness of the long-term disparities in access and experiences within public health due to colonial influences.

Participants noted that environments such as public institutions with colonial histories fostered cultures that marginalised these communities, shaping their interactions with public health systems. Participants, such as Crystal, emphasise the inseparable connection between trust in public health and colonialism, noting the historical weaponisation of trust by public institutions. They stress the lasting implications of this abuse of trust and its impact on the current perceptions of public health of Black communities. They further asserted that despite changes in structures, the fundamental processes underlying public health knowledge and services have remained unchanged.

> Crystal: "*Being someone who is black and also who works in mental health might leave you jaded in some ways to think about what the intention of these organisations are […]. Especially when you know that trust can be weaponised…You know we're talking right about colonialism and establishments and what that meant for people and how that the idea of trust associated with organisations has been impacted from then, right up until now…The structures [have] changed but inherently the idea behind the development is still the same […] it makes sense that people from my community might find it more difficult to trust*."

Shirley discussed the impact of colonialism and White supremacy on the portrayal of Black African and Caribbean communities as aggressors in history. She argued that these communities were compelled to conform to and submit to White western society in order to survive, as they faced violence due to colonial exploitation. She expressed sadness over the inability of Black communities to defend themselves, allowing those in power to shape a narrative of the "Black aggressor."

> Shirley: "*It is actually so strange to how black ethnic minority is seen it as an aggressor of a community but in actual fact in order for us to have been made to conform to the White supremacy, did they not have to show an aggression in the first place? […] What they need to understand is that we are against so much in every aspect."*

Furthermore, Shirley noted how historically Black communities have been used by science as test subjects to enhance the public's health, and the effect this has had on their trust in the public health system.

> Shirley: *"They forgotten that they used to use African countries as their test subjects. I'm not going to trust."*

Sabrina noted that historically, medical research has exploited the trust of Black communities by withholding information about severe side effects, resulting in physical and psychological harm. She emphasised the lack of recognition for this harm, leading to the marginalisation of Black communities and their continuous portrayal as problematic.

> Sabrina: *"Unfortunately, there have been times when the black community have been given certain treatments and medications and had severe effects and we're not always informed that those effects. And then when these effects play out, the very same professionals are not the first ones to hold their hands up and say it was an error on their part. They'll just gaslight you and invalidate your experience."*

Cleo emphasised the presence of racism in public health and its institutional nature. She expressed concerns about the lack of knowledge regarding diseases in Black bodies, highlighting the potential negative impact on diagnoses and health outcomes. Cleo also criticised the limited representation of black bodies in medical textbooks, noting that this issue only gained attention due to a black medical student's advocacy.

> Cleo: "*You had to get a [Black medical] student to tell you that you have to look at the complexion of a black person. You can't make a*

> *decision about whether it's A,B and C because you know you've only got copies of you. So the deeper I look into it, the more I realize how intrinsic, you know, racism is really sort of."*

Tyler exemplified how these gaps in knowledge have had indirect effects on his life, influencing how his mother was viewed by services when he was younger.

> Tyler: "*When I was a baby, I had something called a Mongolian blue spot, which is kind of looks like a blue, bluish bruise that's often on the bottom of a newborn, often mixed heritage babies. The midwife had concerns that my mum was kind of hitting me or abusing me physically…they didn't know what it was... My mum was horrendous to be, you know, accused or even suspected of doing that…."*

Charlie's exploration of the historical mistreatment of Black women in public health has aided her in understanding her own experiences. Discovering the distressing mortality rates of Black women during childbirth in 1990s London highlighted the ongoing trauma that affects the birthing experiences of Black women in the UK today.

> Charlie: *"I was shocked to learn in the 90s how black women were dying during childbirth in East London. Black women in South and East London […] because they weren't being offered c-section. They weren't being offered the best options to make them have their babies safely. […] And all this trauma sustained when I was giving birth. So actually, it's my experiences. I've opened my eyes and now I see how I was treated."*

Diana highlighted the impact of the colonial perspective on race in shaping the operations of public health services today. She shared her personal experience of public health officials making comments about her appearance, specifically referring to her muscular and strong physique as an assumption that she can endure pain based on racial stereotypes.

> Diana: *"I go to the doctors, and I have a sort of pain, the normal comment is 'You're very muscly. You have the type of ethnicity.*

> *You're strong, you can endure pain. You can handle it'. And I'm like no. […] sorry, my ancestors already suffered. I don't think I need to suffer more.*"

3.3.2. Political Influences

This subcategory discusses how participants trust in political leaders and institutions impacts their trust in public health. The majority expressed a lack of confidence in current government and public health organisations, a sentiment that was exacerbated during the pandemic. This distrust affected their perception of public health measures, causing suspicion about underlying motivations.

Becky cited the government's inconsistent policy actions, including during the COVID-19 pandemic and post-Brexit, as evidence of unreliability, contributing to her distrust and her perception of an underfunded NHS.

> Becky: "*I don't think we can trust the government with anything at this point. They've shown that they lie. You know, there were parties in Downing Street. [The] same group of people are the people who told us there would be 30 million a week for the NHS after Brexit. Those are the people who are now in the government and there's no money for the NHS [...] They have consistently shown themselves to be dishonest and not worthy of being trusted.*"

Sabrina underscored the longstanding tension and mistrust between Black African and Caribbean communities and the UK government. She attributed this to institutional racism impacting their early life experiences. Sabrina also stressed the government's role in perpetuating these prejudices and traumas.

> Sabrina: *"I think there's an element of me that I've never trusted them anyway, and for a lot of reasons. I would say that as a black person, I don't think most of us trusted long before the pandemic*

> *that the government has our best interest. I think a lot of it is growing up, experiences seeing kind of the way in which institutional racism plays out in England, full stop, and how the government perpetuated."*

Tyler expressed his dissatisfaction with the government, citing their lack of accountability for their actions as a key factor to his low trust.

> Tyler: *"I didn't really trust them [the government] anyway but I think my current trust is even lower if possible […] They haven't really acknowledged what they've done, where they've gone wrong."*

Iro linked his distrust in public health to certain political leaders, expressing fear that government actions may further stigmatise racialised communities.

> Iro: *"My trust in him [Boris Johnson] is at an all-time low, very sceptical, and very mindful of their agendas that may stigmatise against particular ethnic groups in terms of the stereotypes that make them prioritise certain things over others."*

Shirley perceives public health policies as being developed without considering the needs and opinions of racialised communities, influencing her views on the government and its motives.

> Shirley: *"The cuts that the government is making, you know, and if they're not listening to people's viewpoints and they're just making more cuts."*

3.4. Proximal Influences

This subcategory underscored the impact of community and immediate surroundings on trust development in public health among Black African and Caribbean communities. It is widely believed that proximal factors exert a greater impact on the development of trust in comparison to distal factors. The study's participants underscore the importance of community engagement in the processing of collective experiences and the provision of support and resources. Examples of the initial coding under this category can be found in Appendix N.

3.4.1. Community Influences

This subcategory focuses on how communities define their relationship with public health. Participants emphasised the presence of trustworthy relationships within their communities, promoting transparency and reciprocity. Communities were also described as playing an important role in supporting individuals in processing negative experiences and protecting them from further harm.

Some participants mentioned that learning about negative experiences in their communities influenced their trust in public health institutions. Charlie, for example, identified her church community as a trusted source for her health, where openness and trust form the basis of relationships, allowing her to be open and receive support.

> Charlie: *"I talk to people within my church communities, who I know I can trust […] I also belong to an even smaller community, which you can be even more open. And because it's a smaller community we are really based on trust."*

Charlie shared a personal experience where she questioned medical advice due to the pain associated with the provided treatment option. As an alternative, she sought guidance from her trusted community and felt supported to make an informed decision about her health based on their input.

> Charlie: *"And if I hadn't been able to do my own research and speak to people in my church. I was open to people I'm close to and so many people were then open and honest with me and said we have the same problem. The option your GP is giving didn't work for us because of the size and enormity of the problem."*

Cleo recognised the influence that negative community accounts have on her perception regarding public health services and the potential consequences they can bring. While she herself has not encountered significant negative experiences, being informed about the harm inflicted upon her community has made her wary of public health matters.

> Cleo: *"I've had what I would consider to be fairly OK experiences within public health. However, I have heard of other people's experiences that have been absolutely traumatising. So, on one hand, I can say I'm a lucky person[...] But then I'm always cautious that I might deal with the wrong person."*

Sabrina observed that the lack of trust in public health services within communities is closely linked to their restricted socioeconomic choices, which ultimately compels them to reluctantly depend on these services. This sets off a recurring pattern where individuals approach public health support with scepticism, questioning the guidance they receive and motivating them to explore alternative viewpoints and guidance.

> Sabrina: *"These are [the services we have] so we have no choice. We have to go through with what we're given. But at the same time, it leaves me incredibly distrustful so it means that actually, I do not take what professionals say as gospel. I have to get my own kind of advice as well for my community."*

Tyler comments on how growing up in a community with a diverse racial representation, including Black health professionals, has provided him with a sense of safety regarding public health.

> Tyler: *"I've always also lived in the city. [I] don't know if that has an impact. And I guess, I've always seen, and been seen, by black professionals […] professionals from other kind of minoritised groups. I think that does create a level of safety."*

3.4.2. Immediate Surroundings Influences

The subcategory delves into how the immediate surroundings impact trust in public health. It includes family and close relationships that significantly influence individuals' lives, experiences, and learning. Participants shared how oppressive experiences within their immediate environment influenced their perception of public health.

Sabrina shared the traumatic encounters her family had with public services, which has led to their present hesitancy in trusting public health institutions.

> Sabrina: *"I've had, just in my family line, very horrendous experiences and so like for example very close family members that when kind of racism was more explicit. […] I had family that have died at the hands of police because of the police brutality. And so because of that, there's always been something that's down in my family about how much we do trust."*

Tom and Ruth acknowledged the influence of their families on their perception of trust in public health. Tom approached services with hesitance and caution due to negative experiences his family encountered. On the other hand, Ruth's early memories of her immediate family facing unfair treatment shaped her perspective on public health institutions.

> Tom: *"I trust a lot the views of other people, people I trust like my family and if they have had a bad experience with someone or a service, then it means I need to be careful."*
>
> Ruth: *"[…] but even as a child, I've witnessed how my mom has been treated. And that put me off a bit."*

Patricia discussed how the need for support for vulnerable family members outweighs her distrust of services, resulting in a challenging relationship with services.

> Patricia: *"I have to go to the GP. It's not like I trust them really. […] I will always fight like going after something I need or something my kids need."*

Diana reflected on the privilege of having family members with knowledge in public health. This enables her to determine the quality of care she should receive, influencing her decision-making.

> Diana: *“Then I’ve also got a mum who's a nurse. I'm privileged because I have something to compare. I can ask someone.”*

Cleo reflected on her reluctance to trust individuals outside of her family and immediate circle. Cleo explained that in order to make an informed decision and develop trust, she must have a recommendation from a trustworthy source.

> Cleo: *“I'm more likely to trust them if they're already in my circle or known by my family. If they are sort of totally independent, I'm going to sort of be a little bit more cautious. I sort of need to know that they are who they say they are. Sort of like a recommendation which also needs to come from a place of trust.”*

3.5. Individual Trust Influences and Implications

This category explores the development of trust in public health and its impact on individuals' interactions with the public health system. It examines the factors that influence the formation of trust at an individual level, and the implications of this trust for the wider contextual factors. It examines how power dynamics at the individual level affect the formation of trust and the perpetuation of oppressive systems in public health institutions. Examples of the initial coding under this category can be found in Appendix O.

3.5.1. Intuition

This subcategory examines the impact of intuition on the development of trust in public health among Black African and Caribbean individuals. It suggests that contextual circumstances shape intuitive processes, leading to an unconscious assessment of trust, mistrust or distrust in public health.

Participants described intuition as a difficult-to-define feeling that influences their conscious evaluation of trust. Shirley reflected on instances when she ignored her intuition, resulting in harm and reinforcing its validity in assessing trustworthiness of individuals and institutions.

> Shirley: *"There's been times I felt I couldn't put my finger on it, but over time I started noticing something in their behaviour that confirmed they aren't trustworthy […] I'll get that feeling and ignore it because I think maybe I'm being sensitive, so then I don't follow what my impression says. And then lo and behold, every time I've done that in some way, then the trust has been broken […] and then I've been harmed in the process."*

Sabrina described instances in which her intuition prompted a sense of caution and how challenging it is to follow the feeling in the absence of evidence supporting its veracity. She conceptualised this feeling as arising from various parts including her knowledge of the intentional harm inflicted on communities but also her spirituality and relationship with God, instilling an instinctive sense of distrust in public health.

Sabrina shared experiences where her intuition triggered caution, highlighting the difficulty of trusting the feeling without concrete evidence. She attributed this intuitive sense to factors such as the awareness of intentional harm done to communities and her spiritual relationship with God, fostering an inherent sense of distrust in public health.

> Sabrina: *"There is also an element of intuition, sometimes I can't quite put a word or explanation to why I feel a certain way […] It's not necessarily something that they've done, but there's something that just doesn't feel right. There's something that I just feel like I have to be on my guard. I feel like I have to be a bit cautious and it's really difficult because there's no evidence sometimes […] I think it's only as I've got older and I've kind of grown spiritually in my faith that I have learned to lean on it… I ask myself how is it that God might be speaking to me and so forth […] then being in academia and healthcare, knowing how things done can be quite intentional, it just further cements it."*

Tyler discussed how his past encounters with public health led him to trust his intuition more. He recognised that his intuition acts as a safeguard, warning him about potentially risky situations and relationships.

> Tyler: *"I think for me I go more with my intuition now, so if I'm in a*

> *situation and it just doesn't feel right, those are my kind of red flags. That's what's alerting me. I've only really been leaning on that more so during my experiences in healthcare."*

Cleo noted how her intuition assists her in making informed judgements, particularly when the narrative presented to her is inaccurate or inconsistent.

> Cleo: *"I think I'm quite an instinctual person […] sometimes I find that somebody could be saying something to you, but it's not adding up with how you feel you, how you're receiving it […] maybe in the sort of unconscious way I'm testing what they're telling me against what I know."*

Crystal highlighted that trust in relationships initially relies on intuition but emphasised the growing significance of observing others' actions over time. Diana cautioned against relying solely on intuition, as it can lead to misconceptions, stressing the importance of evaluating individuals based on their actions.

> Crystal: *"Knowing how to trust someone might start with a certain degree of intuition, I think, and perhaps a kind of gut feeling that you might have initially. […] But then over time, I look at their actions."*

> Diana: *"Even though you got that feeling that intuition, I am still looking for a kind of action, an action-based assessment. You know, let me see your actions and then I know if I can trust you or not, because I don't want to prejudge anything".*

3.5.2. Actions Fostering Trust

This subcategory focuses on how personal experiences with public health services shape trust development. It identifies actions that cultivate trust in public health within these communities such as transparency, empathetic listening, accountability, and reliability.

Patricia shared her experience, noting that reliability and transparency were key factors in developing trust with some public health professionals. She also stressed the significance of creating an environment where information is openly shared with service users to foster trust.

> Patricia: *“I would trust them if they actually acted on their promises. Like if they said the doctor will come around to see you by 2:00 PM, then it happened by then or if there was an emergency, they would tell me always. So, there's always some information and I don’t feel blindsided.”*

Charlie emphasised the importance of actions that show respect for others' perspectives and create space for dialogue in building trust. She reflected on the value of not imposing personal beliefs on others, but instead offering information and resources to enable informed decision-making.

> Charlie: *“If the person then goes this extra mile and say actually ‘I understand why you're still questioning’. I respect that. And what if I give you this to read? Or what if you go and speak to so and so? [...] They're trying to accommodate my question, so I trust them more.”*

I Crystal highlighted the significance of active listening and maintaining confidentiality in building trust. SAZ emphasised the role of transparency in fostering decision-making autonomy, thereby promoting trust in public health.

> Crystal: *“It’s being in a position where I feel comfortable and confident to in some ways be vulnerable with someone. And feel that I'm being listened to and understood, I think is a big part of [it]. And that I feel that I can share information […] and it is not going to be abused or misused or shared beyond the confidentiality.”*

> SAZ: *“So, for example, if I'm going in for a procedure, I think all the information would be laid out. They would tell me the risks and stuff like that, which I will be able to understand and make a decision.”*

Shirley emphasizes the importance of genuine remorse and accountability, acknowledging that mistakes are inevitable for individuals and institutions. Recognising the harm caused and acknowledging breaches of trust creates an environment conducive to forgiveness and openness.

> Shirley: *“Trust for me also has to do with genuineness and I guess remorse if you make mistakes. I think the major part is accountability. I will hold you accountable for your actions the same way I would appreciate you holding me accountable, […] we're not perfect. […] if you show genuine remorse, I might be able to forgive you.”*

3.5.3. Higher Trust Profile

This subcategory examines the outward expression of an individual's trust in public health. It focuses on identifying the behavioural and psychological characteristics of those who have a higher level of trust.

Becky shared that she feels less guarded and more open when she perceives others as trustworthy, associating trustworthiness with a sense of safety.

> Becky: *“If I trust someone, I think I'm less guarded. And if I trust somebody, then I know that I'm safe and I don't need to, you know, protect myself with as stringent boundaries.”*

Grace shared her perspective, highlighting that she becomes open and authentic when she trusts others. She also mentioned her inclination to show empathy and tolerate the fallibility of others' actions once a relationship of trust and respect is established.

> Grace: *“If I believe them to be trustworthy, then I am more open, I am more myself. I give them opportunities, even if they get it wrong sometimes. I am really willing to give them information because I know that they're going to handle that information, especially if it's personal with like respect […] in a way that keeps me safe.”*

Iro related trusting others with a change of cognitive processes, particularly the absence of overthinking and diminished inhibitions.

> Iro: *"If I believe someone to be trustworthy, I think it's a case where you don't overthink the situation […] your inhibitions are drawn down, where your instincts to just go with the flow don't feel in any way over thought or over analysed or congested with overthinking in that sense."*

Shirley noted that in trustworthy relationships, she feels comfortable being her true self. She also highlighted the importance of reciprocity in trust, where both parties play a role in supporting and creating a sense of safety for each other.

> Shirley: *"You've got me 100% truthfully, unconditionally, you know, and I'm that kind of solution focused. So, I will always spend hours to try and find a solution. Just as much as what I put into myself, I put into you."*

3.5.4. Implications (Higher Trust)

This subcategory delves into the implications of having a higher level of trust in public health. It is suggested that trustworthy relationships increase engagement with public health services, enabling the provision of preventive care.

Higher trust also promotes greater cooperation with public health guidelines and policies.

Charlie shared her experience, recalling feeling reassured by public health services in her youth when she had familiar doctors. Positive early experiences influenced her current perspective, motivating her to utilise services and support the delivery of preventive care.

> Charlie: *"When I was younger, I knew exactly who my doctor was. And I knew if I called that, you know, I could speak to so and so and that they had a rundown of what any kind of issues were and they would do things like, you know, additional kind of checks just to make sure everything was OK."*

Cleo shared her experience of receiving consistent care from her GP surgery, which has increased her trust in public health. She highlighted the importance of the context of the surgery, such as its location in a racially diverse borough and the presence of medical professionals from various racial backgrounds. Knowing that members of her community also visit this surgery instils confidence that the staff is acting in her best interest, motivating her to utilize the service when necessary.

> Cleo: *"I've been in the same GP surgery all my life; I've got to know the doctor there. I've got to know the people there. I think they're going to do the best for me. […] I think it's also a GP surgery that sees people in their diversity and you know, and I know a lot of people that go to that doctor's surgery as well […] there has always been so much diversity in the medical professionals in the surgery too. I am lucky to live in a borough like that "*

3.5.5. Actions Hindering Trust

This subcategory explores actions that undermine trust in public health at the individual level. Participants noted that abuses of power, such as discrimination, dismissal, and breaches of confidentiality, contribute to this mistrust.

Patricia and Ruth recounted their personal experiences of unfair treatment based on their racial identities. Patricia recounted a distressing pregnancy and childbirth experience during the pandemic, where she observed a stark change in staff behaviour upon disclosing her Black identity. She described her needs being neglected and her experiences dismissed, resulting in a serious health scare.

