

BRIEF: 10 WAYS LOCAL GOVERNMENTS IN MULTICULTURAL URBAN SETTINGS CAN SUPPORT VACCINE EQUITY IN PANDEMICS

INTRODUCTION: NATIONAL SUCCESSES MAY HIDE LOCAL VACCINE INEQUITIES

At national and aggregate levels, COVID-19 vaccination across G7 countries appears successful. To date, 79.4% of the total population of G7 countries have received a first dose, 72.9% a second, and 45.4% a booster shot (28th April 2022 data) ¹ In France, 80.6% of the total population has had a first dose, 78.2 % have had two doses, and 55.4% have had their booster jabs (28th of April 2022 data).² In the UK, 79.3% of the total population has received one dose, 74.1% a second one, and 58.5% have received a booster.¹ In Italy, 85.2% of the total population has had a first dose, 80.4% have had two doses, and 66.5% have had their booster jabs (28th of April 2022 data). These figures indicate enthusiasm across G7 countries for COVID-19 vaccines.

Yet high overall vaccination rates at the national level, disguise significant in-country disparities. For example, by the end of 2021, less than 50% of residents of the Northern Districts of Marseille were vaccinated, compared with over 70% in wealthier neighbourhoods.³ In the Ealing borough of Northwest London, 70% of the eligible population has had a first dose – which is almost 10% percent below the national average. ⁴ (4th of April 2022 data). Disparities are also seen in other urban metropolises across the G7.

Box 1. Key terms

- **Vaccine equity** is fair and just access to vaccines for all people. Lower vaccine uptake among some groups in relation to others can point to *inequities* which may be related to aspects of vaccination programmes, as well as to other social, economic or political factors.¹⁰
- **Structural inequalities** refer to the systematic disadvantage of one social group over another as a result of intersecting “drivers - such as, racism, sexism, classism, able-ism, xenophobia, and homophobia - that make those identities salient to the fair distribution of health opportunities and outcomes” ¹¹.
- **Systemic or structural racism** emphasises how “public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity” ¹².
- **Local governance of vaccine rollouts:** Vaccination relies on a series of public, private and civil society actors working together at different levels of administration and geographical reach. These different actors include, among others, local authorities and other policymakers, civil society organisations and community groups, and health providers.

This brief investigates these disparities through the lens of “vaccine (in)equity”, focusing on the role of local actors. It builds on ethnographic and qualitative research carried out in the Northern Districts of Marseille and ongoing research engagement around vaccine equity in Ealing (Northwest London), as well as qualitative research carried out in Italy among networks of healthcare providers, intercultural mediators, and civil society organizations that collaborated during the COVID-19 campaign in the Emilia Romagna region and in Rome.

Understanding vaccine inequity is particularly important as under-vaccinated populations – ethnic and cultural minorities, and those living in deprived areas, undocumented migrants – were more likely to get COVID-19, and to experience worse health outcomes. ^{5 6 7 8} For example in Ealing, four months into the vaccination campaign, just 57.6% of people in the

lowest decile of deprivation had received a dose, compared to 81% of people in the least deprived decile. ⁹ Furthermore, 89.2% of white British residents in Ealing were vaccinated compared to 64% of people from Pakistani and 49.3% of people from Caribbean backgrounds.⁹ In Rome, as in other G7 urban metropolises, our evidence points to particular disparities in vaccine uptake among undocumented populations and settled citizens. The drivers of vaccine inequity in these urban

environments are complex and involve the interaction of many factors including economic inequality, structural racism, unequal access to healthcare, mistrust in health providers and state actors, and more.

In this brief, we contend that local governments, health actors, community groups and residents play key roles in shaping vaccine (in)equity. There has been little systematic learning about “vaccine engagement” at the local level. We explain how experiences of structural inequalities intersect with local people’s experiences, and how these have been reflected or ignored in local government approaches to promoting and delivering COVID-19 vaccines. We delineate here lessons for vaccination ‘catch-up’ programmes which aim to reach those still to receive their full COVID-19 immunisation regime, as well as for emergency vaccination programmes in future.

This brief is based on research conducted between October and December 2021 in Marseille and ongoing engagement in Ealing which started in May 2021. It identified how local governments, health actors, community groups and residents play key roles in shaping vaccine (in)equity. This brief was developed for SSHAP by Santiago Ripoll (IDS), Tabitha Hrynick (IDS), Ashley Ouvrier (LaSSA), Megan Schmidt-Sane (IDS), Federico Federici (UCL) and Elizabeth Storer (LSE). It was reviewed by Eloisa Franchi (Università degli Studi di Pavia) and Ellen Schwartz (Hackney Council Public Health). The research was funded through the British Academy COVID-19 Recovery: G7 Fund (COVG7210038). Research was based at the Institute of Development Studies (IDS), University of Sussex, and the Laboratoire de Sciences Sociales Appliquées (LaSSA). The brief is the responsibility of SSHAP.

