Institute for Community Studies

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Case study: Boston, US

Research conducted by
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Executive summary

The Boston Metropolitan Area is the most populous city in New England with an estimated population of 4,628,910 in 2018. It is a racially and ethnically diverse area, with less than half (47%) of the city's population identifying as white. Boston is home to some of the most premier academic medical centers and institutions of higher education in the world (1); and for 24 consecutive years held the title held the title, "city with the most dollars from the National Institutes of Health" (2). However, not all Bostonians benefit from the medical and scientific advances the city is known for (3) There are pronounced racial inequities in Boston (3, 4) which led to communities of colour being disproportionately impacted during the COVID-19 pandemic.

This case study was delivered in partnership with We Are Better Together Warren Daniel Hairston Project (WAB2G) to examined community perceptions of vaccine distribution. WAB2G is a grassroots organisation that connects and heals women and girls affected by homicide and incarceration to prevent the cycles of violence and victimisation. This case study is drawn from conversations with Black women with experience of community violence and focuses on their experience of the COVID-19 pandemic and vaccine roll-out.

We explored their perceptions of the vaccine roll-out and the extent to which they were able to access the COVID-19 vaccine. Our findings indicate vaccines in Boston are accessible and there have been a number of successful efforts designed to reach the Black community. However, mixed messages about vaccines at the national level and on social media when combined with a legacy of medical mistreatment, and present-day structural racism provoke hesitancy among women.

Demographic profile

- Racial segregation is a key characteristic of Boston's neighborhoods that has been pronounced for nearly a century (5); the majority of Boston's Black populations is primarily concentrated in only four neighborhoods.
- The Black population in Massachusetts, and in Boston specifically, is diverse; one-third of the Black population in Massachusetts was not was born in the USA (6) and the Black population in Boston is comprised of African Americans as well as people of Haitian, Cape Verdean, and Jamaican descent.
- In 2019, Boston was rated 7th in income inequality among large U.S. cities (7). The racial wealth gap in Boston is especially pronounced. In 2015, White households had a median of $247,000 in wealth, Caribbean Blacks have a median of $12,000 and Dominicans and African Americans have zero (8)

History: marginalisation and resistance

Boston has a high degree of income inequality which is especially pronounced along racial segregation lines. Inequality has fostered a long legacy of activism in the city. In areas where municipal services have been absent or substandard, residents have organised to support community wellbeing. This is true in the case of housing and community development (9), transportation (10; 11) and environmental justice (12; 13), among other areas.

Public health and health care activism have also been ongoing in Boston and have helped to shape the health care and health efforts. For example, the Dorchester neighborhood in Boston was home to one of the first community health centers (CHC) in the country. CHCs emerged during the civil rights movement, resulting from a fight for racial justice and a recognition of the need to address the broader determinants of health, food and housing insecurity, transportation barriers and unemployment. CHCs are a critical tool for addressing fundamental factors related to health well-being: poor sanitation, hunger, unemployment, and poor-quality housing stock (14). Today there are more than two dozen CHCs in the City of Boston and, in many ways, their work has not changed. They continue to adapt practice methods to address the effects of institutionalised racism, using health as an entry point to services for those who have been systematically marginalised by racial oppression (15; 16; 17).

In the 1970's Boston saw more health care activism with the emergence of Black Panther party clinics. The Black Panther Party (BPP) aimed to protect the Black Community, defending against violence, and promoting equal treatment, including community health equity (18). In Boston this included, the Franklin Lynch Peoples' Free Medical Center which offered free healthcare, but also classes to those interested in learning basic skills (18).

Today, health inequity remains a significant issue and, as a way to address this, the Boston Public Health Commission (BPHC) have focused health equity through a racial justice lens. They have assembled an Anti-Racism Advisory Committee and have trained all staff receive racial justice and health equity (19). The City also declared racism a public health issue. Despite progress, local activists still contend that there is a need to address health equity in Boston and that this will require a broad focus on economic development that centers Black lives especially given the economic impact of the pandemic on Black Businesses and residents in Boston (20).