> Patricia: *"They assumed I was White because I am European and my accent. Once they actually saw me, I was already seven months old pregnant. They immediately mentioned that I was not White as it was written on paper, and they seemed very surprised [...] It felt like quite a dramatic change. It felt like everything was brushed under the carpet, nothing was explained to me anymore and I felt I was treated differently. The questions felt more intrusive. […] I had to have an emergency c-*

> *section. It was quite traumatic."*

Ruth recounted the traumatic experience of receiving neglect from healthcare staff during her hospital admission. She expressed being stigmatised for asking questions and highlighted that her needs were not addressed with the same level of attention as others.

> Ruth: *"When I was in hospital, I rang the bell several times, but the nurse would not come […] no one came to my room till about five hours later, no lunch, nothing. […] I was the only black person in the ward. I questioned them […] then I noticed that when they come to do their rounds, they went to every single bed, checked if they had had a bowel movement, but I was never asked that question. Once again, I'm seen as a troublemaker."*

Diana shared her experience of being dismissed, treated unfairly, and given an incorrect diagnosis during an unexpected health emergency. Despite her visible pain and immobility, her struggles and emotions were disregarded. She also mentioned a significant breach of confidentiality, which has negatively impacted her trust in public health.

> Diana: *"I had major pain in my body and sometimes half of my body would paralyse to the point that I would not be able to walk, this is a scary situation for someone so young. […] And then going to the doctors in A&E for urgent support, explaining the type of pain that I had. It's crazy because I was in clear pain, I had one side paralysed. I had to be put in a taxi when I was at work. I had to be carried because I could only move one leg and one arm. I was totally incapable and at the right place, and instead of offering a wheelchair, they let me wait on the floor, for hours and hours on end. The thing that they asked me to do is urine tests. I don't understand why but the doctor let me leave and says it looks like you have a urine infection. I'm pretty sure this is my back. I'm in pain, I'm crying, I can't bend, I can't walk properly […] And then to complicate this, actually in that specific hospital stole my data. It made me worry about going home and having a creepy person waiting for me. My trust in that specific hospital is zero out of five, no trust at all. "*

3.5.6. Lower Trust Profile

This subcategory examines the individual-level manifestations of lower trust in public health. It focuses on identifying the behavioural and psychological characteristics of those with lower trust in public health.

Charlie shared being stereotyped when asking questions about her children's health and wanting to be involved in the decision-making process. These encounters intensified her emotions, influencing her behaviour.

> Charlie: *"As a black woman, sometimes I am made to feel like this kind of argumentative middle-aged black woman for asking a question. […] I've challenged decisions they try to make about my children. […] I had to get all Caribbean and to say to people "look, I have enough knowledge, I'm educated. I can make that decision.""*

SAZ articulated how her negative experiences with public health services have resulted in a degree of scepticism towards public health and a corresponding need for reassurance, even when there is no basis for doubt.

> SAZ: *"Even though a doctor is telling me to take something and sometimes they do talk about side effects […] I kind of have to go home and find out a bit more about it. Just for, you know, reassurance's sake."*

Patricia discussed her mistrust in public health services, which leads her to spend considerable time researching or taking actions to address her health issues before seeking medical help. This extra effort is aimed at ensuring the needs of her family and herself are adequately addressed.

> Patricia: *"I have to go to the GP because it's what I have to use. I do everything that is recommended, like I look for information before I go to the GP […] I will chase them. I will always fight and go after something I need or something my kids need. […] I know it's not my job, but I will do that myself to guarantee I have what I need."*

Sabrina discussed the mental and emotional strain of seeking public health support, highlighting the negative and traumatic experiences her family has endured. Despite these challenges, they must disregard and regulate these feelings to access services. This hidden burden, which often goes unrecognised, fosters polarisation and mistrust in public health.

> Sabrina: *"Anything that we've [my family and I] had to get help for, we've had to fight constantly for and had to deal with the attitudes and just negative comments, negative statement from professionals that you would think were there to help you but are not."*

Ruth reflected on the influence of her low trust in public health on her interactions with services. She expressed her resolve to exhaust personal resources before seeking support and her hesitation to accept help. Ruth discussed the need to adopt a self-protective stance when engaging with public health, including dressing in a manner that commands respect without conveying superiority to minimise the chances of facing discrimination.

> Ruth: *"I never go there with airs and graces. Actually, I try and do as much as I can for myself. If I can physically wash myself, I will try to. […] I do not trust any official… I will do my best not to ask for nothing, even though I am entitled to it a hundred percent. I want to be relying on myself because of the way I have been treated. […] I never go to a hospital dressed in a tracksuit, and it may sound silly, but as a black person, I think you have to even dress up to have respect. […] Yeah, it's that silly but I want respect. The labour that goes into getting respect cause respect should be naturally, immediately earned. It's not something that is naturally, automatically provided."*

3.5.7. Implications (Lower Trust)

This subcategory delves into the implications of having a lower level of trust in public health. It is theorised that mistrustful relationships will lead to reduced engagement with services, potentially resulting in individuals reaching a crisis point. Low trust is also linked to increased scepticism and seeking alternative perspectives from trusted sources such as their communities.

Patricia expressed how negative encounters with GPs have made her hesitant to book appointments due to fear of potential harm, which is particularly challenging as she has young children.

> Patricia: *"The GP was very dismissive. […] If I come with an issue, I expect at least some advice from it, not just like a dismissive attitude […] I don't actually schedule many appointments anymore because I'm afraid and I have two babies under two so I really should feel like I could come to my GP."*

Sabrina remarked that her negative experiences with public health services lead her to avoid utilising them unless in a crisis. She highlighted the importance of her family and community in evaluating advice from public health workers to minimise harm and avoid marginalisation.

> Sabrina: *"If I might be honest, I avoid them at all costs. I go only when I have to. So, it tends to then be just crisis. It tends to be just if things are very severe. That's when I have those experiences and that's when I will go to them. I am quite fortunate that I have a family where we have a lot of health professionals, doctors, nurses, that are able to kind of share insights into certain things. So even if they do give advice, I then have to confirm with in my community as I've been in situations when I was younger, where I took the advice of doctors and there were quite severe and harmful long-term effects."*

Charlie described her hostile relationship with public health services, feeling safer outside of their realm. The COVID-19 pandemic intensified this strain further.

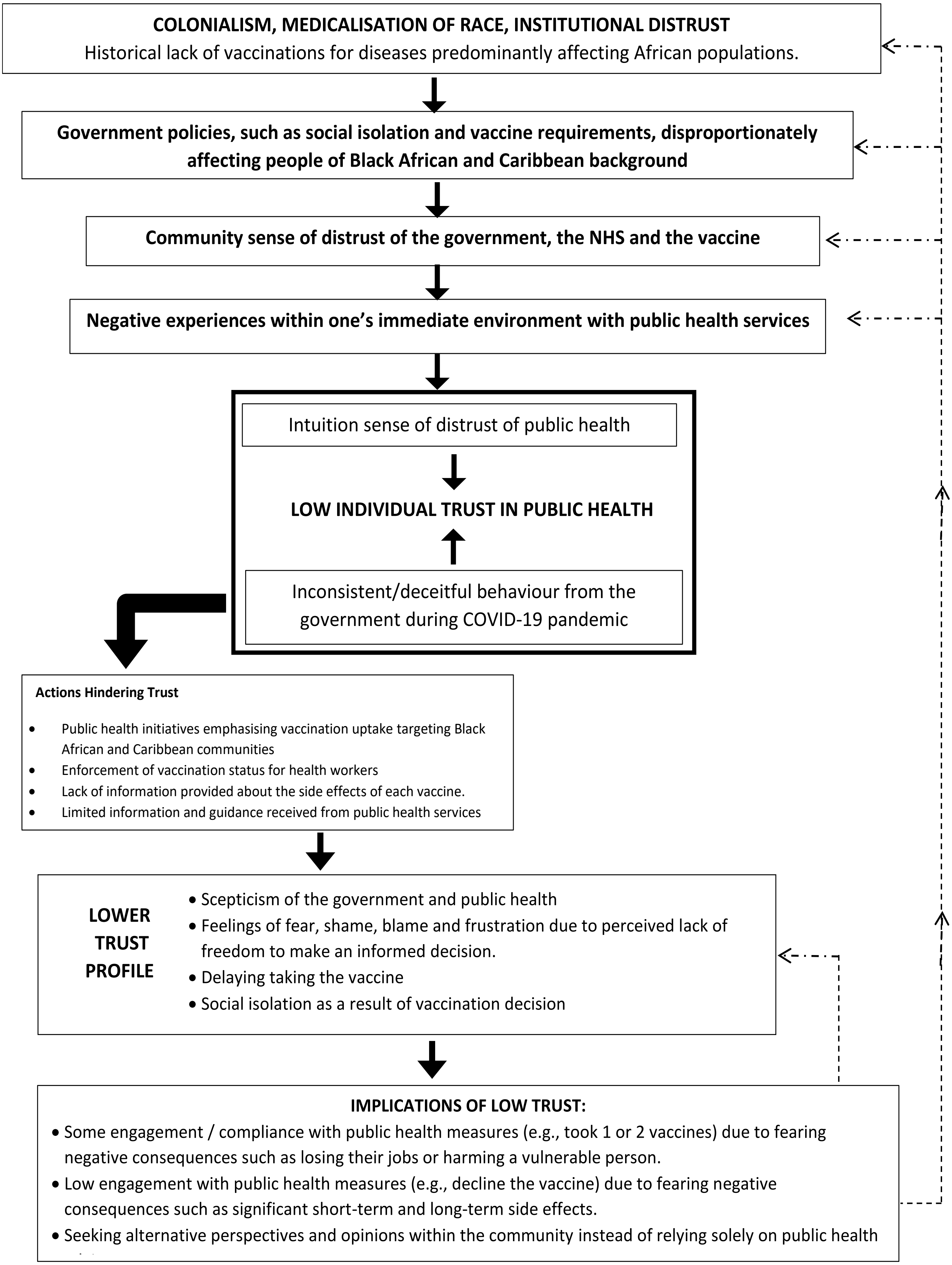
> Charlie: *"It's almost like you're close to somebody, but actually it's this kind of antagonising relationship where you think "ohh sometimes I'll be better off out of this relationship". […] It was bad before, but since the pandemic my relationship with the NHS, it's almost like I don't even like to contact the NHS."*

Meanwhile, Becky revealed that her experiences led her to utilise public health services exclusively for emergencies. Being a Black Caribbean woman, she emphasised the common practice of relying on elders and natural remedies, highlighting her trust in them for health matters.

> Becky: *"I trust myself and the elder people in my community. I think because with Caribbean, we use lots of natural remedies. We're not people who go to the pharmacy for everything. […] I would say that older people in my community are the people that I trust, primarily with my health and with sort of smaller concerns. If something is acutely wrong and I'm very unwell, then I will place some trust in public health."*

3.6. Application of the Ecological Model to the COVID-19 Pandemic

This section explores the application of the ecological model, starting with participants' recognition of the impact of broader contextual factors and concluding with the implications of participants' mistrust in public health during the COVID-19 pandemic. Participant quotes are incorporated for clarity and to facilitate comprehension. Examples of the initial focused on COVID-19 can be found in Appendix P.



COLONIALISM, MEDICALISATION OF RACE, INSTITUTIONAL DISTRUST
Historical lack of vaccinations for diseases predominantly affecting African populations.

Government policies, such as social isolation and vaccine requirements, disproportionately affecting people of Black African and Caribbean background

Community sense of distrust of the government, the NHS and the vaccine

Negative experiences within one's immediate environment with public health services

Intuition sense of distrust of public health

LOW INDIVIDUAL TRUST IN PUBLIC HEALTH

Inconsistent/deceitful behaviour from the government during COVID-19 pandemic

Actions Hindering Trust

- Public health initiatives emphasising vaccination uptake targeting Black African and Caribbean communities
- Enforcement of vaccination status for health workers
- Lack of information provided about the side effects of each vaccine.
- Limited information and guidance received from public health services

LOWER TRUST PROFILE

- Scepticism of the government and public health
- Feelings of fear, shame, blame and frustration due to perceived lack of freedom to make an informed decision.
- Delaying taking the vaccine
- Social isolation as a result of vaccination decision

IMPLICATIONS OF LOW TRUST:

- Some engagement / compliance with public health measures (e.g., took 1 or 2 vaccines) due to fearing negative consequences such as losing their jobs or harming a vulnerable person.
- Low engagement with public health measures (e.g., decline the vaccine) due to fearing negative consequences such as significant short-term and long-term side effects.
- Seeking alternative perspectives and opinions within the community instead of relying solely on public health

Figure 3. Application of the Model to the COVID-19 Vaccination Drive.

Figure 3 illustrates the application of the ecological model of trust in public health within Black African and Caribbean communities during the COVID-19 pandemic and the UK Vaccination Drive.

Participants highlighted the impact of distal, proximal, and individual factors on their trust in public health and subsequent decision-making. They acknowledged historical and systemic injustices leading to limited healthcare access, fostering mistrust in government and public health advice.

Participants also noted the exploitation and exclusion of Black bodies from scientific inquiry, shaping their perspectives on public health and the utilisation of scientific research in addressing a global health crisis.

> Shirley: *“They forgotten that they used to use African countries as their test subjects. […] I'm not going to trust that I'm going to get the same vaccine as my fellow white person.”*
>
> Crystal: *“A lot of research trials do not include black participants […] black and ethnic backgrounds were like underrepresented in the kind of trials for COVID-19. I was just like “What am I actually like putting into my body?” […] Made me think in terms of whether I felt I could trust the vaccine or not.”*
>
> Iro: *“Did you not care about the other diseases affecting the poor continents? Ebola for example. Ebola and the way that was dealt with or stigmatised as a black disease. Whereas now with COVID, because of the impact it had on them, there's no stigmatisation.”*

Participants shared their longstanding distrust of the government, which heightened their scepticism about their intentions during the COVID-19 pandemic, reigniting fears of victimisation within black communities.

They also discussed inconsistencies in the government's messaging about vaccinations and the allocation of vaccines to foreign countries. This raised questions about the government's priorities and whose interests were being served. The discussions underscored the interdependence of trust in public health and trust in the government.

> Crystal: *"I think what's particularly interesting is that people from other ethnic backgrounds now saying we don't trust the government with these kinds of like scandals. Where like people from black communities have been saying this since the government was designed."*

> Crystal: *"They specifically sent it to other Western societies, and they wanted to leave continents like Africa without vaccinations. So, things like that where I'm just like now I don't trust the government had my best interest in mind. […] I was working in public health […] I'd watch the news and what they were saying completely didn't match what we were saying."*

> Iro: *"I found it difficult to trust because it came from the government, it felt like they were being sold to us. I felt that there was an agenda around the vaccine, beyond health."*

Participants noted that their communities viewed the actions of public health and the government through different perspectives. Government initiatives were seen as potentially harmful, leading to a need of self-preservation. Sabrina highlighted the historical distortion of Black communities as perpetrators and their portrayal during COVID-19 as obstructing vaccination efforts, reinforcing negative stereotypes.

> Sabrina: *"It's the harm that's been done to our black community by professionals, by politicians, by government in the way that these services structures are set up. And then when we've been at the other end of it, our voices are not heard, the services do not change around. They reframe it, that it was just you that's the problem or it's your body and so forth. I would say it's [that] we're protecting ourselves against further harm as opposed to 'we just don't understand what it's about'."*

Participants explored the impact of their families on their decision-making process regarding the safety of the vaccine. They took into account their families' opinions and circumstances, considering how their choice would impact their interactions within the family unit.

> Iro: *"Some of my family were against the vaccination. […] I took my time*

> *to get it because my family told me like no, I'm not getting it, don't trust it."*
>
> Crystal: *"Speaking to family and thinking about why it might not be helpful in terms of things like being someone who wants [to] have children in the future and like not knowing what it does to your reproductive system."*

Participants shared their intuitive distrust of the vaccine, rooted in their lack of trust in the government and public health. They believed that government actions further eroded trust in public health services and mandates.

They discussed how vaccination initiatives may have created a social climate of negativity, leading to feelings of isolation, shame, blame, and fear among Black African and Caribbean individuals. Scepticism towards the government resulted in reluctance to follow public health recommendations.

Participants expressed concerns about initiatives that limit their decision-making autonomy, heighten negative emotions, and lack information from familiar health sources, leaving them vulnerable.

> Charlie: *"I was changing jobs, and I had an interview for this position […] I was caught when the NHS was saying vaccination was a requirement for jobs within the NHS. And normally I would cuss and say no. I'm not doing this, but I still wanted to leave my other job because that was causing me so much suffering. So, it was like swapping one suffering, which is the worst suffering."*
>
> Sabrina: *"I absolutely understand in terms of the vaccines and so forth. And so do a lot of people within my social network, within the community that have chosen not to have the vaccine […] they give us these promises and tell us it's going to be OK, when they haven't even done the research within our community. It feels very much like it's being forced, when we're being told against our will, that doesn't ignite trust, it just further exacerbates the distrust."*
>
> Grace: *"Initially I didn't want to take it. I kept getting reminders and emails from my surgery that I must come and get it. It was no*

> *information. It wasn't this kind of information that you could make sense of […] I took it because I had to travel."*
>
> Shirley: *"You didn't feel comfortable telling people you didn't do the jab because you're seen as the bad person because of the way things have been worded or presented. You're uneducated because you're black. You're in the communities, the one that's killing us cause you're not doing your job […] Why did they think it was OK to have this blaming culture?"*
>
> Ruth: *"It had a massive impact on relationships. It isolated you. Yeah. Because they're seeing you as you are the covid person. Yeah, but I'm not, I've just chosen not to have the vaccine […] They made it their mission to make videos of people in the church that've had the vaccine and make us feel guilty. […] So you're meant to feel like a leper if you don't follow the norm."*

Participants' existing distrust in public health and the government was intensified by government actions. While some participants "decided" to vaccinate against the virus, they felt compelled to do so for family, work, or avoidance of discrimination. The pandemic highlighted ongoing injustices faced by Black communities, reinforcing a sense of being unsafe and undervalued in public health.

> Tyler: *"The inequalities that have come out of, like, the COVID pandemic […] I think, you know, that does affect your trust because you think well, that could be me, that could be some of my family."*
>
> Amanda: *"They created so much fear around the vaccine. If you don't take it, you won't be able to work, you won't travel, go out for meals etc, and then we learned they acted differently."*
>
> Shirley: *"They instilled fear in us. I thought to myself, what is the intent? […] I never got to the point that I decided to take it. My rights were taken from me. I have three children, single parent on the one income coming in. And if I didn't take this job, I would not be able to take care of my children. There was no choice. How can I trust you?".*

4. DISCUSSION

4.1. Overview

This chapter will summarise the findings of the research, relating them to the research questions, theoretical models, and existing scholarly work. The researcher will assess the quality and limitations of the study and examine its implications and recommendations for future research. The chapter will conclude with the researcher's reflections and a succinct overview of the research study.

4.2. Contextualising Research Findings

This section aims to provide a comprehensive overview of the research results, relating them to the two research questions and the pertinent literature. The first research question sought to understand the conceptualisation of trust in public health within Black African and Caribbean communities. The second centred on discerning the significance of this trust. A grounded model was constructed to encapsulate the concept of trust in public health among these communities, thereby addressing both research questions.

The model presented in Section 4.2 depicts an ecological conceptualisation of trust, highlighting various factors that influence trust within Black communities. Trust in public health as conceptualised is a multifaceted and enduring phenomenon that manifests across various levels. It is shaped by individual, proximal, and distal factors, and is further reinforced by experiences of oppression and powerlessness within the realm of public health and wider society.

4.2.1. The Ecological Model of Trust in Public Health within Black African and Caribbean Communities

4.2.1.1. Trust, Race and Power: The model posits that power dynamics at societal levels significantly influence resources, belief systems, and collective experiences of Black African and Caribbean communities in the UK, impacting their trust in public health entities.

Participants' narratives illuminate how power is intertwined with race, highlighting historical dominance of Whiteness and institutions over racialised communities, leading to disparities in resources, opportunities, and decision-making power.

This perspective aligns with scholarly research indicating significant influence of experiences of oppression and powerlessness on trust (Catala, 2015). Power imbalances, evident in historical events such as colonialism and the slave trade, foster long-lasting disparities breeding mistrust (Cook et al., 2005).

