

## Equity in COVID-19 Vaccines: Emerging Lessons from the Front Lines



As of March 2021, the United States is administering more than 3 million COVID-19 vaccines a day.<sup>1</sup> From the day vaccines were on the horizon, Congress,<sup>2</sup> governors,<sup>3</sup> and the Biden administration<sup>4</sup> committed to equitably distributing them, pointing to disproportionately high rates of COVID-19-related illness and death among Black, Indigenous, and people of color (BIPOC). These disparate outcomes from COVID-19 are linked to longstanding inequities in health care and systemic racism within society.<sup>5</sup>

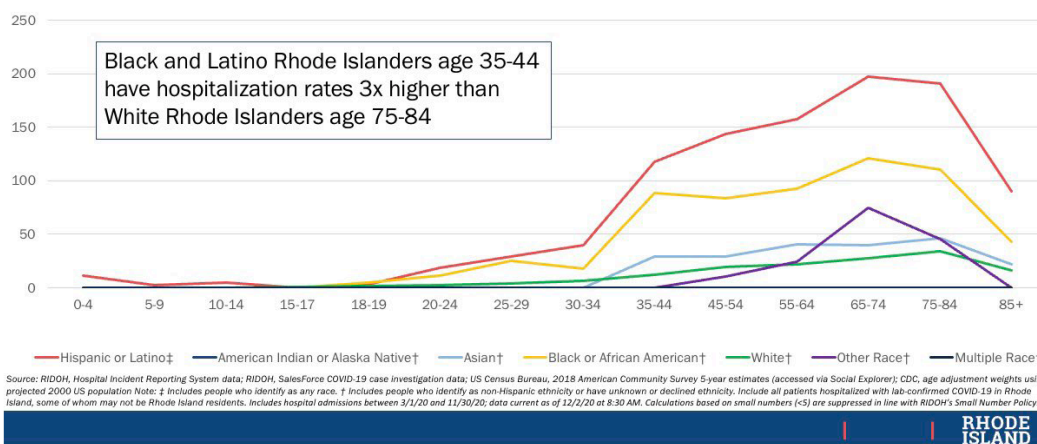
Accomplishing equitable distribution, however, generally has not been achieved.<sup>6</sup> In ramping up vaccine distribution quickly, state leaders report trying to balance low supply and high demand while also navigating competing demands for prioritization. One concerning choice was the conscious decision by some state leaders to move toward strategies based on age (as Connecticut and Maine did)<sup>7</sup> and away from equity-based strategies that focus on essential workers,<sup>8</sup> who are disproportionately more likely to be BIPOC.<sup>9</sup> And even as supplies have increased, the pattern across virtually every states is consistent: Black and Hispanic people continue to get fewer vaccine shares relative to the COVID-19 death and illness they experience.<sup>10</sup>

It is essential for policy makers and the public to understand that BIPOC are bearing the brunt of this pandemic, both in terms of their health and their financial wellbeing. Since the pandemic began, BIPOC have been disproportionately more likely to become infected, to be hospitalized, and to die compared to their percentage of the population.<sup>11</sup> For example, data from Rhode Island indicate that **Black and Latino individuals ages 35-44 are three times more likely to be hospitalized from than older White individuals ages 74-85** (see page 2).

And now, they are not being given access to vaccinations in ways that are proportionate to either their share of the population or their risk of illness and death. Moreover, the

## Age-adjusted rates of COVID-19 hospitalizations by age group & race/ethnicity

Hospitalization risk increases with age, but impacts people of color at higher rates and at younger ages.



**Rhode Island Department of Health**

Source: Rhode Island Department of Health (RIDH), Age-adjusted rates of COVID-19 hospitalizations by age group & race/ethnicity. Sources: RIDOH, Hospital Incident Reporting System data; RIDOH, Salesforce COVID-19 case investigation data; US Census Bureau, 2018 American Community Survey 5-year estimates; CDC age adjustment weights

pandemic is not just a health, but also an economic crisis for BIPOC. Because these communities are more likely to have front-line jobs (placing them at much higher risk of increased exposure), they are less likely to be able to work from home. As a result, their jobs often force them to choose between prioritizing their economic livelihood and their health.<sup>12</sup> Thus, a vaccination strategy that is fundamentally aimed at reducing death and illness from COVID-19 must intentionally focus on effective vaccination of BIPOC populations.