Civil society

Central to this case study is the grassroots organisation We Are Better Together Warren Daniel Hairston Project (WAB2G). This organisation serves a diverse population of Black and Latinx women and their families including services for incarcerated and formerly incarcerated individuals many of whom are experiencing, or have experienced, mental health and substance use disorder. Many communities that WAB2G serve are experiencing substance abuse disorder and/or violence and, as a result of this, live in intergenerational families that include grandparents, adult children, and grandchildren.

At the onset of the pandemic, WAB2G was funded by the city to provide relief services, which included safety information, food, and housing assistance. In the first two months they reached 225 women of color and their families. In addition, WAB2G with partners at the Boston Public Health Commission continued to serve women in recovery through educational and planning initiatives.

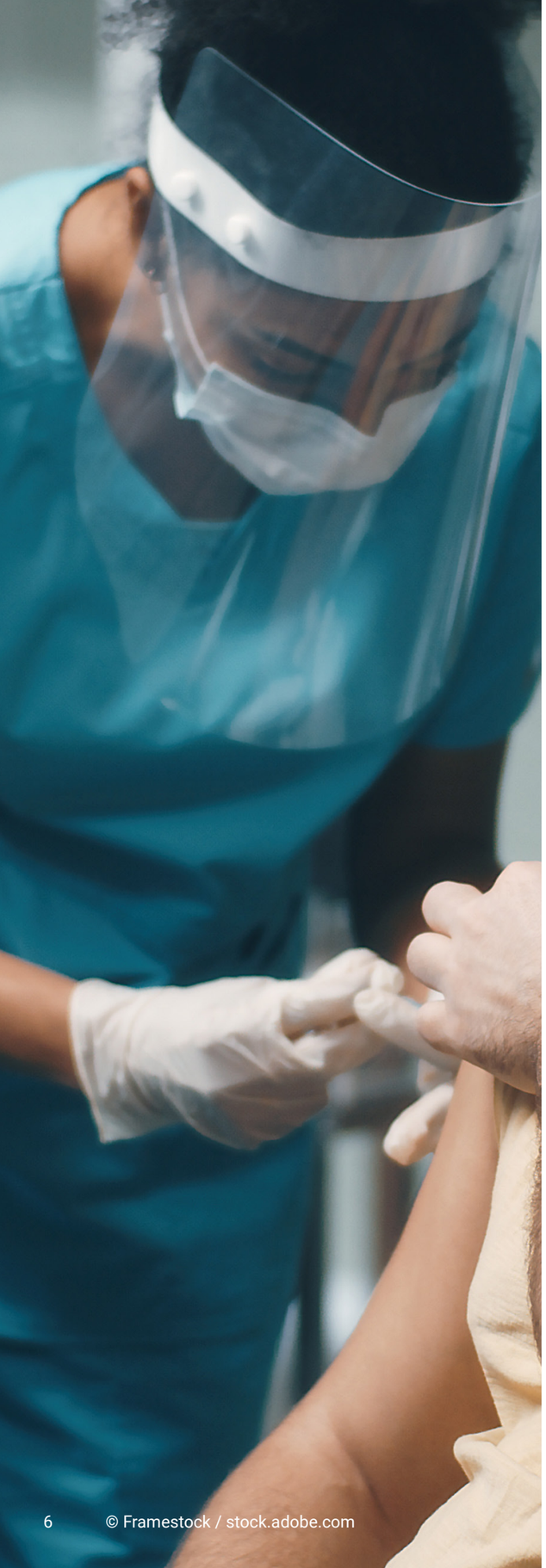
The relief that WAB2G provides to the people it serves includes; socially distanced in person outreach and advocacy, food distribution and rental assistance, supportive text-messaging, and telephone outreach, as well as Zoom support groups. Because they are embedded in the community WAB2G has access to women who may not be able to easily engage with institutions and organisations.

Health infrastructure

Boston is often referenced as a "medical Mecca" and is host to some of the most renowned hospitals, medical schools, physicians, and medical scientists (21). More than 20 major hospitals are located in the Greater Boston Metropolitan Area, including Mass General, Boston Children's Hospital, Brigham, and Women's Hospital. However, most community and specialty hospitals are inaccessible to Black residents (22). Segregation patterns are dominant and deeply embedded within Boston healthcare landscape. This disparity can be attributed to the concentration of high-quality hospitals and medical providers in white neighborhoods, low-cost health insurance plans not providing coverage at high-priced medical centers, and the distrust by Black populations to medical institutions predominantly staffed by white physicians (22).