Yamagishi (2011) found that individuals who hold authoritative positions demonstrate a higher level of competence in effectively handling the negative outcomes of a trust violation situation.

As a result, this not only serves as a safeguard against instances of oppression, but also impacts their capacity for empathising with individuals who may lack the means and skills to manage the adverse consequences of a compromised trust dynamic.

Studies have shown that the intricate and diverse nature of the relationship between race and power is influenced by historical and systemic elements that perpetuate power imbalances (Gruenfeld et al., 2008). These factors are likely to have an impact on trust.

4.2.1.2. *Distal Influences:* The model proposal that distal influences play a significant role in shaping trust in public health. Participants in the study recognised that their perception of public health cannot exist in isolation from the social and political structures in which it operates.

Participants recognised the influence of historical and structural contexts, such as colonialism and the marginalisation of Black people, on their perceptions of trust. They noted the enduring impact of colonialism on knowledge production, medical science, and the treatment of Black bodies, as evident in their own healthcare experiences. Historical trust exploitation, especially in medical research, was identified as causing enduring distrust towards public health. Such findings echo previous research linking knowledge of past racial prejudice with hesitancy to trust medical professionals (Sengupta et al., 2000).

Participants expressed an awareness of current political and organisational systems that often de-emphasise the damage inflicted on Black communities, further exacerbating feelings of mistrust. Disregarding the colonial legacy overlooks the enduring impact of imperialism on the UK's cultural landscape (Ashcroft et al., 2013).

Participants expressed concerns about the limited information available on the presentation of diseases on Black skin and the lack of diversity in medical textbooks. They asserted that such deficits have contributed to their experiences being misdiagnosed, aggravating feelings of mistrust. This is corroborated by studies that found a critical underrepresentation of dark skin tones in medical curricula (Louie & Wilkes, 2018).

4.2.1.3. Proximal Influences: Van der Horst and Coffé (2012) and Jason et al. (2016) highlight the importance of trust in establishing relationships in diverse settings, evolving within groups over the course of time and through cooperation. The current study builds upon this, introducing the concept of proximal influences, or the impact of close relationships in the development of trust in public health.

The concept of proximal influences is also consistent with Bronfenbrenner (1979) ecological systems theory, which states that people's primary socialisation and interpersonal experiences are influenced by their proximal surroundings.

Participants acknowledged a deep sense of belonging and support within their communities, recognising their community's role in interpreting historical events and maintaining cohesion. They perceived their communities as reliable sources of support and resilience.

Participants expressed a sense of belonging within their communities that extended beyond immediate social circles, seeing these communities as sources of support, cohesion, and reliability, supporting McMillan and Chavis' (1986) sense of community theory. Participants underline the community's role in interpreting historical events and providing expertise and resources, including healthcare professionals, within their communities.

Participants highlighted the interdependent relationship with their community and families, recognising their support, dependability, and resources, which nurtured trust, reciprocity, and safety. The participants emphasised the importance of social support in mitigating the negative effects of interactions with public health, aligning with previous research on the role of social support in trauma (Calhoun et al., 2022).

Consistent with trust literature (Uslaner, 2002), participants in the study expressed a higher level of trust in the health advice and guidance from their families and communities, considering their familiarity and taking their views into account.

4.2.1.4. Individual Influences: Trust at an individual level was described as influenced by distal and proximal influences. Participants described how the interactions between distal and proximal influences resulted in an unconscious assessment of public health. This assessment was sometimes described as spiritual and “a gut feeling”, resulting in an intuitive sense of trust or mistrust.

The presented model suggests that intuition in public health is an internal self-preservation process that is naturally biased and influenced by past personal and collective experiences in public health and understanding of how harm has been inflicted upon the Black African and Caribbean communities.

Intuition, as defined by McCrea (2010), refers to the immediate understanding without conscious reasoning and is often characterised as a 'gut feeling' about the appropriateness of a person, place, situation, or object. They hypothesised that intuition is acquired through personal experience, attributing people's tendency to "trust their gut" to traumatic experiences. However, there is a gap in the research when it comes to understanding the role of intuition in developing trust, especially in the context of systemic trauma.

While trust is commonly seen as a deliberate, calculated choice (Gille et al., 2017), a body of research argues that trust is also a result of emotions, and as such, is driven by gut feelings as much as by logical calculation (Seligman, 2000). Participants reflected that their intuitions often correctly indicated untrustworthy situations, and hence, they learned to rely on this inner sense for assessing the actions of public health entities.

Participants acknowledged that disregarding their intuitive sense of trustworthiness led to negative outcomes. Over the course of time, they learned to rely on their intuition and use it to assess others, particularly in contexts of high vulnerability and minimal information. In situations where a public health official's account contained discrepancies and errors, intuition was regarded particularly useful in assisting participants in making informed decisions.

This is in line with studies which have investigated the role of intuitive bias in decision-making and discovered that intuition comes with subjective ease (Simmons & Nelson, 2006), causing individuals to hold their intuitions in high confidence.

Despite its benefits, relying solely on intuition can create bias and lead to inaccurate perceptions, potentially restricting access to support. One's trust level hinges on the actions of public health, the perception that these actions serve their best interest, and how these actions impact them (Mayer et al., 1995).

A dichotomy was evident between actions that fostered trust and actions that undermined trust, however participants conceptualised trust as a process with a spectrum of actions. Most experiences with public health services led to mistrust due to actions such as discrimination, withholding information, and breaching confidentiality. These negative experiences have been found to prompt self-preservation responses such as avoidance, scepticism, and self-management.

This is consistent with research (Wilkes & Wu, 2019) indicating that experiences of discrimination and power imbalances influence the development of trust, particularly in racialised individuals.

Participants reported numerous instances of mistrust caused by dismissive, discriminatory, and abusive behaviour by public health officials. They responded with self-preservation measures, including avoidance, self-management, and research into potential solutions. This heightened mistrust and self-preservation align with Carter's (2007) race-based traumatic theory, suggesting that racism, experienced directly or vicariously, can induce effects akin to Post Traumatic Stress Disorder (PTSD) and consequently have damaging psychological, social, and physical effects on racial minority individuals and communities.

Racial trauma in public health does not occur in a vacuum; rather, it exists at interpersonal, institutional, and environmental levels, affecting individuals and communities (Brondolo et al., 2009) and reminding individuals of both their own prior encounters with racism and the lengthy history of racism directed at similar others.

The model hypotheses that racism within healthcare settings occurs as a result of vicarious traumatisation transmitted intergenerationally (Williams & Mohammed, 2013). This vicarious, intergenerational trauma has implications for the psychological, social, physical health of communities, and their collective identity (Helms et al., 2012).

The presence of racism in healthcare settings further burdens racialised individuals, silencing their experiences, exacerbating the trauma and fostering a climate of invisibility and denial around racial issues (Goosby & Heidbrink, 2013).

Racialised individuals face the added emotional labour of navigating racial microaggressions daily while challenging dominant ideologies that dismiss the importance of race and racism (Evans & Moore, 2015). This results in crisis-based service use, perpetuating the circle of fear as described by Keating and Robertson (2004).

This mistrust reduces participation in public health measures and increases the likelihood of seeking services during crises. Communities, thus, play a crucial role in providing safe spaces and resources for self-empowerment and resistance against coercion.

However, the relationship individuals maintain with public health is not uniformly negative. Some individuals reported positive interactions with certain health officials, suggesting that trust varies across different actors within the health system (Gille et al., 2022).

Individuals felt trust in public health officials who exhibited traits like transparency, accountability, dependability, and respect. This trust resulted in positive behaviours and feelings towards public health services, such as cooperation and empathy, contributing to feelings of safety and confidence.

Contrary to traditional binary conceptualisations of trust (Schilke et al., 2015), the model sees trust as a reflexive, relational, and dynamic process (Celestina, 2018). It exists in varying degrees, and in certain contexts individuals can simultaneously trust and mistrust.

An ongoing relationship of trust with public health services facilitates proactive and preventive approaches to public health, with individuals feeling secure to cooperate with public health measures and seek preventative care.

These trust relationships significantly impact a variety of behaviours and attitudes, such as the propensity to seek medical attention, disclose confidential information, and adhere to treatment protocols.

These findings align with earlier research suggesting that trust significantly impacts behaviours and attitudes such as seeking medical attention, disclose confidential information and cooperating with treatment protocols (Rhodes & Strain, 2000). Policymakers should be mindful of the complexity of trust and its implications for public health.

4.2.1.5. The COVID-19 Pandemic: A microcosm of Structural Racism: Racism is a public health concern that exacerbates health disparities at the organisational and population levels (Danso & Danso, 2021). The COVID-19 pandemic has exposed systemic issues, including the detrimental effects of racial prejudice. By applying a model to the pandemic, the disparities experienced by racial minority groups in the UK have been brought to light, revealing the influence of structural inequalities on trust, behaviours, and health decision-making. This highlights the urgent need to address and dismantle systemic racism in order to promote health equity.

During the study, a significant number of participants received one or more SARS-CoV-2 vaccinations (see Table 2), which contrasts with reported low vaccine uptake rates in these communities during the COVID-19 pandemic (ONS, 2021). However, participants clarified that their decision to get vaccinated was not driven by increased trust in the government, vaccines, or public health. Rather, it was a response to coercive measures such as mandatory vaccinations for HCWs. As found in literature (Stolow et al., 2020), participants associated the use of fear tactics in public health messaging with decreased trust, scepticism, and negative psychological consequences, including low mood, anxiety, and risky behaviour.

This finding is consistent with a wealth of research which has found the pervasiveness of structural racism in public institutions continue to traumatise and retraumatise Black individuals (e.g. Eliacin, 2013). Trauma-informed theories suggest that prior trauma affects future processing, creating neural responses that are sensitised and can be reactivated by situations and relationships that remind them of past traumas (van der Kolk, 2005).

These findings have implications for the current mental health system, as it often categorises extreme behaviours and distress as symptoms of mental illnesses rather than recognising them as coping adaptations to past or current traumas (Butler et al., 2011). Recognising re-traumatisation and understanding trauma responses is important in providing appropriate care and support.

The pandemic, although perceived as unprecedented by society, stirred memories of previous marginalisation events for participants. Participants' knowledge of historical marginalisation and awareness of current racial disparities in the access to healthcare further influenced their level of trust, impacting their propensity to adopt public health interventions.

They noted the persistence of colonial ideologies treating Black bodies as inferior and distinct, as seen in government and scientific narratives (Otu et al., 2020). The French scientists' proposal for vaccine trials in Africa was observed, exemplifying this narrative.

Many participants acknowledged the interconnectedness of trust in public health systems and government entities, with distrust in government escalating during the pandemic due to policies that drastically impacted their lives. Issues such as caring responsibilities, multigenerational households, and essential jobs made cooperation with safety measures difficult for Black communities, supporting the hypothesis that structural racism is a critical determinant of health, and a public health issue (Jones, 2021)

Several participants acknowledged the significance of public vaccination as a preventative measure to limit the spread of COVID-19. Their concerns and risk perceptions were influenced by their mistrust of the government and public health authorities, resulting in apprehension regarding the vaccine's safety. This was the case for most participants including those who were health professionals, discussing their extensive understanding of the vaccine and who held advanced degrees.

This finding may have implications for assessing government initiatives targeting vaccine hesitancy (Christie, 2021), which mostly focused on vaccine literacy and education, suggesting that the choice to vaccine is better explained by trust. These results concur with Gilles et al. (2011)’s research findings during the H1N1 pandemic, health literacy did not impact ability to follow public health recommendations.

Criticism was also levied against the government's vaccine distribution strategy outside the UK, particularly the neglect of African countries. Participants reported being sceptical about government's motivations and who they were truly serving, reinforcing mistrust.

Booster doses were common in high-income countries while initial doses were slow to reach low-income nations (Bajaj et al., 2022). This inequity was condemned by the World Health Organisation chief being described as "vaccine apartheid" (Bajaj et al., 2022).

The study participants expressed a decline in trust towards the government and public health authorities, perceiving their actions as driven by self-interest. Gruenfeld et al. (2008) identified similar pattern with trust being significantly eroded when authority figures were perceived to be self-serving.

Trust in public health was identified and stressed as a social phenomenon, significantly influenced by communities and families. Participants showed preference for community-derived data over authoritative sources. Decisions regarding vaccination were also influenced by family opinions and circumstances, including potential isolation from family due to vaccine refusal.

The findings align with previous research (e.g. Grey et al., 2013) suggesting that racialised groups rely more on information from their own community than from authoritative sources. This highlights the significant role of Black African and Caribbean communities in providing support and influencing trust in public health.

Min et al. (2020) found that negative emotions like sadness, anger, fear, and astonishment play a role in how trust in the government influences preventive behaviours during COVID-19. The present study supports these findings as participants who experienced negative emotions when deciding on vaccination expressed similar perspectives, with fear being the primary motivation to take the vaccine. Several emotions, including fear of job loss and loss of independence were cited as influencing their decision in relation to trusting COVID-19 vaccines.

Participants linked negative emotions to government initiatives and policies promoting vaccination, leading to blame, prejudice, and fear towards the unvaccinated. This eroded trust in the government and public health advice.

Unvaccinated participants felt stigmatised by the government's messaging, impacting their relationships due to perceived lack of intelligence or selfishness. The attribution of vaccine refusal to a lack of knowledge and capacity to understand was viewed as dismissive, contributing to colonial ideology (Ragaven, 2018) and downplaying the lasting damage inflicted on Black communities. Consequently, this discourse is potentially harmful to public health trust, as it could further marginalize these communities and decontextualize their perspectives and decisions.

4.2.1.6. Comparison with Kelly's Ecological Model: Community psychology illuminates the influential role of context in trust. Through the lens of social justice and an ecological approach to social issues, a novel model of trust was developed. Albeit the model does not directly draw from it, the proposed model mirrors the principles of Kelly (2006)'s Ecological Theory used to understand the relationship between social-cultural contexts and behaviour. This theory is described in further detail in Section 1.8. These principles and theory will be used in this section to further contextualise and understand the significance of the study's findings.

The proposed model portrays trust as an interconnected, multi-element process, shaped by social and relational factors. For example, past experiences of oppression in public health towards Black African and Caribbean communities have bred scepticism and suspicion, impacting interactions with public health services, the government, and leading to protective use of communities. This cycle fortifies the disparity between racialised individuals and public institutions, mirroring Kelly's principle of interdependence. Thus, distrust demonstrated by Black communities towards public health requires recognition of intersecting relationships across every level.

The model further indicates that trust, requires multilevel adjustments to tackle power dynamics and instigate change for individual and community trust in public health. This is in line with Kelly’s adaptation principle, where interventions targeting single issues fall short in rectifying trust issues persisting across multiple levels.

The proposed model also elucidates how historical events, such as colonialism, have shaped adaptive roles and acceptability norms for different behaviours. For example, Black African and Caribbean responses to discrimination have been stereotyped through the colonial lens as violent, while similar reactions from White individuals are seen as normal.

Kelly's principle of cycling of resources facilitates understanding of efficient resource utilisation and generation. Participants indicated that resources within their communities and immediate adjacent systems boosted their public health experiences, fostering self-agency and self-advocacy. Resources included family members and members of their communities who have medical, scientific knowledge or natural remedies knowledge. Such resources were crucial during the COVID-19 pandemic, necessitating greater government trust. Several participants emphasised the significance of these resources during COVID-19, when they were provided with limited information in the context of historical distrust in the government.

Finally, the principle of succession implies that communities are in a constant state of change, and adaptability over time. The trust model suggests that trust in public health is highly context and time dependent. Historical experiences of oppression and marginalisation have shaped community trust over time. Communities continue to develop strategies to resist coercion, accruing health-related resources.

Kelly's theory provides a specific understanding of a social and relational phenomenon relevant for public health and engagement with racialised communities. The model argues for the importance of community and social support in creating structures that assist in processing experiences and establishing trust relationships in public health.

4.2.2. Protective Intersectional Identities

The model provides a conceptual understanding of the trust process in public health within Black African and Caribbean communities, considering the factors influencing its development. It is important to note that the research and its findings did not view Black individuals and communities as a monolithic and homogenous group. The practice of homogenisation has been heavily criticised, with researchers suggesting that it hinders substantive discussions on race, perpetuating the existing power dynamics that favour groups with greater influence (Paulraj, 2016).

4.2.2.1. Proximity to Whiteness: Study participant Tyler's reflections on his privileged aspects of identity within his racialised community highlight the diverse experiences and intersectionality among participants. Having a dual heritage with a White British identity granted Tyler access to inherent privileges, such as having White family members who advocated for him in interactions with public health. This advocacy protected him from aspects of marginalisation.

This finding aligns with previous research showing that individuals with White family members are more effective in contesting psychiatric decisions and advocating for treatment compared to those with Black Caribbean family members (Lawrence et al., 2021).

4.2.2.2. Race and Age: Participants in the study highlighted the impact of the intersection of race and age on their perception of public health. They observed disparities in the quality of care received as adults compared to their younger years. Family members who advocated for them played a protective role during their care as children, however witnessing mistreatment of their racialised family members growing up created feelings of mistrust in public health institutions.

Previous research highlights the crucial role of family members in advocating for individuals, addressing mental health issues, and promoting social and political action (Schaffer, 2021). However, health initiatives often fail to recognize the importance of family involvement, despite the valuable support and connections they provide for enhancing well-being and equity in public health (Weiss-Laxer et al., 2020).

4.2.2.3. *Race and Ability:* Participants in the study acknowledged that good health and the absence of significant health issues resulted in reduced reliance on public health services and protection from marginalisation, leading to fewer complications. However, participants with disabilities and health conditions experienced increased dependence on public health services, facing specialised care needs and heightened marginalisation, resulting in injustice and the need for resistance.

This highlights the intersection of racism and ableism, contributing to distinct inequalities, as noted by Frederick and Shifrer (2019) and emphasising the importance of examining disability and race to improve health outcomes and accessibility in healthcare.

4.2.2.4. *Race and Class:* Participants in this study identified socioeconomic status as a significant factor influencing their trust in public health services. They recognised the complex interaction between race and socioeconomic status, which impacted their access to healthcare. Due to some participants' lower financial standing, they relied on the public health system.

Patients lacking agency to choose their healthcare providers were found to feel vulnerable, shaping their trust formation (Ward et al., 2015). Consequently, lack of choice in such circumstances may negatively influence the development of trust. The presence of choice raises ethical considerations, particularly in individuals' autonomy to refuse treatments such as the COVID-19 vaccine.

4.3. Critical Review and Research Evaluation

The assessment of qualitative research methods and approaches varies among researchers (Yardley, 2000). Yardley's principles were utilised to evaluate the research due to their flexibility and ability to identify strengths and limitations. The study's timeline and critical grounded theory methodology were also thoroughly evaluated.

4.3.1. Quality of Research

According to Yardley's (2000) evaluative guidelines for qualitative research, necessary methodological approaches include sensitivity to context; commitment; rigour and transparency; and impact and importance.

4.3.1.1. Sensitivity to Context: This research maintained a keen awareness of the socio-political context, including the political climate, BLM, and the COVID-19 pandemic. The study's aims were founded on relevant theoretical literature and current socio-political policy developments. The researcher regularly assessed their position using supervision and memo-writing to understand the social context and their own identity in relation to Whiteness and the research subject.

4.3.1.2. *Commitment and Rigour:* To demonstrate commitment, the researcher engaged deeply with the research topic and showed proficiency in the chosen methodology, drawing on Yardley's principles. This included a thorough review of grounded theory (GT) literature, comprehensive coding, constant comparative analysis, consultation with supervisors, and reflective memo-writing. Racialised peers' input was sought to ensure a critical approach to language in the study and recruitment materials.

Rigour in the study was upheld through ongoing supervision, immersive data analysis, and methodological competence. The researcher iteratively examined the data, linked codes and categories to relevant quotes, and demonstrated a deep understanding of the topic through a thorough review of literature on trust, racism, Whiteness, and public health.

4.3.1.3. Coherence and Transparency: Coherence in the study was ensured by aligning research aims, epistemological stance, and methods. The researcher utilised a CGT approach consistent with the critical realist perspective (Madill et al., 2000). Coherence was evaluated through supervision, peer discussions, and participant feedback.