THE IMPORTANCE OF LOCAL GOVERNMENT AND THEIR RELATIONSHIPS WITH OTHER LOCAL ACTORS FOR VACCINE EQUITY

Despite the propensity to measure population health at the national, regional or even local authority level (e.g. a city or county), public health dynamics are highly localised. Uptake of public health measures as well as the nature of public health engagement varies between and within communities. We understand ‘public health initiatives’ in this report broadly, considering public services aimed at improving population health. Failure to recognise substantial differentiation within local populations, can mask significant inequalities in health outcomes, and inequities related to the social determinants of health.¹⁰ Throughout the COVID-19 crisis, ‘big’ data has been prioritised over ‘deep’ data.¹¹ Interventions to improve health at a population level without recognition and action on health inequalities within that population, can end up mainly benefitting those who already enjoy structural and social advantages. Additionally, such healthcare interventions that ignore social diversity can entrench mistrust amongst excluded populations. Local government entities and statutory authorities are well-placed to recognise, understand and make efforts to address localised health inequalities in ways higher level state (and private sector) actors are unable to accomplish. Furthermore, they often already play key roles at local level in education, transport, housing and urban planning – factors closely associated with the social determinants of health.¹² Emergency campaigns provide opportunity to boost equity in these wider, related areas of well-being.

The role of local governments has also been recognised in the more specific public health context of responding to outbreaks of infectious disease, including epidemics and pandemics. There is a tendency during such emergency situations for a ‘tyranny of the urgent’ to take hold.¹³ The need to respond rapidly to save lives and/or to prevent further disease transmission is often used to justify top-down, technocratic, and even militaristic responses that may be inappropriate in local contexts.¹⁴ Yet, if context is considered, vaccine campaigns can serve to build trust among minoritised groups. Local governments can play key roles in ‘localising’ and diversifying top-down or national responses to render them locally appropriate, or initiate their own efforts for more effective outcomes. Local governments have instruments to better understand local needs, through their granular access to statistical data, as well as their direct contact with specific communities. Local governments can also shape the communication strategy to better match diverse local population’s literacy, access, and language needs. Local strategies must be multidimensional, and include: engagement with diversity; attention to building relationships; and appropriate and accessible risk communication.

In the context of COVID-19, research has described the actions of local government actors to do just this. This is the case even in highly centralised, rigid and hierarchical structure of public administration. In China, for example, researchers have shown how local authorities were still able to exercise degrees of discretion and divergence from national policies. They exercised autonomy in relation to enforcement and facilitation of lockdowns, travel restrictions, quarantine, testing, track and trace, supply chain management, information dissemination, discipline, mobilisation of non-state actors, and the reassignment and evaluation of personnel to suit local conditions and meet the needs of their constituents.¹⁵ In Italy too, research has documented the roles of local government actors in response, and the proportional relationship between a response matching local needs and its impact.^{16,17}

Research on Local Directors of Public Health in the UK, where responsibility for public health is more firmly rooted at the local level, found that embedded actors have played critical roles in making context appropriate decisions around COVID-19 testing and vaccine provision, as well as emergency food and emotional support for local people¹⁸. These local directors of public health worked with wider teams and other leaders and institutions at local, regional and national levels to ensure coordinated, yet locally adapted responses. For example, Ealing council public health team collaborated with other council teams (community engagement, knowledge management, communications among others) and the local NHS clinical commissioning group and community groups to coordinate vaccine services. Similarly, regional and municipal health authorities in Italy achieved better results when measures and responses tried to match local needs, and where cooperation between institutional health providers and civil society organizations was in place or sought.¹⁹

Indeed, due to their locally specific knowledge and interactions with local residents and community groups, local government actors can support disease surveillance, case management, contact tracing and risk communication among other critical response activities. Critical to this endeavour is proactive community engagement and working with established relationships with community leaders and groups. Coordination and receiving support from higher level institutions which may have more formalised or specific mandates for epidemic response, is also important in delivering vaccine equitably.²⁰

LOCAL GOVERNMENT'S ROLE IN COMMUNITY ENGAGEMENT

Given the importance of trusting relationships between citizens and their governments in the context of public health and vaccination, ways of building and nurturing such relationships are critical. 'Community engagement' is often recommended as a route to doing this. While there is no universal definition for what this means, a recent review identified the following themes as important in the literature on community engagement:

- the importance of diverse knowledge, community assets and ways of knowing; the co-development of mutually beneficial outcomes;
- collective responses to shared challenges and opportunities through collaboration-based and participatory approaches;
- and the role of collaboration in fostering trust, reciprocity and social capital to maintain partnerships and relationships.²¹

Thus, community engagement has been conceptualised not just for the purposes of building trust and relationships, but for collectively generating and implementing solutions. In the context of local challenges and decision-making (such as on how to conduct a vaccination campaign) community engagement can bring different forms of relevant linguistic, cultural and socio-economic knowledge to the table, and serve the productive purpose of co-creation and co-action to increase the chances of an effective campaign.

What is often practiced as community engagement in the field, however, often falls short of this more productive and collaborative potential. In the field of epidemic response, community engagement is

usually paired with ‘risk communication’. This often results in their conflation, or the reducing of the former, into activities related to the latter. The emphasis is on messaging and ensuring communities understand risk, rather than a more comprehensive acknowledgement and leveraging of their knowledge, skills and capacity to co-design solutions. For example, among forced migrants there are healthcare professionals who may have extremely appropriate training and hard skills to deal with emergency medicine (surgery and/or epidemic risk response) and have appropriate health risk communication strategies can be useful to their own community. Delay in recognizing skills among minoritized/marginalised communities has had an impact on COVID-19 vaccines too.^{22,23}

Another, more insidious risk is that ‘community engagement’ processes may be set up as a way to legitimise the already planned activities, policies and projects of the organisation doing the community engagement. By consulting with a group of citizens, the objective is not necessarily to get their views to adapt practice, but to solicit – and perhaps even manipulate – their approval and consent.²¹ Another critical pitfall of ‘community engagement’ in practice is the tendency to understand ‘community’ as a totalising and homogenising concept which obscures social difference and power dynamics within populations.²⁰ Without an appreciation of power, those who are ‘engaged’, whatever form activities take, may represent only a narrow subset of more advantaged community members. This can translate into activities, policies and programmes which exclude less powerful and more vulnerable members.

HOW CAN LOCAL GOVERNMENTS DRIVE VACCINE EQUITY IN PANDEMIC VACCINE ROLLOUTS?

Lessons for local governments and related local actors in mitigating vaccine inequities in multicultural urban settings are listed below:

- 1. Support decentralisation and adaptability of vaccine programmes.** Key successes in the local governance of vaccine rollouts have banked on the autonomy of local and regional governments. Positive trends in uptake across all social groups have been recorded when local governments have had the space to mobilise to seek alternative or complementary forms of vaccine provision (for example, using alternative facilities, or working alongside trusted civil society actors), assess needs, and deploy community engagement and communication (as compared to the national top-down strategies). Decentralising does not mean relinquishing responsibility by higher levels of administration, as their financial and logistical support and guidance is critical.
- 2. Vaccination targets set to each devolved region must be based on equity as much as absolute numbers.** A need to vaccinate as many people as possible must also be complemented with targets for vaccine equity, which aim to achieve equal vaccine uptake between different community groups. Depending on context, this can be done through targeting of hotspots, or certain at-risk groups (provided that the targeting of at-risk groups does not appear as a form of ‘singling out’ in that particular context). Seeking alternative forms of assessing success in terms of vaccine equity should be explored in tandem with communities and relevant minorities.
- 3. Local authorities must seek to tailor services for minoritized groups from the outset, and at all levels, and offer adequate resources.** Tailored vaccination sites, the use of appropriate languages and hiring health and social workers from within people’s communities, give a sense of safety. This requires working with community organisations and building upon the work of community engagement officers in local councils. More resources are necessary for community groups and for community engagement for public health within local authorities (e.g. staff time). Civil society groups, networks of activists and community champions should also be included in dialogue and the shaping of interventions from the outset.
- 4. Bring adapted vaccination sites and venues to communities and emphasise ‘going to’ residents for community engagement.** Mass vaccination sites have been useful in vaccinating large numbers of people. However, these must be complemented with vaccination sites and opportunities nearest to communities which might include pop-up clinics, vaccination buses, local physicians’ practices and pharmacies, and even door-to-door services for the most vulnerable.

These should be planned rather than reactive and supported by information in multiple languages and accessible formats, as appropriate to the community. More conventional forms of engagement (e.g. public forums and webinars) may attract only already more engaged residents, and so efforts to engage with smaller community groups and to meet them where they are, are important.