Impact of COVID-19

Boston's racial segregated neighborhoods meant that communities of color were disproportionately affected by COVID-19 and suffered exacerbated consequences, including death and hospitalisation. According to the City of Boston, approximately 40% of those diagnosed with the virus in Boston were African American or Black, despite making up only 20% of the city's population (23).



In order to address racial inequities in healthcare access and treatment, several initiatives have been initiated by the City of Boston and Boston Medical Center (BMC). These initiatives included setting up a number of mass public vaccination sites were located in neighborhoods that were perceived to be more vulnerable to the virus due to a high concentration of communities of colour (24).

Community health centers also continue to play a vital role in creating access to vaccines and addressing vaccine hesitancy among the populations they serve. Community health workers are able to address factors that inhibit access to vaccines such as specific patient needs, cultural competency, trust in the vaccine administrator, and language services (24).

Vaccine outreach Efforts

By February 2021, there were clear levels of vaccine inequity among Black and Latinx populations. This led to community advocates, such as the "Vaccine Equity Now!" coalition, demanding that Governor Charlie Baker addresses vaccine inequity in communities of color. As of July 2021, disparities in vaccination rates have narrowed and this can be attributed to various State and neighborhood-level outreach efforts. Due to the demands made by the "Vaccine Equity Now!" coalition and the Vaccine Equity Program, the Commonwealth of Massachusetts has initiated a COVID-19 Community Grant Program, which is aimed at mobilising non-profit, community-based and faith-based organisations to implement community interventions. The aim of this initiative is to help promote COVID-19 vaccines, deliver messaging to prevent the spread of the virus, and organise programming around vaccine drives (25). Since December 2021, the Community Grant Program has distributed approximately $1.3 million to various organisations with the aim of enabling them to implement approaches that are tailored to the populations and communities they serve. Some organisations that have received funding from this program are Everett Haitian Community Center, Massachusetts Alliance of Portuguese Speakers, Somali Parents Advocacy Center for Education (SPACE), Black Ministerial Alliance of Greater Boston, Massachusetts Council of Churches, and Association of Islamic Charitable Projects (26).

Several Boston neighborhoods with low vaccination rates adopted outreach and accessibility initiatives. For instance, a local news channel has reported that one area, which had the lowest vaccination rates in the Greater Boston Metropolitan area, established a vaccine pop-up clinic at a Haitian community center in order to make the vaccine more accessible to Haitian immigrants in the neighborhood. Other initiatives in the area include; a locally-led campaign of door-to-door canvassing campaigns, collaboration with commuter rail train, Vax Express, which provided vaccination shots onboard, gift cards giveaways and 'VaxMillions', a Massachusetts-specific weekly lottery available for vaccinated residents (27).

Another approach to promoting vaccinations have drawn on a voter turnout model. The 'GotVax' initiative mobilises health care providers, students, electoral campaign staff, and community leaders to serve as volunteers to lead outreach and canvassing operations in neighborhoods where vaccine take up is low. This initiative used methods of engagement traditionally employed by political campaigns, such as wide-scale text messaging, phone banking, door-to-door canvassing, driving residents to sites and connecting with public housing managers (28; 29).

The Black Boston Covid Coalition

Spurred by racial inequity in the distribution and take up of vaccine, the Black Boston Covid Coalition (BBCC) is an active leader in all aspects of the city's COVID-19 response directed towards Black populations. BBCC-led vaccine outreach and education campaign, testing, and vaccination efforts have been very effective. Moreover, the BBCC structure has created a mechanism to rally organisations and individuals in communities of colour, successfully mobilising hundreds of volunteers and limited staff work on vaccine education and outreach. Both the city and State, as well as academic medical centers, rely on the trust BBCC has built across Boston neighborhoods (30).

Workshop findings

The Vaccine Hesitancy Focus groups included a total of 29 participants across three different focus group sessions hosted by the We are Better Together Project on Zoom. Participants were asked to share their racial identity and answer questions pertaining to impact of COVID-19 on their lives, their opinions on vaccine hesitancy, how to create better access to vaccines, and their overall impression of the vaccine rollout in Boston.