Transparency was achieved by acknowledging personal assumptions and motivations, utilising reflective journaling, and exploring pre-existing ideas in supervision. The Methodology section provided detailed descriptions of data collection and analysis procedures, while appendices include coding and memo excerpts for enhanced transparency (Spencer & Ritchie, 2011).

4.3.1.4. Impact and importance: This study explored the relationship between Black African and Caribbean communities and public health, focusing on race, racism, powerlessness, and marginalisation. It examined how these factors influence trust and health outcomes, offering potential solutions to address disparities. The findings could significantly impact government policy, clinical psychology interventions, promoting anti-racist practices.

4.3.2. Limitations of the Timing of the Research

This study, conducted during the COVID-19 pandemic and in the context of BLM, shed light on the severe impact of systemic racism on Black communities, particularly regarding public institutions and health outcomes. The research began amidst the global crisis and vaccine availability, highlighting the exacerbation of pre-existing issues such as systemic racism experienced by participants during the pandemic. Despite movement restrictions, remote interviews allowed for diverse participant representation across England.

4.3.3. Limitations of CGT Approach

While CGT offers a strong framework for comprehending complex social phenomena, it runs the risk of essentialism and reductionism (Rocca & Anjum, 2020) when focusing on marginalised groups. This may perpetuate Whiteness discourses and homogenise marginalised experiences.

To address these concerns, the write-up and theoretical model emphasised intersectionality, differences, and power dynamics. Recognising the group's diversity and experiences, and the protective role of privilege and Whiteness against marginalisation, was integral in understanding trust levels in public health.

CGT may overlook important aspects of social existence by solely focusing on power dynamics and marginalisation, neglecting other social processes. Additionally, the methodology may perpetuate power imbalances as researchers have control over the research process and data analysis.

To address this, the researcher in this study utilised reflective logs and reflexive dialogues with their DoS to mitigate biases and enhance independent communication of the data's message. Power dynamics within the research process are a topic for future exploration, elaborated on in Section 4.5.

Taking a value-based community psychology perspective, the researcher emphasised the significance of examining social, cultural, economic, political, and environmental factors beyond the individual level. This approach recognised the influence of resource distribution on social issues and highlighted the importance of understanding political agendas in promoting health outcomes.

Critics have expressed concerns about the unclear nature of CGT's theoretical and methodological approach, calling for clearer integration of critical theory and grounded theory to avoid confusion among researchers (Bryant & Charmaz, 2023).

Conducting CGT research with vulnerable or marginalised populations requires careful consideration of ethical implications, as tokenistic methods can cause emotional harm and mistrust (Mpofu & Conyers, 2002). The researcher in this study dedicated time and importance to building secure relationships with participants.

The researcher prioritised open and clear communication with participants, providing multiple opportunities to ask questions about the research.

Participants were reassured of their right to withdraw at any time, and debriefing sessions offered emotional support.

The researcher expressed gratitude and acknowledged participants' cooperation. Extensive discussions were held on disseminating findings to academic circles, public health services, and grassroots organisations to reach a diverse audience.

4.4. Implications

The multiple implications across various levels and contexts are evident in the participant accounts and proposed model. In this section, the researcher will consider the implications of the proposed theory on multiple levels.

4.4.1. Distal Implications

The ecological model suggests that the collective memory of historical injustices, systemic bias, and racism in healthcare can deeply impact trust in public health institutions, shaping community narratives about trust in public health. It also suggests the intertwining nature between trust in public health with trust in the political and organisational bodies.

These findings may have implications for efforts in decolonising public health, for the development of government initiatives aimed at reducing health disparities and inequalities and for NHS commissioning. Additionally, these findings may contribute to the development of research which addresses the current gaps in knowledge and teaching.

4.4.1.1. Decolonising Public Health: The current public health system is built on a Eurocentric view of health and humanity, which has resulted in systemic biases and injustices traceable back to colonialism (Affun-Adegbulu & Adegbulu, 2020).

A growing body of research indicates that the decolonisation of public health is imperative in order to eradicate deeply ingrained biases and prejudices (Bruce & Clennon, 2022; Affun-Adegbulu & Adegbulu, 2020).

The findings of the research suggest the need to de-politicise public health and transition towards a health justice framework that acknowledges the significant impact of colonialism, racism, and capitalism on health equity (Paul et al., 2020). It highlights the need of viewing health not as an isolated aspect, but rather as part of the larger context of these societal systems.

The process of decolonisation requires a two-way exchange of knowledge, where communities that have been subjected to racial and marginalisation are actively involved in health discussions and practises. This participation is crucial in preventing biased responses to health crises, such as the COVID-19 pandemic response.

Decolonisation should also recognise how Western-produced knowledge devalues Black experiences and promote the integration of diverse knowledge systems and voices in public health decision-making (Montenegro et al., 2020), requiring the legitimisation of alternative thought systems. Leadership transformation is crucial, emphasising equitable representation and empowerment of racialised groups in academia, leadership roles, and faculties (Affun-Adegbulu & Adegbulu, 2020).

The study's findings caution against the potential negative effects of employing fear-based strategies that lack contextualisation, as they may result in the re-traumatisation of communities and a reduction in their level of engagement. The finding highlights the contextual nature of the impact of racial trauma on public health, affecting individuals, communities, and multiple contexts. Contextualised interventions that acknowledge the harm across various levels may be effective in influencing trust in public health interventions. This is significant for evaluating current policies and formulating interventions to address health inequities and disparities.

The findings highlight the importance of formulating strategies that act beyond health education and the significance of the unique insights and perspectives that communities offer as pivotal.

The findings of this study have implications for the development of multi-level interventions that are tailored to each level of influence. These interventions have the potential to induce extensive and long-lasting alterations in health-related behaviours and outcomes, potential effecting broader population-level change.

Additionally, the study reveals that African Diaspora communities embrace the African models of health (Bruce & Clennon, 2022), considering physical, mental, spiritual, and social aspects. This contrasts with Western-centric models that overlook the unique health needs of Black communities, emphasising a holistic approach influenced by faith and traditional remedies.

Improved understanding of disease manifestation in Black individuals could lessen health inequalities in terms of public health access and experiences, while minimising the use of restrictive and punitive methods.

The suggested model could guide the development of training programmes for health professionals, fostering a critical approach that acknowledges the systemic devaluation of Black voices in traditional knowledge systems (Elabor-Idemudia, 2011). This underlines the importance of integrating these voices and understanding the experiences of marginalised communities.

Lastly, the proposed trust model could help decolonise curriculums by integrating non-western community approaches, including healing techniques (e.g. van Andel et al., 2012), recognising the value of these approaches and how mistrust have contributed to these approaches being utilised prior to engaging with public health.

4.4.1.2. NHS Commissioning: Moreover, the study's findings may have implications for the efficacy of NHS commissioning, creating a stable environment conducive to developing comprehensive, evidence-based strategies which inform the process of planning and funding of healthcare services.

The study reveals that trust in public health improves service effectiveness by encouraging participation and facilitating service provision, while mistrust hinders healthcare delivery. These findings emphasise the importance of long-term planning in NHS commissioning, urging statutory providers to recognize community needs and foster authentic partnerships that acknowledge unique health perspectives.

The model's emphasis on interdependence and community engagement, as well as the utilisation of available resources, promotes sustainability and long-term planning in NHS commissioning. This may lead to enduring partnerships, which allow for efficient resource allocation, better service provision, and adaptability to changing healthcare needs.

The proposed model acknowledges the significance of historical mistrust and trust in establishing partnerships among diverse stakeholders engaged in NHS commissioning, such as community organisations, local authorities, and healthcare providers. This recognition may facilitate productive collaboration, joint decision-making, and resource consolidation, ultimately leading to improved health outcomes.

4.4.2. Proximal Implications

4.4.2.1. The Value of Communities: The ecological model views communities as resource-rich systems capable of promoting health outcomes, continuity of care, and addressing unique needs, hence facilitating trust development. It underlines community engagement, indicating that trust in public health is socially and communally developed, encouraging collective action.

This model of trust holds significant implications for community engagement in public health, serving as a theoretical framework to enhance interactions between public health institutions and Black African and Caribbean communities, impacting health outcomes substantially.

The model suggests that trust forms the relationship's foundation and is essential for productive engagement and collaboration. Recognising the elements of trust can guide public health institutions in decision-making, considering community needs and preferences.

Effective communication about intentions, actions, and outcomes can enhance public health institutions' credibility, fostering trust among community members. The model of trust underscores the need for accountability in public health institutions, which includes acknowledging and correcting mistakes and demonstrating commitment to improvement, all critical for trust maintenance.

Trust is not achieved once but requires continuous effort. The proposed trust model can guide long-term strategies for community engagement, emphasising consistency, reliability, and open communication.

4.4.2.2. The Value of Community-led Projects: The findings of this study highlight the significance of grassroots community-led initiatives and services that contribute to this concept of trust and wellbeing by embodying the values of community psychology, fostering empowerment, and providing tailored interventions. Thus, addressing the unique needs of marginalised communities, and fostering trust and cooperation.

The model's emphasis on social and environmental contexts may have implications for the design and implementation of grassroots initiatives, enabling a comprehensive understanding of local culture and dynamics and ensuring culturally appropriate intervention. Focusing on social justice may serve as a catalyst for advocacy and systemic change, leading to more inclusive, equitable practices and facilitating long-lasting change.

4.4.3. Individual Implications

4.4.3.1. Clinical Psychology Practice: The model of trust in public health within Black African and Caribbean communities emphasises the importance of trust within therapeutic relationships. This has significant implications for clinical practice, highlighting the need for consistent, trustworthy, and transparent actions and accountable processes.

Importantly, it challenges traditional approaches in clinical psychology that view distress as solely individual experiences (Wood & Patel, 2017), by providing an ecological perspective that acknowledges the larger social and cultural context influencing these communities.

The model encourages the use of therapeutic approaches, such as African Centred Psychology and Black psychology (Ebede-Ndi, 2016), that provide holistic, culturally sensitive frameworks. Due to the recognition of culture, history, and religion by these approaches, the assessment and intervention process may be enhanced, thereby increasing patient engagement.

Importantly, the model revises the understanding of patient engagement and disengagement, arguing against condemning patients for being "hard to reach" (Liljas et al., 2019). Instead, it interprets actions such as avoidance as self-protective measures motivated by systemic mistrust and fear of additional damage.

In conclusion, the findings advocate for the adoption of anti-racist practices in clinical psychology, emphasising the need for practitioners to acknowledge their role in perpetuating systemic mistrust and to pursue corrective actions. This includes advocating for social justice and working to eliminate health disparities in order to cultivate a more trusting and effective therapeutic relationship.

4.5. Future Research

This study has established a theoretical model of trust in public health within Black African and Caribbean communities. The model illuminates the role of trust within these communities, paving the way for future research.

Future research could expand the proposed model to other marginalised or racialised communities to compare trust dynamics, gaining insights into factors that cultivate or erode trust and the influence of marginalisation in the trust building process across communities. An intersectional approach could be applied, considering how race, gender, and socioeconomic status influence trust, yielding a more nuanced understanding.

Testing the model's validity and reliability through larger scale studies could demonstrate its applicability and relevance to public health, clinical practice, and disciplines such as clinical psychology.

Future research might also apply the model to different contexts, examining the impact of structural and policy interventions addressing structural inequities on trust development. Such research could inform trust-promoting policies and interventions.

The study's findings highlight the need for additional research on disease manifestation in Black individuals and emphasise the importance of decolonising curricula and training programmes. They demonstrate how the lack of representation in training materials influences outcomes and the trust-building process.

Adopting a Community-based Participatory Research approach is also suggested (Collins et al., 2018). The approach emphasises collaboration and a community-oriented perspective, in which community members are regarded as research participants who actively participate in the research process. The approach emphasises co-creation by prioritising the creation of knowledge through mutual learning between researchers and the community. This methodology seeks to mitigate power differentials inherent to the research process by investigating the complexities of trust dynamics in depth. This approach ensures that research outcomes align with community experiences and contributes to a more culturally responsive public health landscape.

4.5.1. Reparation

While the model and research do not explicitly address how trust in public health can be repaired in Black African and Caribbean communities, several discussions emerged about how reparation can be achieved, whether it is possible and what can hinder the process. Participants quotations relevant to reparation can be found in Appendix O.

The research underscores the critical yet complex process of rebuilding trust in public health among Black African and Caribbean communities. The model suggests that systemic mistrust, which has historical roots and is perpetuated by ongoing community interactions, can potentially be repaired. However, the process of reparation must acknowledge the harm inflicted and commit to enduring changes over an extended period. Initiatives must be driven by a profound understanding of these communities and their experiences.

Current reparation attempts have been criticised for exacerbating power differences and augmenting vulnerability, often due to tokenistic usage of gathered information without effecting substantial changes in service delivery (Ocloo & Matthews, 2016). This approach risks further trauma and could hinder the reparation process.

While complete trust reparation might not be achievable, efforts towards reparation could foster engagement with health services and policies. The process of trust reparation is not a one-time event, but a long-term commitment that necessitates ongoing effort, open communication, accountability, and the continual demonstration of trustworthiness.

Thus, exploring trust reparation further could yield valuable insights into fostering public health trust among marginalised communities. These discussions provide a roadmap for considering trust reparation, highlighting the need for acknowledgement, apology, rectification, and clear actions to prevent future breaches.

4.6. Reflexivity

Reflexivity, a vital part of ethical research, was used in this study via supervision discussions and a reflective notebook, aiding deliberate decision-making and evolving understanding of the research process (Willig, 2013). Reflexivity, categorised into personal, epistemological, and critical language awareness, is context-dependent and continuously evolving. However, it's important to note, as Ross (2017) pointed out, that not all decisions made during research are consciously deliberated.

4.6.1. Personal reflexivity

The researcher's reflexive stance was shaped by intersectionality and personal experiences with racism and privilege. Throughout the research process, personal and socio-political events influenced their perspective on racism and how they presented the data. The researcher's initial focus was on studying trust in public health related to COVID-19 vaccination. However, the in-depth interviews revealed a more complex and multifaceted relationship between trust and public health than originally anticipated.

The clinical psychology background of the researcher contributed to their awareness of the potential distress caused by exploring such sensitive topics. The researcher recognised a reluctance to delve deeply into aspects such as internalised racism during interviews. This can be attributed to their focus on social justice and structural racism, and concerns that discussion focused on internalised racism may overshadow the importance of this topic.

Reflection on the influence of their racialised identity and Western beliefs about public health was crucial, acknowledging that these factors could lead to perpetuating Eurocentric ideas and marginalising other voices. They were aware of how their emphasis on social justice may have biased the construction of categories and theoretical models. The emotionally charged interactions with participants, especially when discussing racism in public health, significantly influenced the coding and theme development.

4.6.2. Epistemological Reflexivity

Acknowledging the limitations of the knowledge generated is crucial. In this study, a critical realist epistemology was adopted, treating participants' statements as realist reflections of their individual perspectives and experiences.

The researcher recognised how White supremacy structures have shaped individual experiences in the UK. While interpreting participant's statements, care was taken not to impose subjective evaluations, yet the researcher was aware of potential unconscious influences (Willig & Rogers, 2007).

The formation of categories and overall analysis are likely to have been influenced by the researcher's personal experiences, moral and political beliefs, including their own experiences of racism, rather than being guided primarily by considerations of epistemology and ontology (Nightingale & Cromby, 2002).

4.6.3. Critical Language Awareness

The domain of reflexivity demands contemplation regarding the potential impact of language usage on the responses of participants. The study has relied on a fundamental understanding of linguistic structures.

The researcher demonstrated sensitivity towards the participants' language by employing it in follow-up questions to ensure the effective utilisation of the constructed meaning.

Considering this perspective, the generation of categories via the researcher's language could have potentially eliminated a portion of the participants' intended meaning. Nevertheless, the incorporation of direct quotations was implemented to mitigate this issue.

4.7. Conclusion

To the best of the researcher's knowledge, this is the first UK study to construct a theoretical model for understanding the process by which Black African and Caribbean communities develop trust in public health. It examines the crucial role of trust in these communities and highlights the persistence of racism, which is often overlooked despite its impact on healthcare disparities and social power.

This study has developed a theoretical understanding of how trust is formed in public health within Black African and Caribbean communities and the role of trust in public health for these communities. It underlines the key role of psychological approaches in comprehending complex social phenomena, thereby shaping public health policies and interventions that promote trust and address health disparities.

Trust in public health within Black African and Caribbean communities is conceptualised as a complex, multifaceted, and persistent phenomenon, influenced by individual, proximal, and distal factors. This trust is shaped by experiences of oppression within public health and society, significantly impacting their engagement with services, and participation in public health initiatives. The historical and systemic traumas these communities endure often foster mistrust, reinforcing health disparities and influencing health outcomes.

Recognising the historical and ongoing injustices experienced by Black African and Caribbean communities in public health is of utmost importance for public institutions. Racism, sustained by the post-colonial ideology that it is a matter of individual prejudice, complicates trust-building, generating mistrust, scepticism, and avoidance. This entails acknowledging the effects of colonisation, racism, and disparities in healthcare access. Through acknowledgement and apologies for past harms, institutions can initiate the process of repairing and rebuilding trust.

Addressing the trust dearth requires a systemic transformation in public health, including cultural sensitivity, rectifying historical injustices, and fostering partnerships within communities. Decolonising public health becomes crucial, dismantling Eurocentric models and valuing diverse knowledge systems.

The study recognised communities as resource-rich systems that can promote health outcomes and trust through community engagement. It advocates for tailored, multi-level interventions centred on community engagement and trust to effect enduring change in health outcomes. This vital endeavour has significant implications for health equity, fostering a more inclusive public health landscape.

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6. APPENDICES

Appendix A: Literature Search Strategy

Table 4.
Literature Search Terms

Search Terms
Black African
Black Caribbean
clinical psychology
community psychology
COVID-19
ethnic minority
NHS
public health
race
racial discrimination
racism
trust
UK healthcare

Table 5
Literature Search - Sources

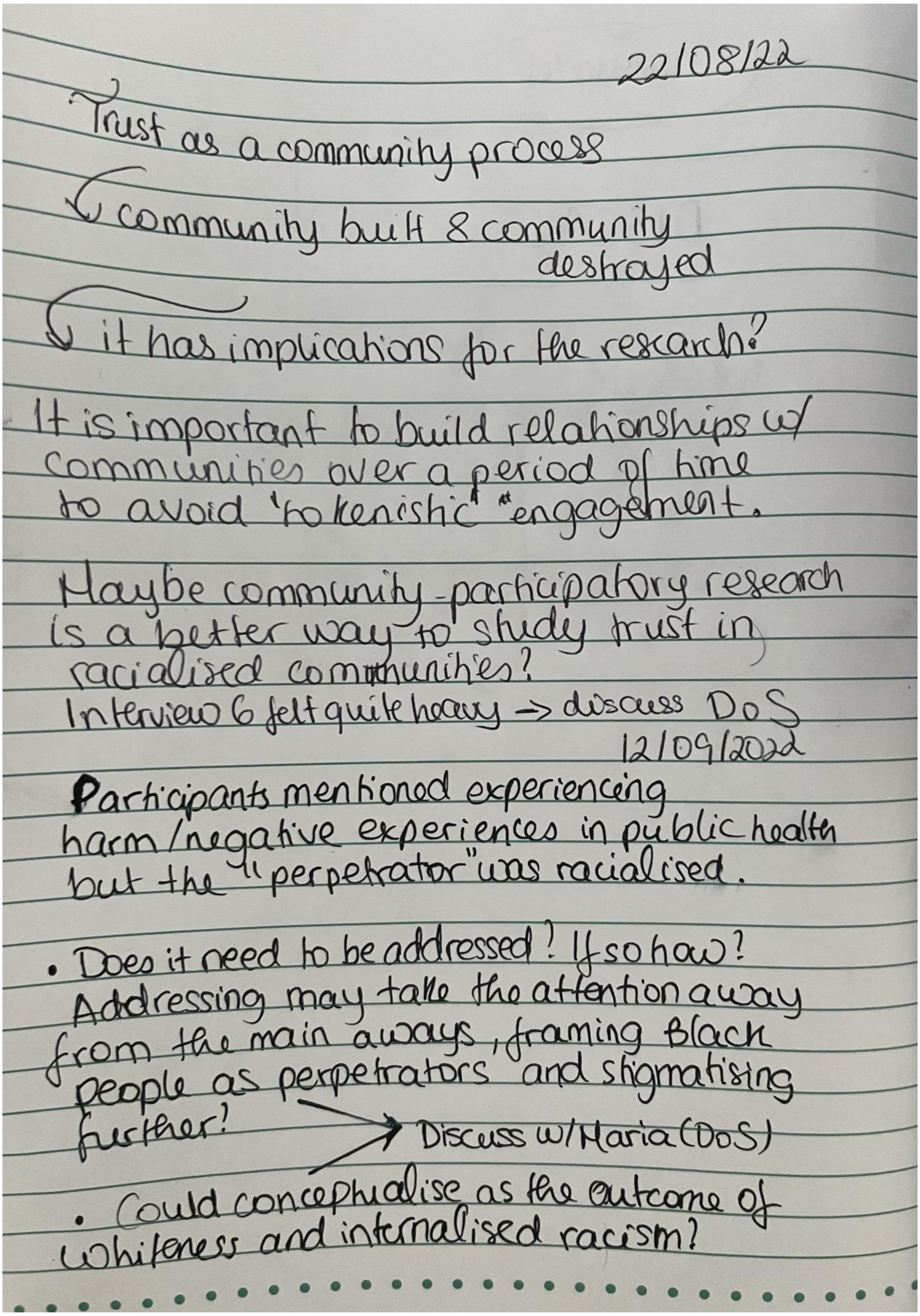
Sources
British Psychological Society
Department of Health and Social Care
Equality and Human Rights Commission
Office for Health Improvement and Disparities
Office for National Statistics
Office of the United Nations Commissioner for Human Rights
Public Health England

The Health Foundation

Table 6
Literature Search - Databases and Search Engines

Databases and Search Engines
CINAHL
EBSCO
Google Scholar
PsyArticles
PsycINFO
PubMed
Scopus

Appendix B: Reflective Diary Log Entry



22/08/22

Trust as a community process

↳ community built & community destroyed

↳ it has implications for the research?

