Local governments can make or break vaccination programmes in multicultural urban neighbourhoods

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Across the G7, countries have succeeded in vaccinating a large proportion of their national populations. Leading the group is Canada, with more than 85% of Canadians having had a first jab. The US, the lowest vaccinated country in the G7, has still managed to vaccinate over 75% of their total population. However, vaccination is not equally distributed: people living in ethnically diverse urban neighbourhoods are less likely to have been vaccinated. This has led to differences in health outcomes, as in many cities, those from immigrant backgrounds, minoritized and racialised communities were more likely to be living in COVID-19 hotspots, and at the same time be more vulnerable to hospitalisation and death.

Racialized and migrant populations were over-represented in COVID-19 cases, due to longstanding structural vulnerabilities. In high-income countries, these populations are disproportionately represented in precarious, underpaid, and essential frontline occupations. They are also more likely to live in overcrowded and multigenerational households in which it is difficult to isolate the sick, and in which within-household transmission can easily occur, leading to higher COVID-19 rates. Frontline workers from these communities have been more likely to be exposed to the virus, and due to longstanding health inequity, also more likely to have co-morbidities and limited access to health services which made them more vulnerable to hospitalisation and death. People from these communities were also less likely to be vaccinated.

Our research in the northern districts of Marseille, the Peel region in Greater Toronto area and the borough of Ealing in northwest London strongly suggests that local governments can reverse these trends. In these three cases, **local authorities worked collaboratively with local health providers, community groups and other local actors, resulting in a significant catch-up in vaccine uptake**. In the latter half of 2021, Peel region increased local vaccine uptake from 50% to 93%, becoming one of Canada's most vaccinated regions. Ealing increased its local uptake by 15%, to match rates in Greater London, while vaccination rates in the northern districts of Marseille doubled from 25% to 50%. Low income, minoritized and racialised communities still remain relatively the least vaccinated groups, yet it is clear that effective community participation and engagement made a difference.

Below are some key points from our research, illustrating how local governments were able to make a difference:

- **The decentralisation and adaptability of vaccine programmes led to successes in COVID-19 vaccine uptake**

Key successes in the local governance of vaccine rollouts have banked on the autonomy that local authorities – at regional and city level – have been granted as a result of decentralisation. Alternatively, when this degree of decentralisation was limited, personal and institutional commitments by local authorities to their populations pushed them to fight for and create these spaces of responsibility in the vaccination response. Local authorities' deep knowledge of the local context and their existing relationships with community groups guaranteed a more tailored response to the diverse populations to whom they are accountable.

- **Sustained and longstanding engagement by local authorities with health providers, community groups and residents had a higher impact on vaccine equity**

Increased vaccine confidence and uptake has been highest when relationships between local authorities and community groups and residents were longstanding. Reactive engagement with community groups as a result of COVID-19 has still had positive effect, but has delayed the building of trust. In turn, community organisations indicated that much of their efforts had not been financed appropriately and led to burnout. Funds for such engagement with local authorities should be readily available in 'normal' times, and new relationships that emerged as a result of COVID-19 should be consolidated and sustained beyond the pandemic.

- **Tailored vaccine services that are designed and delivered with community groups are especially critical in multicultural urban contexts**

Tailored vaccination sites, using appropriate languages and with health and social work staff from within people's own communities, give a sense of safety. This requires working with community organisations and building upon the work of community engagement officers in local councils. Community engagement staff are essential for this role of mediation and translation, and more staff should be recruited to work towards health equity.

- **Vaccination uptake is higher when there are sites and venues as close as possible to the communities**

Mass vaccination sites have been useful in vaccinating large numbers of people. However, these should be complemented with vaccination clinics nearest to communities includign for instance, pop-up clinics, vaccination buses, local physicians' practices and pharmacies, and door-to-door vaccination for the most vulnerable. These need to be planned strategically and in partnership with community engagement officers.

- **COVID-19 required adaptation to the structural inequalities people were experiencing**

Living on low incomes, and depending on precarious frontline jobs, meant many people were forced to carry on working throughout the pandemic, regardless of their health. Only when income support and sick leave were available, and cooperation given by relevant employers (such as warehousing or retail), were people more likely to self-isolate when they had symptoms. At the start of the vaccination programme, these precarious workers were also unable to go to vaccination centres. Vaccine uptake increased when clinic opening hours were extended to evenings and weekends ('after dark' clinics), and when people were able to be vaccinated in their workplaces.

- **Understanding that mistrust stems from historical inequities and social injustices in health, but also in other aspects of people's lives**

Populations living in multicultural areas, especially racialised and minoritized communities have experienced historical discrimination and inequality, and see their interaction with the state and health providers through that lens. Further, inadequate housing, transport and limited secure employment, and welfare exacerbate feelings of being left behind. Health services are often either unavailable, difficult to access or of poor quality and people may experience racism or discrimination when availing them. This creates an 'us vs. them' attitude that leads to mistrust in of vaccination. This may lead people to ask 'why now?', as people's previous experiences of the state may be primarily characterised by neglect or direct hostility (as in the case of surveillance and police violence), rather than by care. Addressing these inequities in housing, employment, public services and health are necessary to build trust.

- **Communicating in languages people are comfortable and proficient in, and offering cultural safety, is a driver of health equity**

When national and local authorities have systematically communicated in the languages people are most proficient and comfortable in, as well as through official languages, uptake and trust has been higher. Recruiting within communities for staff and volunteers that speak local languages in the vaccination programme, and recruiting trained translators has also increased uptake. In turn, it is not only a process of mechanical translation of communication outputs that is important, but engaging in ways that create cultural safety, respecting the different priorities and needs of other cultures.