Impact of COVID-19

Workshop participants described they ways in which COVID-19 was impacting their lives, specially how the pandemic impacted on their mental and physical health. Many women talked about the isolation that accompany lockdown and social distancing leading to feelings of depression and anxiety.

For this group of women, the impact of the pandemic on their mental and physical health was profound. Participants reported the loss of family members and friends, as well as witnessing the passing of the general population and other people of color, as deeply traumatising. They also cited depression, anxiety, geographical distance from social connections, and lack of social support network as the major reasons for feelings of isolation. Some participants sought mental health and counseling services in order to cope with isolation.

The workshops presented a mixed picture of how the negative mental toll of the pandemic affected vaccine hesitancy. A number of women said that the negative impact of COVID-19 on their mental health encouraged them to get vaccinated as it helped alleviate concerns of getting sick and potentially dying. While other participants cited that the complexity and the 'invisible' nature of COVID-19 as a disease made them skeptical to take the vaccine.

Beyond the mental health impacts of COVID-19, workshop participants discussed the physical toll that the pandemic took on their body and the exacerbation of long-term ailments. Participants cited effects on health included; weight gain putting pressure on the respiratory system, worsening asthma, complications with pre-existing health conditions in combination with COVID-19, high blood pressure, 'long' COVID-19 symptoms. One participant mentioned having difficulty navigating the health care system due to the pressure put on the system by COVID-19 cases.

Finally, participants cited struggles with social determinants of health as financial loss due to unemployment, lack of in-person access to therapists, food insecurity, inability to access adequate healthcare services, loss of social support system, restriction on travel, having to relocate due to financial and employment seeking circumstances, lack of access to childcare and specialty care, family separation, and housing insecurity. Participants cited worry for the health and wellbeing of incarcerated family or friends. Workshop participants also highlighted that some of these social determinants of health, such as inequality in the hosing market, were prominent in pre-pandemic Boston as the result of gentrification taking hold across the city (31). High pandemic unemployment rates, as well as the impact of long-haul COVID-19 have left many at risk of eviction. Eviction filings, although currently suspended by the moratorium, in neighborhoods in which the majority of residents are people of color are four times those of White (32). The focus on social inequality and social determinants of health indicate that vaccine hesitant people may have other needs, beyond engagement with the vaccine.

Vaccine hesitancy

We found that many focus group participants reported not being vaccinated. There were a number of reasons presented that accounted for vaccine hesitancy including:

- The wish to weigh the risks and benefits of getting a vaccine. Some participants wanted to 'wait and see' if the vaccine is 'really' going to be effective. Multiple participants reported working in the health care industry and hearing about the negative impact of the vaccine.
- Belief that are currently in good health so the benefit of getting the vaccine may not be worth risking their health and suffering side effects or other health implications of the vaccine.
- Concern at the speed at which the vaccine was developed, especially in comparison to treatments for other life-threatening conditions like HIV and cancer.
- Fear of side effects such as impact of fertility and reproductive systems.
- Lack of trust in Government broadly and the health care systems specifically. There was a sense that the systems did not always have their best interests in mind and was instead motivated by profit.
- Competing concerns, such as having enough money. Some participants viewed getting a vaccine as 'the last thing on their list' of other worries.

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Vaccine roll-out

The workshop participants reflected on the successes and failures of the vaccine roll-out in their community. They indicated that accessibility is 'not an issue' in their community and across all three groups participants discussed the availability of the vaccine. They noted it was available in the community and that transportation to visits was free. They also described efforts in which vaccine was available at housing sites, grocery stores and churches among other places.

"I got my vaccine at the church. It made it easier for me, but it was still a hard thing for me to do."

Participants described a number of factors that convinced them to get the vaccine. The most common was reason for getting vaccinated among participants was having a condition that left them at increased risk. These participants described that it was conversations with their physicians that prompted them to get vaccinated.

In addition, participants described choosing to get vaccinated after conversations with neighbors, family, friends, and other people. The participants reported a high level of trust in the opinions of their peers and also referenced being influenced by public figures.

"My neighbors got the vaccine, and they didn't get the side effects, so I decided to get the vaccine. I've seen Biden, Kamala, and others get the vaccine, so it reassured me. I also spoke to someone from BMC who got the Pfizer and he said it was safe so...I got it and I am fine."

As part of the workshop, participants discussed recommendations and potential areas of improvement for vaccine roll-outs.