It is important to build relationships w/ communities over a period of time to avoid 'tokenistic' engagement.

Maybe community-participatory research is a better way to study trust in racialised communities?

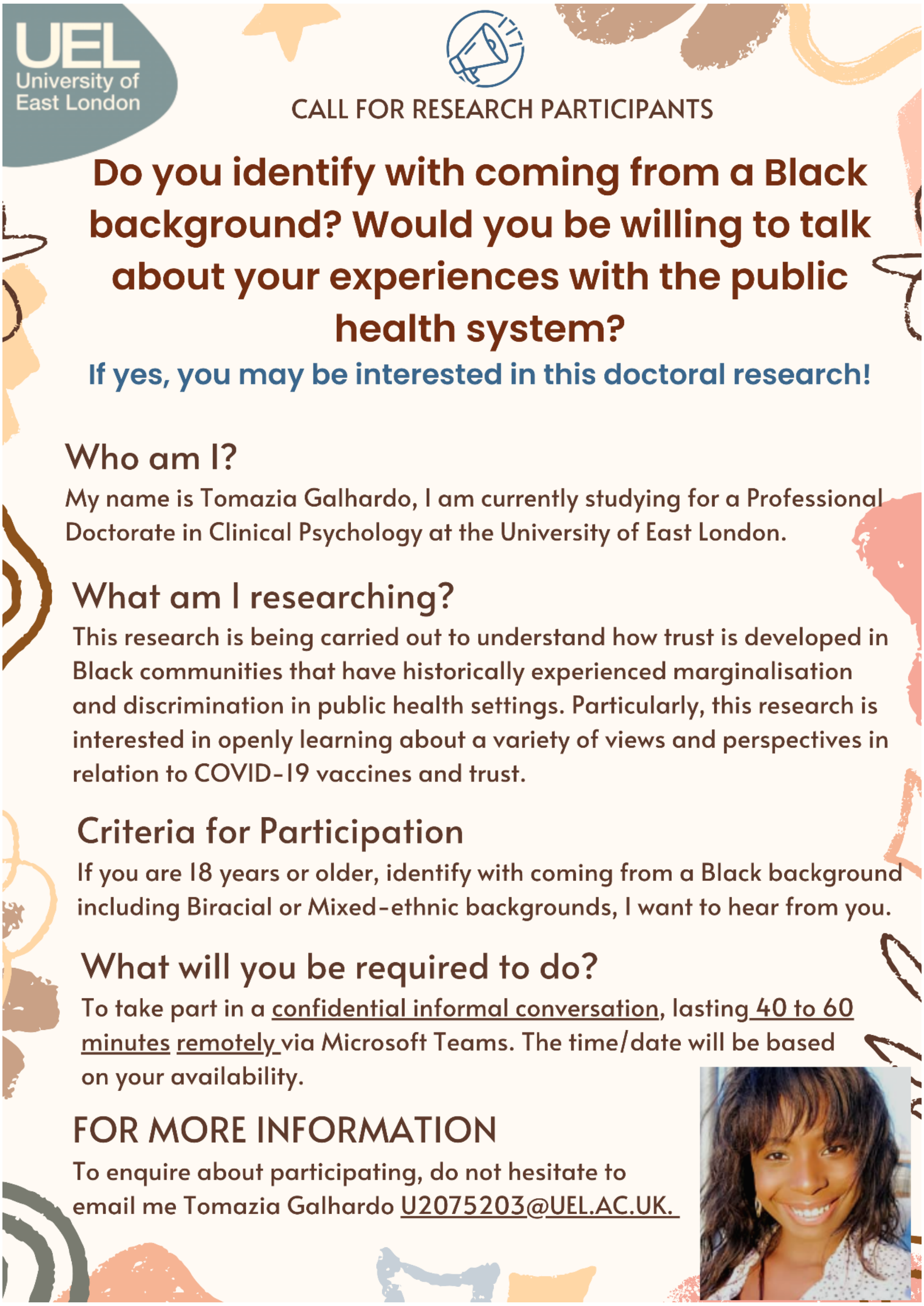
Interview 6 felt quite heavy -> discuss DoS

12/09/2022

Participants mentioned experiencing harm/negative experiences in public health but the "perpetrator" was racialised.

- Does it need to be addressed? If so how? Addressing may take the attention away from the main aways, framing Black people as perpetrators and stigmatising further? → Discuss w/ Maria (DoS)
- Could conceptualise as the outcome of whiteness and internalised racism?

Appendix C: Recruitment Poster



UEL
University of
East London

CALL FOR RESEARCH PARTICIPANTS

Do you identify with coming from a Black background? Would you be willing to talk about your experiences with the public health system?

If yes, you may be interested in this doctoral research!

Who am I?

My name is Tomazia Galhardo, I am currently studying for a Professional Doctorate in Clinical Psychology at the University of East London.

What am I researching?

This research is being carried out to understand how trust is developed in Black communities that have historically experienced marginalisation and discrimination in public health settings. Particularly, this research is interested in openly learning about a variety of views and perspectives in relation to COVID-19 vaccines and trust.

Criteria for Participation

If you are 18 years or older, identify with coming from a Black background including Biracial or Mixed-ethnic backgrounds, I want to hear from you.

What will you be required to do?

To take part in a confidential informal conversation, lasting 40 to 60 minutes remotely via Microsoft Teams. The time/date will be based on your availability.

FOR MORE INFORMATION

To enquire about participating, do not hesitate to email me Tomazia Galhardo U2075203@UEL.AC.UK.

Appendix D: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

‘Trust in public health policy within Black African and Caribbean communities’

Contact person: Tomazia Galhardo

Email: u2075203@uel.ac.uk

You are being invited to participate in a research study. Before you decide whether to take part or not, please carefully read through the following information which outlines what your participation would involve. Feel free to talk with others about the study (e.g., friends, family, etc.) before making your decision. If anything is unclear or you have any questions, please do not hesitate to contact me on the above email.

Who am I?

My name is Tomazia Galhardo I am a student in the School of Psychology at the University of East London (UEL) completing a doctorate in Clinical Psychology. As part of my studies, I am conducting the research that you are being invited to participate in.

What is the purpose of the research?

I am conducting research into trust in public health policy within black communities. This research is being carried out to understand how trust is developed in Black communities. Research has shown that this group of people have historically experienced marginalisation and racism in public health settings. It is possible that these experiences might have implications to their ability to trust public health services and officials.

As there has not been much research in this area, I would like to find out more about this from your point of view. The aim is to understand how trust is developed within Black communities and what role does trust play when it comes to following public health guidance. As way to explore this further, I will ask you questions related to the current COVID-19 pandemic and vaccination drive. This research is interested in openly learning and capturing a variety of views and perspectives in relation to the COVID-19 vaccine and trust, so your input will be very valuable.

It is hoped that this information can be shared with services to help them become more accessible to people from Black ethnic groups by taking steps to rebuild trust with these communities.

Why have I been invited to take part?

To address the study aims, I am inviting people who are 18 years or older and identify with coming from a Black African or Caribbean backgrounds, including Biracial and mixed ethnic backgrounds. As this study hopes to learn further about trust in relation to the Public health system, you must also be entitled to free NHS healthcare and therefore be classified as ordinarily resident in the UK.

I emphasise that I am not looking for ‘experts’ on the topic I am studying. You will not be judged or personally analysed in any way and you will be treated with respect.

You are quite free to decide whether or not to participate and should not feel coerced.

What will I be asked to do if I agree to take part?

If you agree to take part, you will be asked to:

- Take part in an individual interview taking place via Microsoft Teams so you do not have to leave your home.
- The interview will feel similar to an informal chat, there is no right or wrong answer and it is expected to last between 40 minutes and 1 hour.
- The focus of the interview will be to understand your own views of trust and the role it has for you when it comes to following public health guidance.
- The interviews will be audio and video recorded to allow me to transcribe our discussions. However, once the transcription is complete (three weeks following the interview), the audio and video recording will be deleted. I will be the only person listening to the interview.
- The reason it is recorded is so I can type it up into a transcript. This will be read by my supervisor (Dr Maria Qureshi) at the University of East London and the examiners who will be marking my research. Your name, and anyone else you mention will be changed so that you remain anonymous.
- I will not be able to pay you for participating in my research, but your participation would be very valuable in helping to develop knowledge and understanding of my research topic.

Can I change my mind?

Yes, you can change your mind at any time and withdraw without explanation, disadvantage or consequence. If you would like to withdraw from the interview, you can do so by letting me know at any point prior to or during the interview. If you withdraw, your data will not be used as part of the research.

Separately, you can also request to withdraw your data from being used even after you have taken part in the study, provided that this request is made within three weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Are there any disadvantages to taking part?

This study will not directly ask you for information that can cause you psychological and/or physical distress. However, it is important to note that the nature of this study exploring your relationship of trust with public health office may trigger unpleasant memories or the sharing of difficult experiences.

If you experience any emotional distress as a result of taking part, you will be given the appropriate support. In the first place, you will be able to debrief with me following the interview. This will allow you to express yourself and access emotional support from me. You will also be given information for supporting agencies and services that can provide you with further emotional support as part of the debrief sheet, should you need it. Lastly, my supervisor will also be available to debrief you with you if you wish to discuss the impact of the interview further.

How will the information I provide be kept secure and confidential?

Your privacy and safety will be respected at all times. Participants will not be identified by the data collected, on any material resulting from the data collected, or in any write-up of the research.

- You will not be identified in any of the written information resulting from the interview or in any part of the write-up of the research.
- You will be given a pseudonym so that you remain anonymous. This means that whilst some of your answers to my questions will be included in the write up, anyone reading it should not know who it has come from. It is possible that those who know you at the charity might recognise what has been said as familiar, however I will try to reduce this from happening by removing all names.
- I will store the information collected from the interview, including the recording, on a file within a computer which are both password protected to stop anyone else from seeing or hearing it.
- The recording of your interview will be encrypted, and stored on password protected secure servers in line with General Data Protection Regulation (GDPR) and the Data Protection Act (2018).
- After the recording has been typed into a transcript, the recording will be deleted from Microsoft Teams and the transcript will be kept on a password

protected computer for up to three years due to examination purposes and in line with UEL data protection policy. After this point, it will be deleted.

- The transcript will be used to help me describe the main points from the interview and these will be included in the write up.
- Some of the quotes from the interview will be included in the write up. All names you give me will be replaced with pseudonyms to help keep you anonymous.
- The write up will be read by my supervisor, the examiner, and it may also be published in an academic journal for the public to access.
- You can withdraw from the research up to 3 weeks after the interview has taken place. After which, you will not be able to withdraw as the data analysis will have started.
- Sometimes there are occasions where I need to break confidentiality and speak to someone about what you have told me in order to keep you safe. This will happen if you tell me something which makes me worried about your safety or that of another person. An example of this might be telling me you are going to hurt yourself or someone else. I will try to let you know who I need to speak to if this is the case, but it is not always possible.

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the 'public task' condition contained in the General Data Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as 'special category data' in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations, talks, magazine articles, blogs. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally. This means that all personally identifying information will either be removed or replaced.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by Dr Maria Qureshi for a maximum of 3 years, following which all data will be deleted.

Who has reviewed the research?

My research has been approved by the School of Psychology Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me, Tomazia Galhardo on my email address at u2075203@uel.ac.uk.

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Maria Qureshi School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: m.qureshi2@uel.ac.uk

or

Chair of School Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.patel@uel.ac.uk)

Thank you for taking the time to read this information sheet

Appendix E: Interview Schedule

Interview Schedule – Trust in Public Health within Black communities

PART I:

1. What does *trust* mean to you?
2. How do you know whether to trust someone or not?
3. What would you do if you believed a person to be trustworthy or untrustworthy?
4. You have told me what your idea of trust looks like with individuals, do you think your trust might look different with organisations or your community?

PART II:

5. As a member of the public, how would you define your experience with public health services such as the NHS? Do you think your race had an impact on your experience?
6. When it comes public health providers as the NHS, is trusting them important to you? Why?
7. Do you believe that health providers and public health officials act in your best interest? Why?
8. How would you describe your trust in public health providers? Has it changed over time – if so in what ways has it changed and why?
    - *a)* What factors influenced your strong/high trust at that time?
    - *b)* What factors diminished trust in public bodies/what factors led to lower trust?

PART III:

9. When it comes to your health, who do you trust? Where do you get your information from? What is it about these sources that improve your trust in them?

10. Is there anyone or any sources you do not trust and why? What is it about these sources that lowered your trust in them?

11. a) If vaccinated, what factors helped you come to this decision? Did you have any worries? Any hopes?/what did you perceive the benefits to be?

    I. Was there anything about public health providers or officials, that influenced your decision? In what way?

11. b) If unvaccinated, what factors helped you come to this decision? Did you/do you have any worries? Any hopes?

    i. Was there anything about public health providers or officials, that influenced your decision? In what way?

12. Do you trust government advice in relation to the vaccine or other health measures such as social isolation? What has influenced this level of trust? Has that changed over time during the pandemic - why? Prior to the pandemic?

Thank you very much for your time. Any questions?

Appendix F: Consent Form

University of East London

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

‘Trust in public health policy within Black African and Caribbean communities’
Contact person: Tomazia Galhardo
Email: u2075203@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet dated 27/07/2022 for the above study and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.	
I understand that if I withdraw during the study, my data will not be used.	
I understand that I have 3 weeks from the date of the interview to withdraw my data from the study.	
I understand that the interview will be audio and video recorded using Microsoft Teams.	
I understand that my personal information and data, including audio/video recordings from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my interview may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	

I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	
I agree to take part in the above study.	

Participant’s Name (BLOCK CAPITALS)

……

Participant’s Signature

……

Researcher’s Name (BLOCK CAPITALS)