5. **Vaccination must be as convenient as possible and be offered without formal government registration.** People lacking digital access or skills, full citizenship in country of residence, or command of official languages, struggle to navigate online booking systems. Systems should be easily navigable in key local languages, and walk-in options should also be available. Registration with national health services may discourage migrants unsure of their status or entitlements, and fearful of criminalisation or deportation. To ensure access to migrants and refugees who are in doubt of their residency status, make vaccination possible without registration, and at the same time creating a way of knowing when people come for second dose or booster, and if they move geographically that discrepancies can be dealt with. Top-down registration processes are exclusionary, and adapting digital processes to diverse needs of communities is needed. Communities and the Third Sector should be consulted for innovative registration solutions.
6. **Support collaboration and joined-up approaches between local authorities, health providers, community groups and other civil society organisations.** Identify and recruit trusted leaders for the vaccination programme. This collaboration should not be reactive, but built up over time, and can be leveraged to address other issues around health equity. Build on existing relationships and initiatives, and nurture other community-led initiatives. Consolidate collaboration that has emerged during the pandemic. Finance local community groups so they have the financial and human resources for long-term engagement with local authorities and their ongoing work with residents. Recruit local leaders to support in the vaccination programmes yet consider that who is trustworthy may be different depending on the social group being targeted. Avoid generalisations about religious or ethnic groups and seek a diversity of views within them. Support and recruit mediators to bridge social and health workers' activities and who can 'translate' between vaccination teams and communities. Build the interpersonal and intercultural skills of health workers, especially those working in multicultural neighbourhoods. Establish direct lines of communication between intercultural mediators and local health providers to support the development of these intercultural skills, via cross-disciplinary training.
7. **Address structural constraints to facilitate uptake and address longer-term health inequities to build trust.** A context-adapted response should consider the structural constraints that immediately affect uptake. Income support for people on low incomes or in precarious employment during the pandemic has been useful, as well as giving adequate sick leave. Provide vaccines in ways adapted to people's precarious work schedules such as 'after dark' provision, or even offering vaccination in workplaces. Trust is key for vaccine confidence. To counter 'us vs. them' mistrust, the state and local authorities should invest in public services, not only in terms of medical provision, but also in other sectors such as housing, transport, welfare and economic opportunities. Support health clinics and other health infrastructure in the community, as well as make them accessible. Work to increase quality of provision and the tailoring of services to different demographic groups living in the area (language, culture, and so on).
8. **Adapt communication messages, formats and channels to the specific needs of communities at a granular level in languages people are most proficient in.** Develop networks with culturally and linguistically diverse communities and identify their preferred ways of accessing information. Deliver information in multiple formats, in multiple modes (written, audio-visual, signed, interpreting, intercultural mediation), and via multiple channels of communication so to address the intended recipients with the best modes, channels, formats, and languages. Carry out language and translation needs assessments, and translate all guidance and materials into relevant local languages, and in multiple, accessible formats catering for needs of sign language users, hard-of-hearing, and low-literacy groups. Easy access communication in the dominant language helps the main language community as much as speakers of other languages.

Recruit purposefully to build language skills in the local health force, and work with community-based translators and mediators in the vaccine rollout.

9. **Emphasise deliberative dialogue and conversations rather than ‘informing’ approaches.** Having the ‘right information’ is secondary to having the right relationship. Create Q&A spaces where community members can safely voice their fears about vaccines and ask questions (individual or group Q&As with health workers), and spaces where people can speak about their experiences. Ensure multidirectional, language-appropriate communication. Ensure communities can provide feedback on the vaccination programme and the pandemic response in general, and that programmes are adapted appropriately in response to this feedback. Include community members and community organisations in decision-making on public health at a local level.
10. **Gather granular data on vaccine equity, social diversity and health outcomes.** Seek ways – unique to each context- to gather and communicate data on health inequities. It is important to know if certain social groups or minorities are more affected than others by illness, or have access to fewer or lower quality health service in order to address injustices.²⁴ Yet, this must be done in ways that do not ‘single out’ particular communities,²⁵ or feed into racist tropes. Data must be collaborative co-produced, and communities and their leaders given opportunity to choose strategies of representation and data collection. This inclusion will enable tensions to be navigated in ways which reflect diverse communal contexts. Data gathering must also have a strong qualitative component, that incorporates people’s perspectives and experiences when approaching vaccination choices.²⁵

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CONTACT

If you have a direct request concerning the brief, tools, additional technical expertise or remote analysis, or should you like to be considered for the network of advisers, please contact the Social Science in Humanitarian Action Platform by emailing Annie Lowden (a.lowden@ids.ac.uk) or Olivia Tulloch (oliviattulloch@anthrologica.com).

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