- **Focus on youth**
  Workshop participants highlighted the need to educate young people about the benefits of being vaccinated. A few participants said that they could not influence their child to get a vaccine and believed that better education about the vaccines was necessary. One woman referenced potential tools that could be employed to encourage vaccine uptake amongst young people such as social media, video games and celebrities spreading positive messages about vaccines.

  "Maybe if they put it on Tiktok or video games? Maybe a rap star like Lil Wayne saying 'get the vaccine'…My daughter is 21, and my sons are 13 and 18. They don't want the vaccines because they don't want to be influenced by the government."

- **Ensure that people have their immediate needs met before encouraging vaccine uptake**
  One of the reasons highlighted for vaccine hesitancy was people having concerns that take priority over getting vaccinated such as low income and food insecurity. Workshop participants suggested that there was a need to support people with meeting their immediate needs such as housing, clothing, and food before attempting to engage them with vaccines.

  "A lot of people are getting services but so many people are struggling financially, homeless populations, people with no addresses as the result of COVID …offer people resources …provide education and offer resources…people are not getting what they need so the last thing on their list is a COVID shot. we need to reach people with other issues…COVID is on the bottom it is not on the top. People just assume …we need to be open and compassionate to"

- **Ensure that messaging is relatable, honest, and non-judgmental**
  Workshop participants highlighted that messages about COVID-19 vaccines, and crucially, those who disseminate the message need to be reliable. One participant said that outreach should be led by people who 'look like' the community they are engaging with. Participants also said that they thought that getting a vaccine was a personal decision and they did not want to engage in a debate but rather ensure that they have all the information that they need.

  "Professionals who are people of color. I had a doctor who was a Black woman of color, and she answered all of my questions, and she was honest if she didn't know the answer to the question and followed up with an email to answer it. I was prepared to spread the information to my community."

Discussion: the 3 C's

A 2014 report by the World Health Organisation (WHO) on vaccine hesitancy proposed the now influential '3 Cs model': confidence, convenience, and complacency as key in determining vaccine hesitancy. This model provides a useful conceptual scaffolding for discussion of the workshop responses.

Convenience

Workshop participants did not describe convenience as a factor associated with hesitancy. On the contrary, the vaccine was described as being readily available. They reported vaccines being administered at community health centers, public housing sites, pharmacies, churches, neighborhood events and shopping stores in addition to being available at vaccine sites. Participants reported transportation to vaccine sites was not a barrier. Local ride sharing services such as Uber and Lyft provide free transportation to and from vaccine sites. The need to miss work to get a vaccine has been described as a convenience barrier (33) but this was not raised as a concern by women in the group. There may be a stronger association in different employment sectors, but further exploration of work absence as a barrier is needed.

Complacency

Complacency emerged as a theme that contributed to hesitancy. The women who took part in this research, were weighing the risks and benefits of the vaccine and, for many, the benefits were not clear. Women who were most likely to be vaccinated were those who have a chronic condition as they perceived their risk to be outweigh any vaccine related risk. They also described trustful relationships with their providers which may have further contributed to their perceptions of vaccine efficacy.

Complacency can be described as perceiving a low risk combined with low motivation (34). Women in our groups described youth 16-25 as complacent based on this definition. They reported that young people did not believe they were at risk for contracting COVID-19 or for having COVID-19 related complications.