……

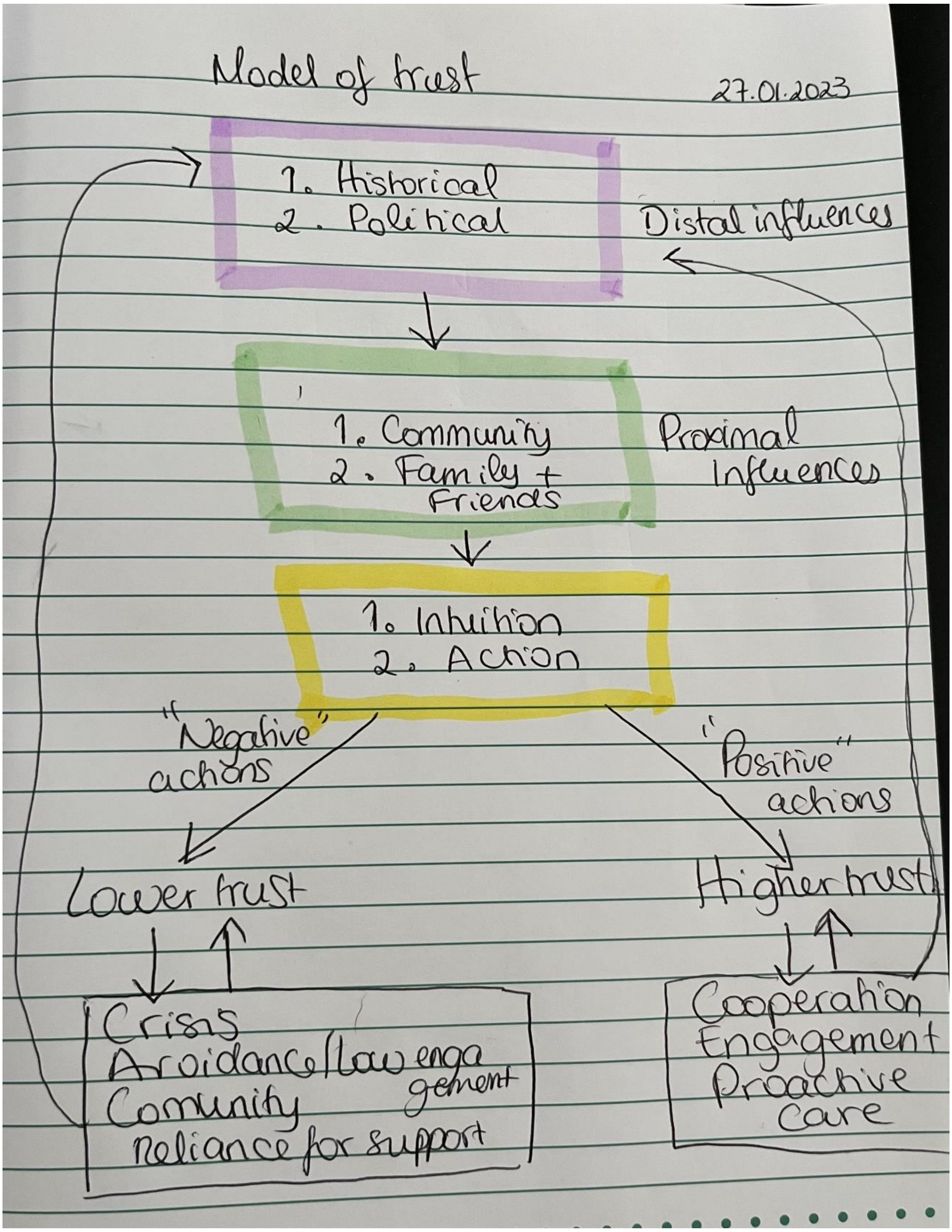
Researcher’s Signature

……

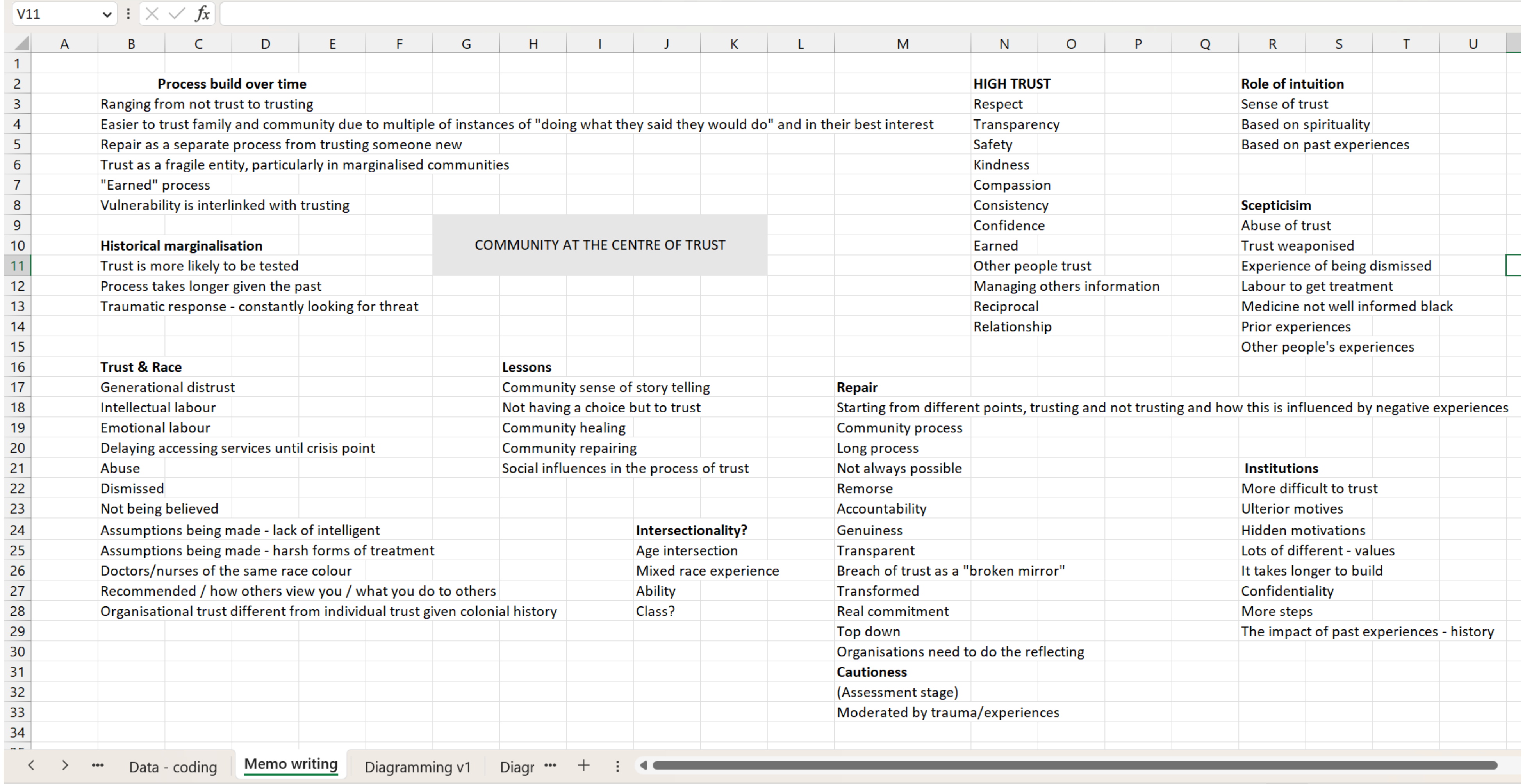
Date

……

Appendix G: Example of diagramming



Appendix H: Memo Examples



Process build over time
Ranging from not trust to trusting
Easier to trust family and community due to multiple of instances of "doing what they said they would do" and in their best interest
Repair as a separate process from trusting someone new
Trust as a fragile entity, particularly in marginalised communities
"Earned" process
Vulnerability is interlinked with trusting

HIGH TRUST
Respect
Transparency
Safety
Kindness
Compassion
Consistency
Confidence
Earned
Other people trust
Managing others information
Reciprocal
Relationship

Role of intuition
Sense of trust
Based on spirituality
Based on past experiences

Scepticisim
Abuse of trust
Trust weaponised
Experience of being dismissed
Labour to get treatment
Medicine not well informed black
Prior experiences
Other people's experiences

Historical marginalisation
Trust is more likely to be tested
Process takes longer given the past
Traumatic response - constantly looking for threat

COMMUNITY AT THE CENTRE OF TRUST

Trust & Race
Generational distrust
Intellectual labour
Emotional labour
Delaying accessing services until crisis point
Abuse
Dismissed
Not being believed
Assumptions being made - lack of intelligent
Assumptions being made - harsh forms of treatment
Doctors/nurses of the same race colour
Recommended / how others view you / what you do to others
Organisational trust different from individual trust given colonial history

Lessons
Community sense of story telling
Not having a choice but to trust
Community healing
Community repairing
Social influences in the process of trust

Intersectionality?
Age intersection
Mixed race experience
Ability
Class?

Repair
Starting from different points, trusting and not trusting and how this is influenced by negative experiences
Community process
Long process
Not always possible
Remorse
Accountability
Genuiness
Transparent
Breach of trust as a "broken mirror"
Transformed
Real commitment
Top down
Organisations need to do the reflecting

Cautioness
(Assessment stage)
Moderated by trauma/experiences

Institutions
More difficult to trust
Ulterior motives
Hidden motivations
Lots of different - values
It takes longer to build
Confidentiality
More steps
The impact of past experiences - history

Appendix I: Ethical Approval Form

School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in **blue** | **Student:** Please complete/read sections in **orange**

Details	
Reviewer:	**Laura Hamblin**
Supervisor:	**Maria Qureshi**
Student:	**Tomazia Goncalves Garcia Galhardo Burnett**
Course:	**Prof Doc Clinical Psychology**

Title of proposed study:	Trust in public health policy within Black African and Caribbean communities

Checklist (Optional)			
	YES	**NO**	**N/A**
Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.)	☐	☒	☐
Detailed account of participants, including inclusion and exclusion criteria	☐	☒	☐
Concerns regarding participants/target sample	☐	☒	☐
Detailed account of recruitment strategy	☒	☐	☐
Concerns regarding recruitment strategy	☐	☒	☐
All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	☒	☐	☐
Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	☒	☐	☐
Clear and detailed outline of data collection	☒	☐	☐
Data collection appropriate for target sample	☒	☐	☐
If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	☐	☐	☒
If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	☒	☐	☐
Concerns regarding data storage (e.g., location, type of data, etc.)	☐	☒	☐
Concerns regarding data sharing (e.g., who will have access and how)	☐	☒	☐

Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	☐	☒	☐
If required, General Risk Assessment form attached	☒	☐	☐
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	☐	☒	☐
Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	☐	☒	☐
If required, Country-Specific Risk Assessment form attached	☐	☐	☒
If required, a DBS or equivalent certificate number/information provided	☐	☐	☒
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	☐	☐	☒
All relevant information included in the participant information sheet (PIS)	☒	☐	☐
Information in the PIS is study specific	☒	☐	☐
Language used in the PIS is appropriate for the target audience	☒	☐	☐
All issues specific to the study are covered in the consent form	☒	☐	☐
Language used in the consent form is appropriate for the target audience	☒	☐	☐
All necessary information included in the participant debrief sheet	☒	☐	☐
Language used in the debrief sheet is appropriate for the target audience	☒	☐	☐
Study advertisement included	☒	☐	☐

Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	☒	☐	☐

Decision options	
APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.
APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED <u>BEFORE</u> THE RESEARCH COMMENCES	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **<u>before</u>** the research commences. Students are to do this by filling in the confirmation box at the end of this form once all amendments have been attended to and emailing a copy of this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records. **Minor amendments guidance:** typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.
NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	In this circumstance, a revised ethics application **<u>must</u>** be submitted and approved **<u>before</u>** any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application. **Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study

Please indicate the decision:	APPROVED - MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES

Minor amendments
Please clearly detail the amendments the student is required to make
3.4 Video conferencing – need to be specific about the use of MS Teams. Additionally, interview schedules should not and cannot be changed, so consider rewording this to state that in line with GT you will review and respond to the data as collection occurs and explore pertinent arising topics with latter participants through the use of prompts in relation to existing questions/schedules. You also refer to 'feedback from organisations' here but there is no discussion of this elsewhere. Who are they? How are they involved? At what stage? How will you approach? Any associated docs or permissions? 3.5 please state any inclusion/exclusion criteria in relation to attitudes to covid 19 and vaccinations. It might be best to achieve a sample that do not all share the same views. Additionally, immigration status/migration history could potentially influence your findings here in that public health messaging may not only have been from the UK, so may wish to control for / capture this. Discuss and consider with your supervisor. Are persons of mixed heritage permitted to take part in your study? You need to be clear on this "black African and Black Caribbean" may be too linear (update participation docs with any changes). 3.11 and 4.2 Data is not anonymous and cannot be anaonymised fully due to data collection method. You need to discuss this as de-identification (including identifying events/places where relevant). SECTION 5 Consideration should be made to ensure you are monitoring risk throughout the data collection period (interview), state strategy for minimising, monitoring and responding. Think about video, audio etc. Will you note this in transcriptions? Appedices: Student checklists and guidelines need to be removed (this application doc should ONLY include what will be sent to your participants).

Invite to participate: **Purpose of the research section is heavily biased. You should consider writing a more neutral section. It reads as though you would like to investigate their perceptions of racism and marginalisation rather than discussion of your actual research questions.** **Your discussion of de-identification in the “How will the information I provide be kept secure and confidential?” should be reworked in line with earlier comments. This should be assured, not attempted.** **Remove the word Fake and replace with more appropriate terminology i.e. pseudonym as you have done elsewhere in your document.** **You and your supervisor should check regulation on breaking confidentiality and informing the participant to ensure compliance.**

Major amendments
Please clearly detail the amendments the student is required to make

Assessment of risk to researcher		
Has an adequate risk assessment been offered in the application form?	**YES** ☒	**NO** ☐
	If no, please request resubmission with an **adequate risk assessment.**	
If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:		
HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	☐
MEDIUM	Approve but include appropriate recommendations in the below box.	☒
LOW	Approve and if necessary, include any recommendations in the below box.	☐

Reviewer recommendations in relation to risk (if any):	Please insert any recommendations

Reviewer's signature

Reviewer: (Typed name to act as signature)	Laura Hamblin
Date:	**11/07/2022**

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Ethics Committee

RESEARCHER PLEASE NOTE

For the researcher and participants involved in the above-named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.

Confirmation of minor amendments

(Student to complete)

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data

Student name: (Typed name to act as signature)	**Tomazia Goncalves Garcia Galhardo Burnett**
Student number:	**U2075203**
Date:	**27/07/2022**

Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required

University of East London

School of Psychology Ethics Committee

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for a proposed title change to an ethics application that has been approved by the School of Psychology

By applying for a change of title request, you confirm that in doing so, the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed, then you are required to complete an 'Ethics Application Amendment Form'.

How to complete and submit the request	
1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	Using your UEL email address, email the completed request form along with associated documents to Dr Jérémy Lemoine (School Ethics Committee Member): j.lemoine@uel.ac.uk

4	Your request form will be returned to you via your UEL email address with the reviewer’s decision box completed. Keep a copy of the approval to submit with your dissertation.

Required documents

A copy of the approval of your initial ethics application.	**YES** ☒

Details

Name of applicant:	**Tomazia Goncalves Garcia Galhardo Burnett**
Programme of study:	**Prof Doc Clinical Psychology**
Title of research:	**Trust in Public Health Policy within Black African and Caribbean Communities**
Name of supervisor:	**Maria Qureshi**

Proposed title change

Briefly outline the nature of your proposed title change in the boxes below

Old title:	Trust in Public Health Policy within Black African and Caribbean Communities
New title:	Trust in Public Health within Black African and Caribbean Communities
Rationale:	I am requesting a title change because the current title does not accurately reflect the research conducted and its findings. Originally, it was hoped to investigate trust in public health policy, however the research findings focused more on experiences and perceptions of public health.

Confirmation		
Is your supervisor aware of your proposed change of title and in agreement with it?	**YES** ☒	**NO** ☐
Does your change of title impact the process of how you collected your data/conducted your research?	**YES** ☐	**NO** ☒

Student's signature	
Student: (Typed name to act as signature)	**Tomazia Goncalves Garcia Galhardo Burnett**
Date:	**13/03/2023**

Reviewer's decision		
Title change approved:	**YES** ☒	**NO** ☐
Comments:	**The new title reflects better the research study and will not impact the process of how the data are collected or how the research is conducted.**	
Reviewer: (Typed name to act as signature)	**Dr Jérémy Lemoine**	
Date:	**15/03/2023**	

School of Psychology Ethics Committee

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for a proposed title change to an ethics application that has been approved by the School of Psychology

By applying for a change of title request, you confirm that in doing so, the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed, then you are required to complete an 'Ethics Application Amendment Form'.

How to complete and submit the request

1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	Using your UEL email address, email the completed request form along with associated documents to Dr Jérémy Lemoine (School Ethics Committee Member): j.lemoine@uel.ac.uk

4	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.

Required documents

A copy of the approval of your initial ethics application.	**YES** ☒

Details

Name of applicant:	**Tomazia Goncalves Garcia Galhardo Burnett**
Programme of study:	**Prof Doc Clinical Psychology**
Title of research:	**Trust in Public Health Policy within Black African and Caribbean Communities**
Name of supervisor:	**Maria Qureshi**

Proposed title change

Briefly outline the nature of your proposed title change in the boxes below

Old title:	Trust in Public Health Policy within Black African and Caribbean Communities
New title:	Trust in Public Health within Black African and Caribbean Communities: Grounded Theory as applied to the COVID-19 Vaccine Uptake
Rationale:	Following the Viva, one of the amendments suggested by the examiners was to change the title of my thesis project to reflect the project's focus on the impact of COVID-19 Pandemic. I discussed this with my supervision and we agreed on a new title which better reflects the application of the grounded theory

	model to the COVID-19 pandemic. Therefore, I request that the title of the thesis please be changed to: "Trust in Public Health within Black African and Caribbean Communities: Grounded Theory as applied to the COVID-19 Vaccine Uptake"

Confirmation

Is your supervisor aware of your proposed change of title and in agreement with it?	**YES** ☒	**NO** ☐
Does your change of title impact the process of how you collected your data/conducted your research?	**YES** ☐	**NO** ☒

Student’s signature

Student: (Typed name to act as signature)	**Tomazia Goncalves Garcia Galhardo Burnett**
Date:	**24/08/2023**

Reviewer’s decision

Title change approved:	**YES** ☒	**NO** ☐
Comments:	**The title change was suggested in the viva.**	
Reviewer:	**Dr Jérémy Lemoine**	

(Typed name to act as signature)	

Appendix J: Risk Assessment Form

University of East London
Pioneering Futures Since 1898

UEL Risk Assessment Form

Name of Assessor:	**Tomazia Goncalves Garcia Galhardo Burnett**	**Date of Assessment**	**11/04/2022**
Activity title:	**Interviews**	**Location of activity:**	**Microsoft Teams**
Signed off by Manager **(Print Name)**	**Dr Maria Qureshi**	**Date and time** **(if applicable)**	**June – September 2022**

Please describe the activity/event in as much detail as possible (include nature of activity, estimated number of participants, etc)

If the activity to be assessed is part of a fieldtrip or event please add an overview of this below:
Overview of FIELD TRIP or EVENT:
As part of my thesis research, I am conducting interviews to further understand how trust in public health policy is developed in black communities. The background research suggest that people from black ethnic backgrounds are less likely to trust and adhere public health policies due to a complex history with public health officials involving marginalisation and racism. Whilst the interview will not directly ask questions relating to racism, it is possible that it arises as part of the discussion.

Guide to risk ratings:

a) Likelihood of Risk	**b) Hazard Severity**	**c) Risk Rating (a x b = c)**
1 = Low (Unlikely)	1 = Slight (Minor / less than 3 days off work)	1-2 = Minor (No further action required)
2 = Moderate (Quite likely)	2= Serious (Over 3 days off work)	3-4 = Medium (May require further control measures)
3 = High (Very likely or certain)	3 = Major (Over 7 days off work, specified injury or death)	6/9 = High (Further control measures essential)

<table>
<tr><th colspan="8">Hazards attached to the activity</th></tr>
<tr><th>Hazards identified</th><th>Who is at risk?</th><th>Existing Controls</th><th>Likelihood</th><th>Severity</th><th>Residual
Risk Rating
(Likelihood x Severity)</th><th>Additional control measures required
(if any)</th><th>Final risk rating</th></tr>
<tr><td>Potential of sharing stories of racism or discrimination by the hands of PH officials that might distress</td><td></td><td></td><td>1/2</td><td>1</td><td>Minor 1-2</td><td>Offering opportunities to have a debrief with the interview, resources, contact for supervisor</td><td></td></tr>
<tr><td>Self-risk</td><td></td><td></td><td>2</td><td>1-2</td><td>Minor 1-2</td><td>Seeking support from the supervisory team, individual tutor, support I have</td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

Review Date

Appendix K: UEL Data Management Plan

UEL Data Management Plan

Completed plans must be sent to researchdata@uel.ac.uk for review

If you are bidding for funding from an external body, complete the Data Management Plan required by the funder (if specified).

Research data is defined as information or material captured or created during the course of research, and which underpins, tests, or validates the content of the final research output. The nature of it can vary greatly according to discipline. It is often empirical or statistical, but also includes material such as drafts, prototypes, and multimedia objects that underpin creative or 'non-traditional' outputs. Research data is often digital, but includes a wide range of paper-based and other physical objects.

Administrative Data	
PI/Researcher	**Tomazia Goncalves Garcia Galhardo Burnett**
PI/Researcher ID (e.g. ORCiD)	0000-0001-6104-7863
PI/Researcher email	U2075203@uel.ac.uk
Research Title	Trust in public health policy within Black African and Caribbean communities

Project ID	N/A
Research start date and duration	March 2022 – September 2023
Research Description	There is increasing evidence that trust in public health officials, their messages and organisations has implications for health decision-making and behaviour. Historical experiences of institutional racism in healthcare have been associated with lower levels of trust for minority ethnic groups, causing them to act cautiously and show resistance. This phenomenon was once again highlighted in the current context of COVID-19, with Black African and Caribbean communities being found less likely to follow with public health advice. This project is interested in the process of trust building for Black African and Caribbean communities that have historically been discriminated and marginalised by the public health system. This is an area that has been largely neglected in the literature. Understanding how trust is formed in these communities might have relevant implications for clinical psychology practice, including understanding factors affecting 'relationship to help'. To explore this, in this study I will draw on the present COVID-19 pandemic and current vaccination drive as a case study, and explore it using a Community Psychology perspective. To do so, this study aims to recruit 12 to 15 voluntary participants through purposive sampling via social media to take part in semi-structured interviews. Data will be analysed using a Grounded Theory approach to develop an inductive conceptualisation of trust towards public health policy for Black African and Caribbean communities. Should the study be unable to recruit enough participants, data will be analysed using a thematic analysis qualitative approach.
Funder	N/A – part of Professional Doctorate in Clinical Psychology
Grant Reference Number	N/A

(Post-award)	
Date of first version (of DMP)	04/04/2022
Date of last update (of DMP)	
Related Policies	Research Data Management Policy BPS Practice Guidelines Third Edition 2017 NHS England response to the specific equality duties of the Equality Act 2010 UEL Statement on Research Integrity UEL Statement on Research Ethics The Data Protection Act UEL Data Backup Policy
Does this research follow on from previous research? If so, provide details	N/A
Data Collection	
What data will you collect or create?	12 to 15 voluntary participants will be interviewed by the researcher. Individual semi- structured interviews will be conducted via Microsoft Teams. Interviews will be audio and video recorded and recordings will be saved in .mp4 format. Transcription will be created and saved as Word documents (.doc file formats). The transcripts will be organised and analysed by the researcher. Personal data will be collected on consent forms and prior to the interview. This includes name, email address or telephone number for purposes of arranging the interview. Demographic data will also be collected, in specific, age, gender and level of education.

	No sensitive data will be collected. No further data will be created in the process of analysing the transcripts.
How will the data be collected or created?	Interviews will be conducted and recorded remotely using Microsoft Teams installed on the interviewer's personal laptop, with the resulting .mp4 files transferred to OneDrive. Recordings will be stored following the file-naming convention: [ProjectCode]-[InterviewerInitials]-[ParticipantNumber]-[Location]-[Date].Ext. Interviews will be auto-transcribed. The auto-transcriptions will be reviewed and edited by the researcher. These will also be stored following the same type of file-naming convention. Video recordings from Microsoft teams will be auto transcribed and stored on UEL OneDrive The researcher will review and edit this transcription (removing identifiable information in the process) before downloading into a word doc. This transcription will then be stored in a password protected file on both the researcher and supervisor's secure accounts. Consent will be collected using MS Forms. Electronic consent forms will be saved in a separate encrypted UEL OneDrive folder to other research data and will be deleted from Microsoft Forms once successfully transferred to UEL OneDrive. An interview schedule will be developed so that a standard format is followed.