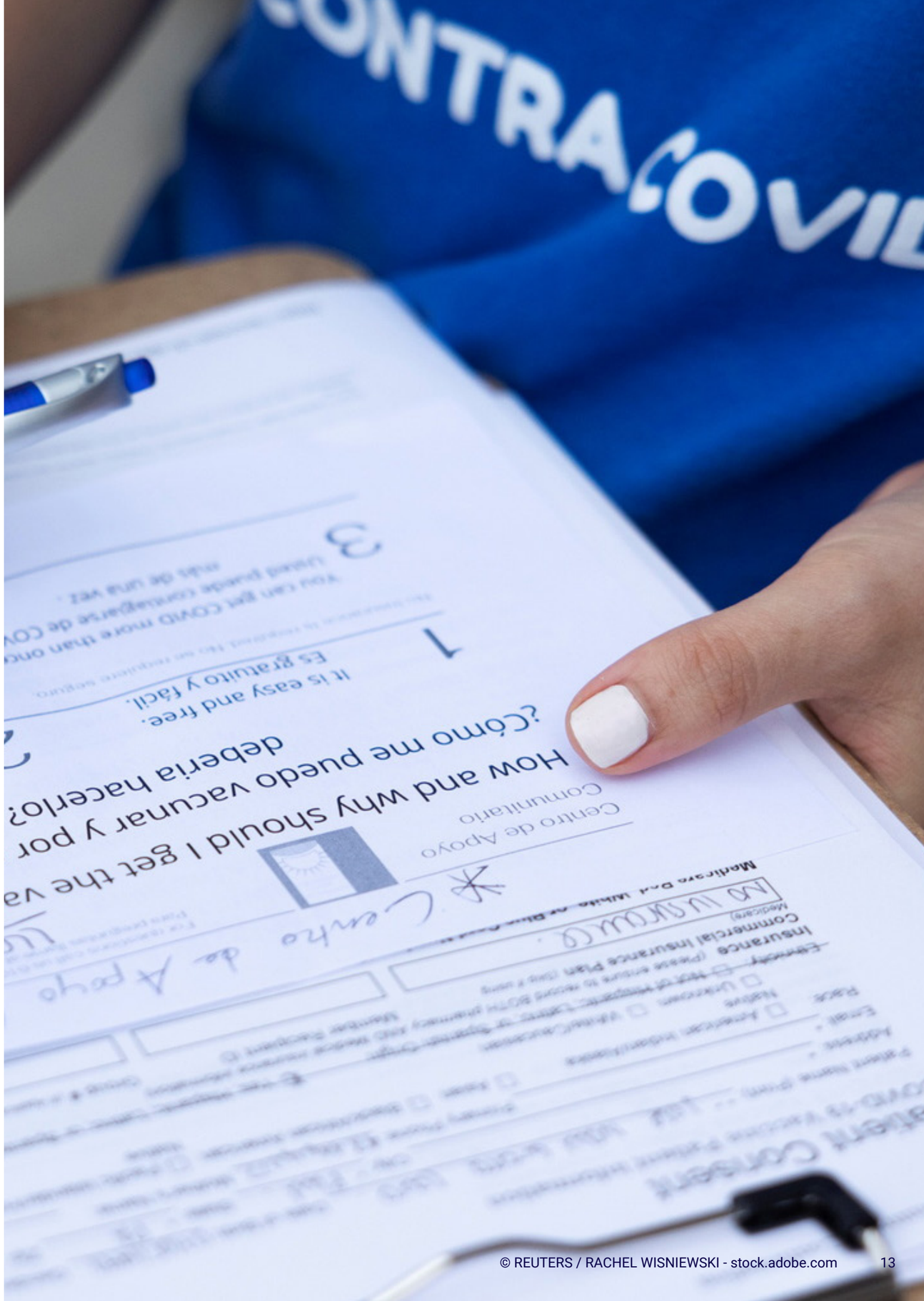
Confidence

Confidence has been described as having trust in the safety of the vaccine as well as in government, science, and health care (35). Women in our groups who were hesitant, explicitly, described having little to no trust in health care. They further described capitalist motivations behind pharmaceutical companies and questioned the safety and efficacy of the vaccine. Women also noted the ways in which Black people have been exploited by the public health system, as well as health care and government systems. They were also keen to note that hesitancy was not unique to Black people and that trust in government and vaccines was present across populations.

Conclusion

The women involved in this case study are a group at the intersections of poverty, gender, and racial inequality. They form part of a population with a high potential for vaccine hesitancy. Boston is an area that has been successful in ensuring that vaccines are convenient. A number of community-backed engagement schemes have seen to be successful. Women in marginalised communities did not experience significant obstacles or practical barriers in getting a vaccine. Instead, the study finds that a lack of trust in Government and health services are key concerns that influence a lack of engagement with vaccines.

The case study provides a platform for the women involved in this research to put their recommendations about working with hesitant individuals in their communities. Their advice calls for clear and concise information to inform their decisions about vaccine engagement as well as honesty from Government and healthcare provider. Women noted the importance of not judging hesitant people instead the importance of supporting people with their needs, establishing relationships and providing information so that people can make their own decisions about the vaccine.



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