Documentation and Metadata	
What documentation and metadata will accompany the data?	Consent forms Information sheets for participants Debrief forms Participant recruitment poster Demographic information
Ethics and Intellectual Property	
Identify any ethical issues and how these will be managed	UEL Ethics approval will be sought before recruitment can take place. During recruitment, information sheets will be given to potential participants and given again prior to interviews. Written informed consent to share and archive research data in the future will be requested and obtained through MS forms. Consent forms will also detail that participation is voluntary and that they can withdraw from the interviews at any point. Participants will be informed that their identifying data will be kept confidential and stored securely. Additionally, that their contribution will be anonymised during analysis, that analysis will be undertaken by the researcher only and that they are entitled to withdraw their contribution up until the point of analysis, this date will be given to participants throughout all information given. Participants will be informed that they are welcome to take breaks or step out during the interview if they choose. Also, that if any material that comes up in the interview that may necessitate a breach of confidentiality (i.e. indicating significant risk to safety or wellbeing), they will be consulted before any next steps are taken, as long as it is possible.

	The anonymisation process will ensure that personal identifiers, both direct and indirect, that may lead to a participant being identified will be removed. This means that their name, the name of others, their address, postcode, telephone number, photograph or image, or some other unique personal characteristic that may lead to them being directly identified, will be removed during the data analysis to protect their identities. The pseudonymisation process refers to the processing of personal data in such a way that the data can no longer be attributed to a specific data subject without the use of additional information. In order to do this, each participant will be given an opportunity to choose their own names for the data set. There will be no record or key of these to further protect their identity and ensure non-attribution to an identified or identifiable individual. Participants will be de briefed post interview. All participants have the right to withdraw from research prior to data analysis. Interviews will be videorecorded and the files will be saved, encrypted, and stored on password protected secure servers (UEL OneDrive for business) in line with General Data Protection Regulation (GDPR) and the Data Protection Act (2018). Any distress occurring during the interview will be managed in the same way the researcher would manage distress in clinical work. In other words, participants will be offered opportunities to debrief post interview. They will also be given resources and signposted to relevant organisations. Finally, the contact information for the researcher and supervisor will also be shared should they wish further debrief. My supervisor will always be aware of where and when interviews are occurring. Debrief forms will include details of resources for support in the event of any distress or matters arising following participation.

Identify any copyright and Intellectual Property Rights issues and how these will be managed	**None**
Storage and Backup	
How will the data be stored and backed up during the research?	All data will be stored on UEL OneDrive for business cloud. - Audio/video files and transcripts will be stored on separate password protected folders only accessible by the researcher on a UEL OneDrive for business. - Transcripts will be stored on both the researchers and supervisors secure accounts (so there is a backup) Contact details and other identifiable information such as audio/video files will be stored in a folder separate from the transcripts. Consent will be collected using MS Forms. Electronic consent forms will be saved in a separate folder on UEL OneDrive to other research data and will be encrypted.
How will you manage access and security?	Participants contact details provided to receive a summary of the study findings will be stored on a password-protected document on the researcher's UEL OneDrive, which only the researcher and supervisor will have access to. This will be stored on a separate document, in a separate folder, to the research data. This document will be deleted once these participants have been provided with a summary of the findings. Only the researcher and supervisor will have access to anonymised transcripts. Examiners will be provided with access through secure links to excerpts of the anonymised transcripts via UEL OneDrive. Data stored on OneDrive is encrypted, this means that access is limited to me and secured through Multi-Factor Authentication. I will share data with my supervisor upon

	request using OneDrive secure links. My password-secured laptop will be used to access UEL storage, but no data will be stored locally on the laptop itself and synching of files will be deactivated. Transcriptions will be typed or copied into a Word document and saved separate to the above information (on UEL OneDrive).
Data Sharing	
How will you share the data?	Short extracts of transcripts will be provided in the final write-up of the research and any subsequent publications. The final write-up will be uploaded onto UEL repository. Identifiable information will not be included in these extracts. Anonymised transcripts will not be deposited via the UEL repository due to issues with confidentiality.
Are any restrictions on data sharing required?	Only researcher and supervisors will have access to data (i.e., no one outside the research team will be able to access the data)
Selection and Preservation	
Which data are of long-term value and should be retained, shared, and/or preserved?	Electronic copies of consent forms will be kept until the thesis has been examined and passed. They will then be erased from the secure server. Audio and video files will be deleted as soon as they have been transcribed.
What is the long-term preservation plan for the data?	The final research write-up will be deposited and disseminated via the UEL Research Repository. This will not include data such as anonymised transcripts. Transcripts will be kept for three years on UEL's OneDrive by the research supervisor, after which point they will be deleted. These are kept securely within UEL servers but may be

	needed for further publication following the thesis examination. Participants will be made aware of these data storage intentions in the consent and debrief forms.
Responsibilities and Resources	
Who will be responsible for data management?	Tomazia Galhardo Supervised by Dr Maria Qureshi
What resources will you require to deliver your plan?	Laptop and access to UEL's OneDrive for Business.
Review	
	Please send your plan to researchdata@uel.ac.uk **We will review within 5 working days and request further information or amendments as required before signing**
Date: 23/05/2022	Reviewer name: Penny Jackson Assistant Librarian (Research Data Management)

Appendix L: Patient Debrief Sheet

University of East London

PARTICIPANT DEBRIEF SHEET

‘Trust in public health policy within Black African and Caribbean communities’

Thank you for participating in my research study on the subject of trust in public health policy for people coming from Black communities. This document offers information that may be relevant in light of you having now taken part.

How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL’s online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations, talks, magazine articles, blogs. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally, this means that personally identifying information will either be removed or replaced using a pseudonym.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by Dr Maria Qureshi for a maximum of 3 years, following which all data will be deleted.

What if I been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

- **Boloh helpline:** A helpline and webchat for Black, Asian and Minority Ethnic children, young people, parents or carers affected by the pandemic. Offers emotional support and practical advice. You can call them on 0800 151 2605 or contact them via www.helpline.barnardos.org.uk

- **BLAM (Black Learning Achievement and Mental Health):** An organisation that offers mental health support to people from Black British communities, including racial wellness workshops. You can contact them via blamuk.org

- **Rethink Mental Illness:** A charity that provides support and information for anyone affected by mental health problems, including local support groups. You can call them on 0808 801 0525 or contact them via www.rethink.org

- **True Vision:** Provides information about hate crimes and an online form for reporting them. You can contact them via report-it.org.uk

- **Samaritans:** Samaritans is a charity aimed at providing emotional support to anyone in emotional distress, struggling to cope. You can call the on 116 123 or contact them via email on jo@samaritans.org.

- **MIND:** Mind is a mental health charity that offers information and advice to people with mental health problems. You can call them on 0300 123 3393 or contact them via email on info@mind.org.uk

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Tomazia Galhardo – u2075203@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Maria Qureshi

School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: m.qureshi2@uel.ac.uk

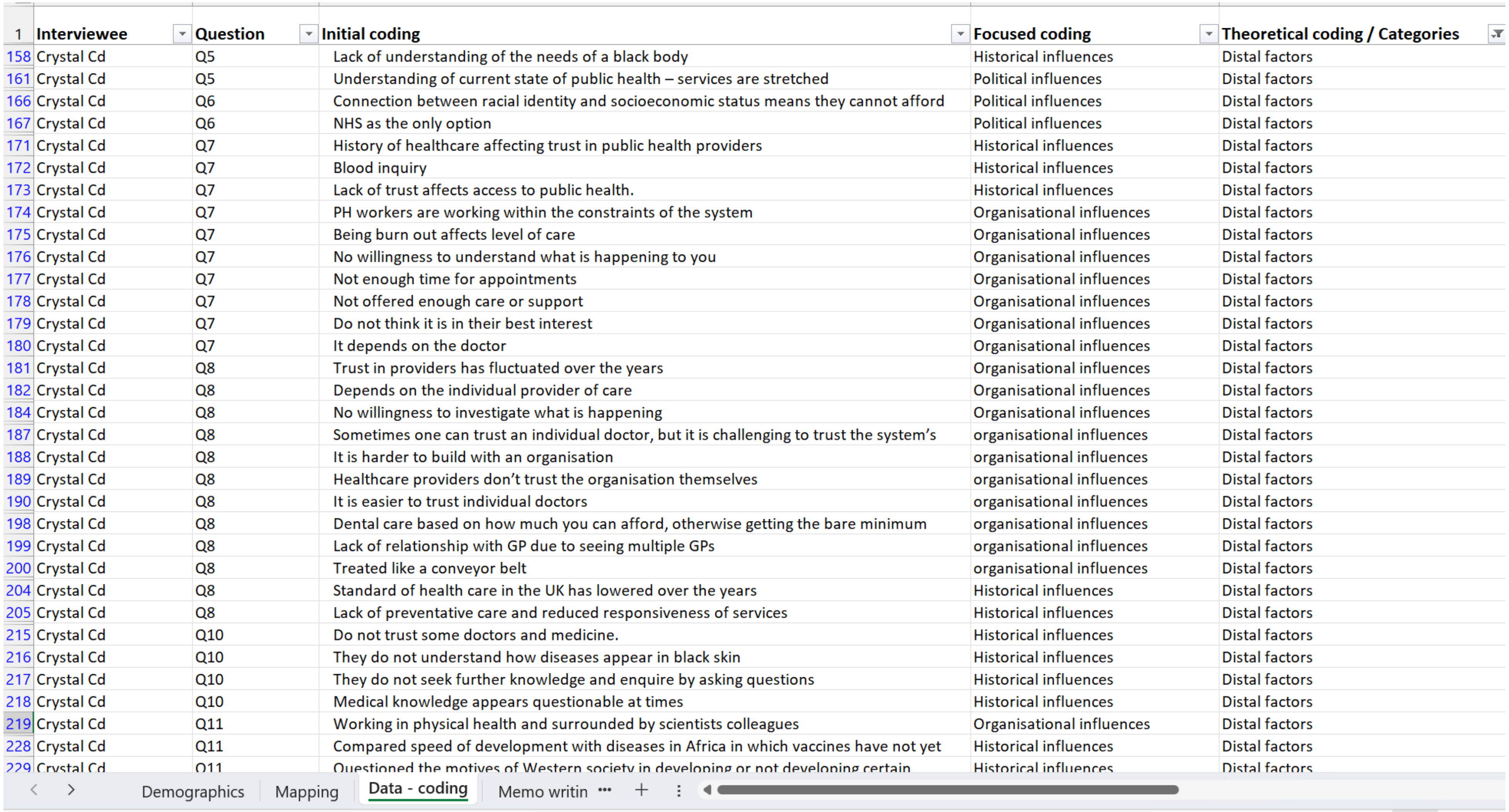
or

Chair of School Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.patel@uel.ac.uk)

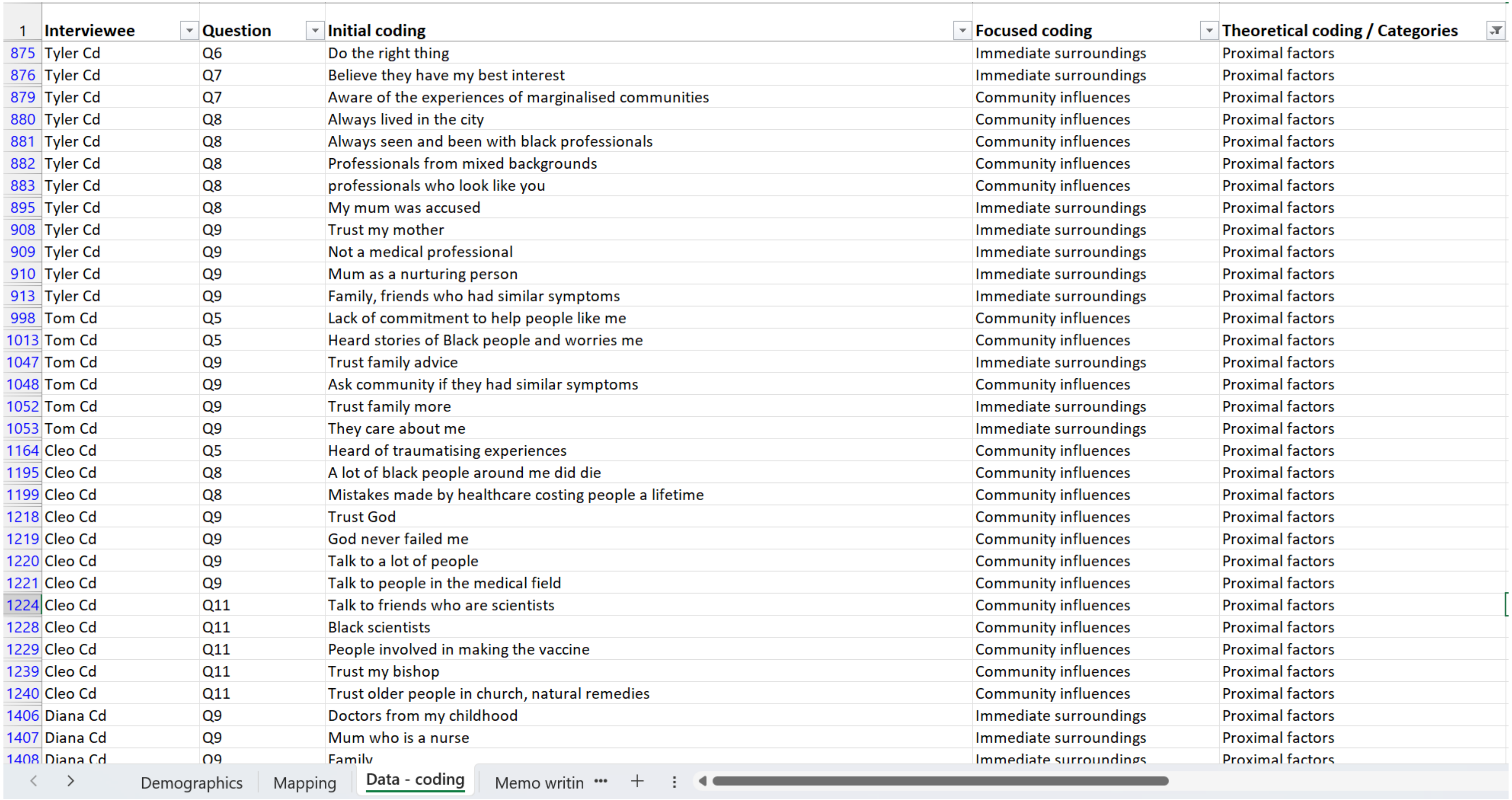
Thank you for taking part in my study

Appendix M: Examples of initial codes grouped under category Distal Influences



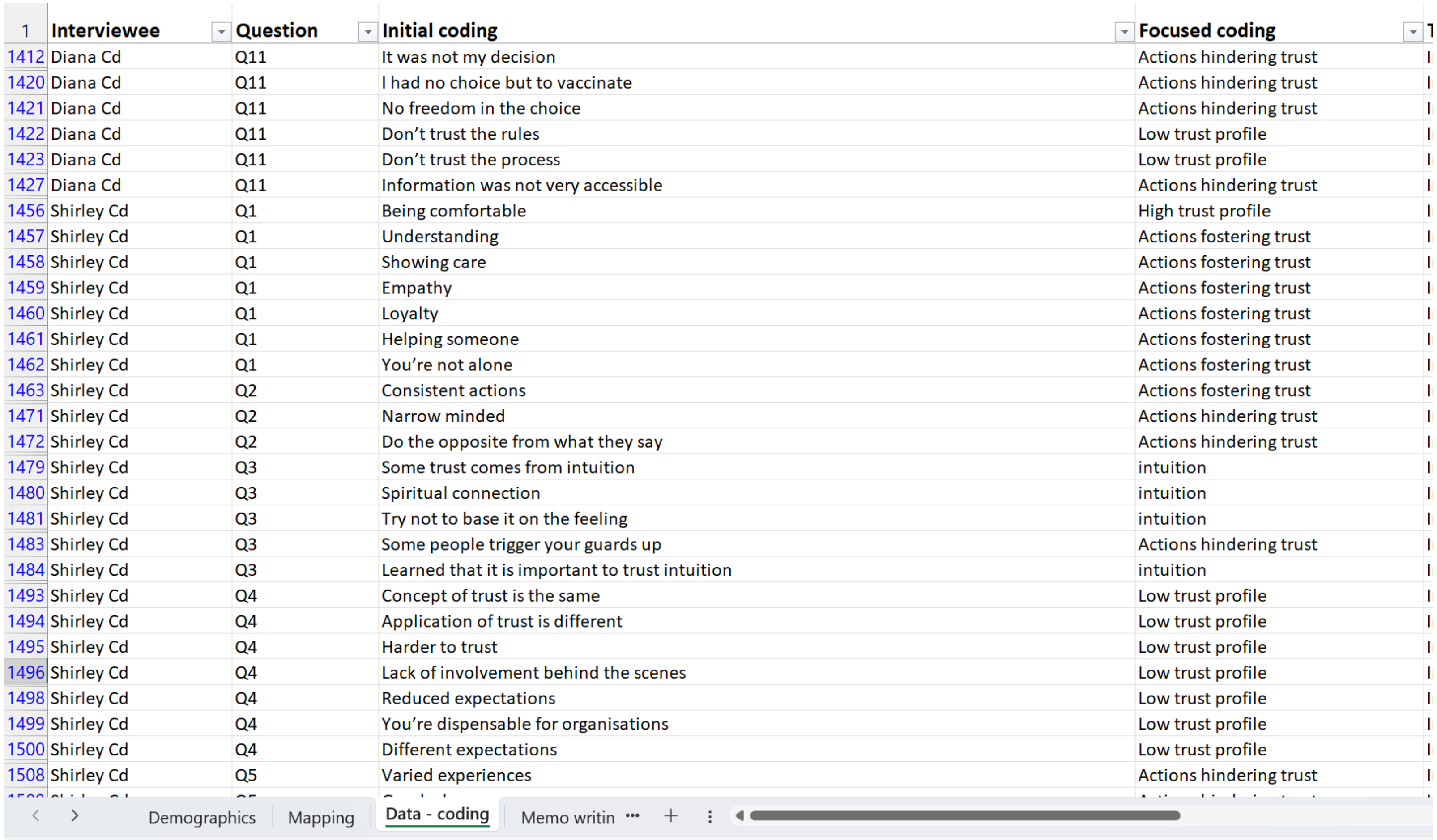
1	Interviewee	Question	Initial coding	Focused coding	Theoretical coding / Categories
158	Crystal Cd	Q5	Lack of understanding of the needs of a black body	Historical influences	Distal factors
161	Crystal Cd	Q5	Understanding of current state of public health – services are stretched	Political influences	Distal factors
166	Crystal Cd	Q6	Connection between racial identity and socioeconomic status means they cannot afford	Political influences	Distal factors
167	Crystal Cd	Q6	NHS as the only option	Political influences	Distal factors
171	Crystal Cd	Q7	History of healthcare affecting trust in public health providers	Historical influences	Distal factors
172	Crystal Cd	Q7	Blood inquiry	Historical influences	Distal factors
173	Crystal Cd	Q7	Lack of trust affects access to public health.	Historical influences	Distal factors
174	Crystal Cd	Q7	PH workers are working within the constraints of the system	Organisational influences	Distal factors
175	Crystal Cd	Q7	Being burn out affects level of care	Organisational influences	Distal factors
176	Crystal Cd	Q7	No willingness to understand what is happening to you	Organisational influences	Distal factors
177	Crystal Cd	Q7	Not enough time for appointments	Organisational influences	Distal factors
178	Crystal Cd	Q7	Not offered enough care or support	Organisational influences	Distal factors
179	Crystal Cd	Q7	Do not think it is in their best interest	Organisational influences	Distal factors
180	Crystal Cd	Q7	It depends on the doctor	Organisational influences	Distal factors
181	Crystal Cd	Q8	Trust in providers has fluctuated over the years	Organisational influences	Distal factors
182	Crystal Cd	Q8	Depends on the individual provider of care	Organisational influences	Distal factors
184	Crystal Cd	Q8	No willingness to investigate what is happening	Organisational influences	Distal factors
187	Crystal Cd	Q8	Sometimes one can trust an individual doctor, but it is challenging to trust the system's	organisational influences	Distal factors
188	Crystal Cd	Q8	It is harder to build with an organisation	organisational influences	Distal factors
189	Crystal Cd	Q8	Healthcare providers don't trust the organisation themselves	organisational influences	Distal factors
190	Crystal Cd	Q8	It is easier to trust individual doctors	organisational influences	Distal factors
198	Crystal Cd	Q8	Dental care based on how much you can afford, otherwise getting the bare minimum	organisational influences	Distal factors
199	Crystal Cd	Q8	Lack of relationship with GP due to seeing multiple GPs	organisational influences	Distal factors
200	Crystal Cd	Q8	Treated like a conveyor belt	organisational influences	Distal factors
204	Crystal Cd	Q8	Standard of health care in the UK has lowered over the years	Historical influences	Distal factors
205	Crystal Cd	Q8	Lack of preventative care and reduced responsiveness of services	Historical influences	Distal factors
215	Crystal Cd	Q10	Do not trust some doctors and medicine.	Historical influences	Distal factors
216	Crystal Cd	Q10	They do not understand how diseases appear in black skin	Historical influences	Distal factors
217	Crystal Cd	Q10	They do not seek further knowledge and enquire by asking questions	Historical influences	Distal factors
218	Crystal Cd	Q10	Medical knowledge appears questionable at times	Historical influences	Distal factors
219	Crystal Cd	Q11	Working in physical health and surrounded by scientists colleagues	Organisational influences	Distal factors
228	Crystal Cd	Q11	Compared speed of development with diseases in Africa in which vaccines have not yet	Historical influences	Distal factors
229	Crystal Cd	Q11	Questioned the motives of Western society in developing or not developing certain	Historical influences	Distal factors

Appendix N: Examples of initial codes grouped under category Proximal Influences



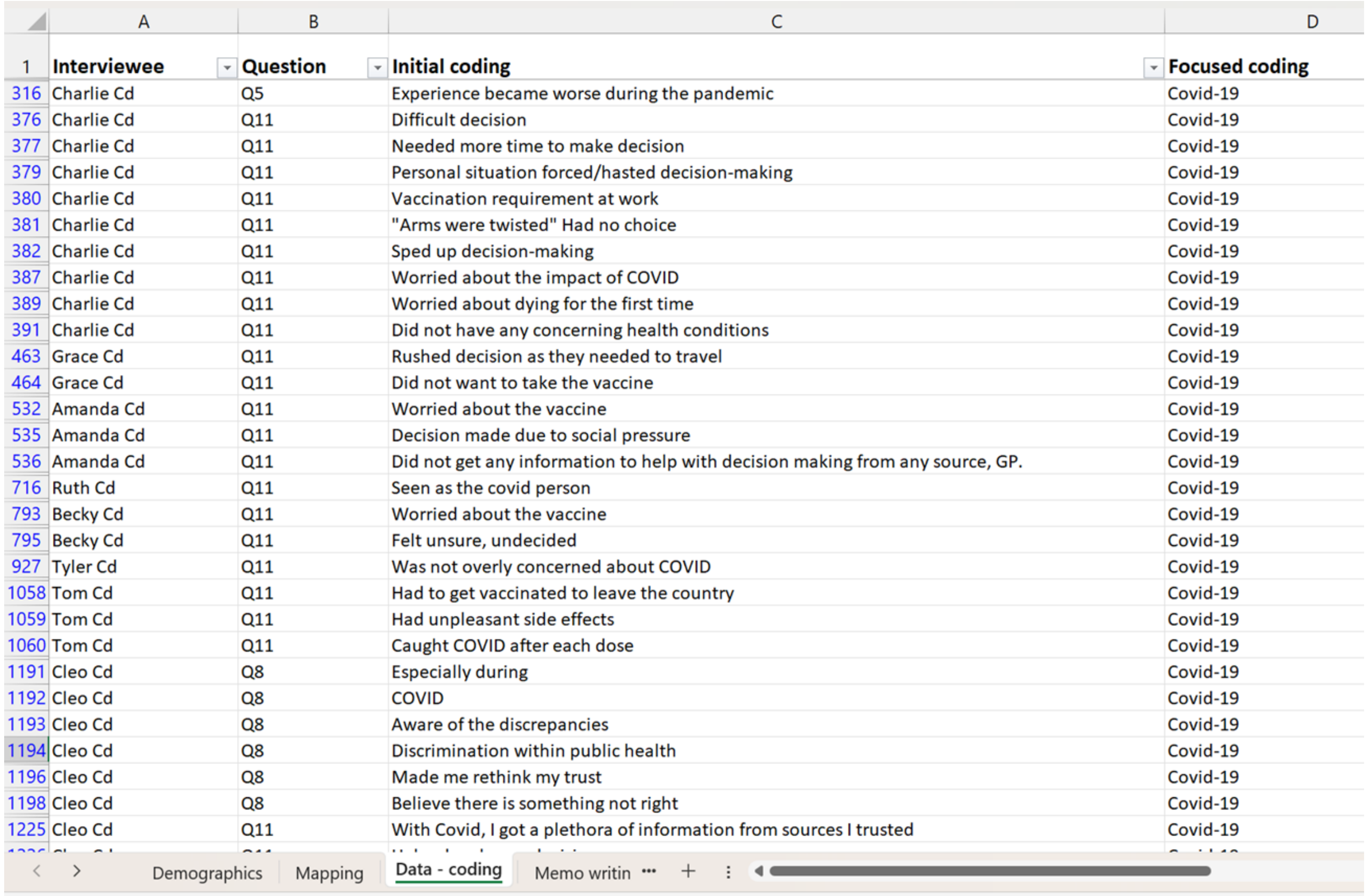
1	Interviewee	Question	Initial coding	Focused coding	Theoretical coding / Categories
875	Tyler Cd	Q6	Do the right thing	Immediate surroundings	Proximal factors
876	Tyler Cd	Q7	Believe they have my best interest	Immediate surroundings	Proximal factors
879	Tyler Cd	Q7	Aware of the experiences of marginalised communities	Community influences	Proximal factors
880	Tyler Cd	Q8	Always lived in the city	Community influences	Proximal factors
881	Tyler Cd	Q8	Always seen and been with black professionals	Community influences	Proximal factors
882	Tyler Cd	Q8	Professionals from mixed backgrounds	Community influences	Proximal factors
883	Tyler Cd	Q8	professionals who look like you	Community influences	Proximal factors
895	Tyler Cd	Q8	My mum was accused	Immediate surroundings	Proximal factors
908	Tyler Cd	Q9	Trust my mother	Immediate surroundings	Proximal factors
909	Tyler Cd	Q9	Not a medical professional	Immediate surroundings	Proximal factors
910	Tyler Cd	Q9	Mum as a nurturing person	Immediate surroundings	Proximal factors
913	Tyler Cd	Q9	Family, friends who had similar symptoms	Immediate surroundings	Proximal factors
998	Tom Cd	Q5	Lack of commitment to help people like me	Community influences	Proximal factors
1013	Tom Cd	Q5	Heard stories of Black people and worries me	Community influences	Proximal factors
1047	Tom Cd	Q9	Trust family advice	Immediate surroundings	Proximal factors
1048	Tom Cd	Q9	Ask community if they had similar symptoms	Community influences	Proximal factors
1052	Tom Cd	Q9	Trust family more	Immediate surroundings	Proximal factors
1053	Tom Cd	Q9	They care about me	Immediate surroundings	Proximal factors
1164	Cleo Cd	Q5	Heard of traumatising experiences	Community influences	Proximal factors
1195	Cleo Cd	Q8	A lot of black people around me did die	Community influences	Proximal factors
1199	Cleo Cd	Q8	Mistakes made by healthcare costing people a lifetime	Community influences	Proximal factors
1218	Cleo Cd	Q9	Trust God	Community influences	Proximal factors
1219	Cleo Cd	Q9	God never failed me	Community influences	Proximal factors
1220	Cleo Cd	Q9	Talk to a lot of people	Community influences	Proximal factors
1221	Cleo Cd	Q9	Talk to people in the medical field	Community influences	Proximal factors
1224	Cleo Cd	Q11	Talk to friends who are scientists	Community influences	Proximal factors
1228	Cleo Cd	Q11	Black scientists	Community influences	Proximal factors
1229	Cleo Cd	Q11	People involved in making the vaccine	Community influences	Proximal factors
1239	Cleo Cd	Q11	Trust my bishop	Community influences	Proximal factors
1240	Cleo Cd	Q11	Trust older people in church, natural remedies	Community influences	Proximal factors
1406	Diana Cd	Q9	Doctors from my childhood	Immediate surroundings	Proximal factors
1407	Diana Cd	Q9	Mum who is a nurse	Immediate surroundings	Proximal factors
1408	Diana Cd	Q9	Family	Immediate surroundings	Proximal factors

Appendix O: Examples of initial codes grouped under category Individual Influences



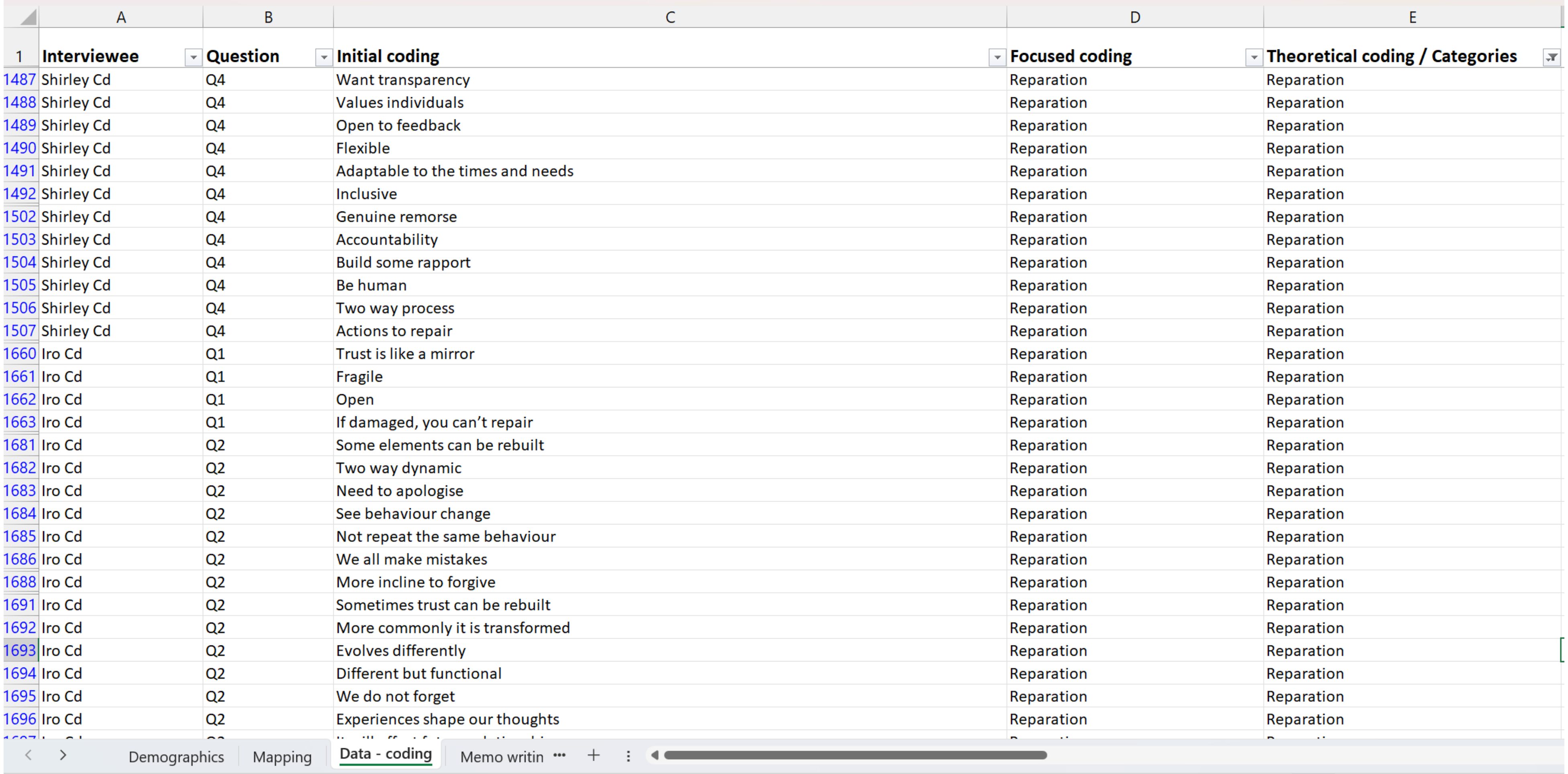
1	Interviewee	Question	Initial coding	Focused coding
1412	Diana Cd	Q11	It was not my decision	Actions hindering trust
1420	Diana Cd	Q11	I had no choice but to vaccinate	Actions hindering trust
1421	Diana Cd	Q11	No freedom in the choice	Actions hindering trust
1422	Diana Cd	Q11	Don’t trust the rules	Low trust profile
1423	Diana Cd	Q11	Don’t trust the process	Low trust profile
1427	Diana Cd	Q11	Information was not very accessible	Actions hindering trust
1456	Shirley Cd	Q1	Being comfortable	High trust profile
1457	Shirley Cd	Q1	Understanding	Actions fostering trust
1458	Shirley Cd	Q1	Showing care	Actions fostering trust
1459	Shirley Cd	Q1	Empathy	Actions fostering trust
1460	Shirley Cd	Q1	Loyalty	Actions fostering trust
1461	Shirley Cd	Q1	Helping someone	Actions fostering trust
1462	Shirley Cd	Q1	You’re not alone	Actions fostering trust
1463	Shirley Cd	Q2	Consistent actions	Actions fostering trust
1471	Shirley Cd	Q2	Narrow minded	Actions hindering trust
1472	Shirley Cd	Q2	Do the opposite from what they say	Actions hindering trust
1479	Shirley Cd	Q3	Some trust comes from intuition	intuition
1480	Shirley Cd	Q3	Spiritual connection	intuition
1481	Shirley Cd	Q3	Try not to base it on the feeling	intuition
1483	Shirley Cd	Q3	Some people trigger your guards up	Actions hindering trust
1484	Shirley Cd	Q3	Learned that it is important to trust intuition	intuition
1493	Shirley Cd	Q4	Concept of trust is the same	Low trust profile
1494	Shirley Cd	Q4	Application of trust is different	Low trust profile
1495	Shirley Cd	Q4	Harder to trust	Low trust profile
1496	Shirley Cd	Q4	Lack of involvement behind the scenes	Low trust profile
1498	Shirley Cd	Q4	Reduced expectations	Low trust profile
1499	Shirley Cd	Q4	You’re dispensable for organisations	Low trust profile
1500	Shirley Cd	Q4	Different expectations	Low trust profile
1508	Shirley Cd	Q5	Varied experiences	Actions hindering trust

Appendix P: Examples of initial codes related to COVID-19



1	Interviewee	Question	Initial coding	Focused coding
316	Charlie Cd	Q5	Experience became worse during the pandemic	Covid-19
376	Charlie Cd	Q11	Difficult decision	Covid-19
377	Charlie Cd	Q11	Needed more time to make decision	Covid-19
379	Charlie Cd	Q11	Personal situation forced/hasted decision-making	Covid-19
380	Charlie Cd	Q11	Vaccination requirement at work	Covid-19
381	Charlie Cd	Q11	"Arms were twisted" Had no choice	Covid-19
382	Charlie Cd	Q11	Sped up decision-making	Covid-19
387	Charlie Cd	Q11	Worried about the impact of COVID	Covid-19
389	Charlie Cd	Q11	Worried about dying for the first time	Covid-19
391	Charlie Cd	Q11	Did not have any concerning health conditions	Covid-19
463	Grace Cd	Q11	Rushed decision as they needed to travel	Covid-19
464	Grace Cd	Q11	Did not want to take the vaccine	Covid-19
532	Amanda Cd	Q11	Worried about the vaccine	Covid-19
535	Amanda Cd	Q11	Decision made due to social pressure	Covid-19
536	Amanda Cd	Q11	Did not get any information to help with decision making from any source, GP.	Covid-19
716	Ruth Cd	Q11	Seen as the covid person	Covid-19
793	Becky Cd	Q11	Worried about the vaccine	Covid-19
795	Becky Cd	Q11	Felt unsure, undecided	Covid-19
927	Tyler Cd	Q11	Was not overly concerned about COVID	Covid-19
1058	Tom Cd	Q11	Had to get vaccinated to leave the country	Covid-19
1059	Tom Cd	Q11	Had unpleasant side effects	Covid-19
1060	Tom Cd	Q11	Caught COVID after each dose	Covid-19
1191	Cleo Cd	Q8	Especially during	Covid-19
1192	Cleo Cd	Q8	COVID	Covid-19
1193	Cleo Cd	Q8	Aware of the discrepancies	Covid-19
1194	Cleo Cd	Q8	Discrimination within public health	Covid-19
1196	Cleo Cd	Q8	Made me rethink my trust	Covid-19
1198	Cleo Cd	Q8	Believe there is something not right	Covid-19
1225	Cleo Cd	Q11	With Covid, I got a plethora of information from sources I trusted	Covid-19

Appendix Q: Examples of initial codes related to Reparation



	A	B	C	D	E
1	Interviewee	Question	Initial coding	Focused coding	Theoretical coding / Categories
1487	Shirley Cd	Q4	Want transparency	Reparation	Reparation
1488	Shirley Cd	Q4	Values individuals	Reparation	Reparation
1489	Shirley Cd	Q4	Open to feedback	Reparation	Reparation
1490	Shirley Cd	Q4	Flexible	Reparation	Reparation
1491	Shirley Cd	Q4	Adaptable to the times and needs	Reparation	Reparation
1492	Shirley Cd	Q4	Inclusive	Reparation	Reparation
1502	Shirley Cd	Q4	Genuine remorse	Reparation	Reparation
1503	Shirley Cd	Q4	Accountability	Reparation	Reparation
1504	Shirley Cd	Q4	Build some rapport	Reparation	Reparation
1505	Shirley Cd	Q4	Be human	Reparation	Reparation
1506	Shirley Cd	Q4	Two way process	Reparation	Reparation
1507	Shirley Cd	Q4	Actions to repair	Reparation	Reparation
1660	Iro Cd	Q1	Trust is like a mirror	Reparation	Reparation
1661	Iro Cd	Q1	Fragile	Reparation	Reparation
1662	Iro Cd	Q1	Open	Reparation	Reparation
1663	Iro Cd	Q1	If damaged, you can’t repair	Reparation	Reparation
1681	Iro Cd	Q2	Some elements can be rebuilt	Reparation	Reparation
1682	Iro Cd	Q2	Two way dynamic	Reparation	Reparation
1683	Iro Cd	Q2	Need to apologise	Reparation	Reparation
1684	Iro Cd	Q2	See behaviour change	Reparation	Reparation
1685	Iro Cd	Q2	Not repeat the same behaviour	Reparation	Reparation
1686	Iro Cd	Q2	We all make mistakes	Reparation	Reparation
1688	Iro Cd	Q2	More incline to forgive	Reparation	Reparation
1691	Iro Cd	Q2	Sometimes trust can be rebuilt	Reparation	Reparation
1692	Iro Cd	Q2	More commonly it is transformed	Reparation	Reparation
1693	Iro Cd	Q2	Evolves differently	Reparation	Reparation
1694	Iro Cd	Q2	Different but functional	Reparation	Reparation
1695	Iro Cd	Q2	We do not forget	Reparation	Reparation
1696	Iro Cd	Q2	Experiences shape our thoughts	Reparation	Reparation

Appendix R: Examples of initial codes related to Reparation

Demographics Form

- What is your age?:
- How would you describe your gender/gender identity?
- How would you described your ethnicity or racial identity:
- How would you described your COVID-19 vaccination status?:
- What is your education level?

The final body of research may include short excerpts from what you share today. To preserve your anonymity, we will use pseudonym or alias to refer to what you have said.

- What pseudonym or alias would you like me to use?