We are at a critical moment for ensuring health care equity and correcting the fundamental disparities that the pandemic has laid bare. Intentional investments in equitable distribution of the vaccines — and equitable public health strategies designed to end the pandemic — have the potential to establish a course-correction on which we can build long-lasting structural change. Focusing on the experiences and needs of BIPOC must

be at the center of today's response and future efforts to build resilience, prepare for the next public health crisis, and create a more equitable health system overall. To this end, Families USA has developed a roadmap of promising approaches for equitable distribution of vaccines in the short term, based on input from state and local partners. The roadmap synthesizes early lessons and provides key insights and concrete approaches that state partners and leaders can use moving forward.

This roadmap is the first in a series of publications and other work that Families USA will undertake with partner organizations to ensure the equitable distribution of COVID-19 vaccines. Further research, including roundtables, focus groups, and support of a consumer advocate learning network, is underway. Please connect with us at [Familiesusa.org](https://familiesusa.org) for updates on this work.



## Roadmap for the Equitable Distribution of COVID-19 Vaccines

*Overarching Principle: A vaccination strategy that aims to reduce death and illness from COVID-19 must intentionally focus on effective vaccination of communities of color.*

### 1 USE A DATA-DRIVEN APPROACH

To develop policies for allocating vaccines in an equitable manner, gather data to determine who is most likely to contract COVID-19 and to experience negative consequences such as death and hospitalization. National, state, and local dashboards<sup>13, 14</sup> that track cases, hospitalizations, and vaccine allocation disaggregated by race, ethnicity, and other demographics are an important foundation for this type of data. However, there has been inconsistent and incomplete data and reporting on race and ethnicity at the local, state and national levels on testing, cases, hospitalizations, deaths and now vaccines.<sup>15</sup> To get more granular, states and localities are employing other assessment tools to inform equitable approaches and ascertaining which communities might need additional resources and support to maximize vaccine uptake. Governmental officials and public health experts should consider the following examples as part of an equitable vaccine distribution strategy:

» [COVID 19 Community Vulnerability Index \(CCVI\)](#)<sup>16</sup>

» [CDC's Social Vulnerability Index \(SVI\)](#)<sup>17</sup>

» [Area Deprivation Index \(ADI\)](#)<sup>18</sup>

» [Map: County-Level Access for Black and White Individuals to Potential COVID-19 Vaccine Administration Facilities](#),<sup>†, 19</sup>

Importantly, while these indices are a helpful barometer for a data-driven approach, they are incomplete and require local input to increase success. For example, the Social Vulnerability Index (SVI), like the U.S. Census, leaves out Middle Eastern and North African populations,<sup>20</sup> and even when data does take into account race and ethnicity, there is still heterogeneity within communities that is important to understand.<sup>21</sup> In order to effectively tailor responses to specific communities, state leaders need to supplement assessment tools with qualitative data via direct input from key community stakeholders.

### Spotlight on Protect Chicago Plus

*[Protect Chicago Plus](#), an initiative of Mayor Lightfoot, used SVI data to prioritize 15 high-need communities “to ensure that a significant part of the City’s vaccine supply goes to these communities.”*

<sup>†</sup> Geomapping such as this example from the University of Pittsburgh School of Pharmacy and West Health can help state leaders understand where vaccination sites should be located and how far individuals have to travel to access services.

## 2 CONNECT WITH THE COMMUNITY AND PROVIDE RESOURCES

When things are moving quickly — as they are in the world of COVID-19 vaccine distribution — understanding the local context is key. In particular, some community leaders are organizing to distribute the vaccines and engage their neighbors to increase uptake while simultaneously providing contours to a successful public health approach in their own community. Locally-organized efforts led by trusted pillars of the community can be essential to success. State and local public health partners should identify, learn from them, address barriers and provide them resources to execute vaccination initiatives.

When figuring out how to scale vaccine efforts state leaders can identify and encourage effective approaches by hosting community listening sessions and by emulating successful case studies from within their own state and around the country. One example from Philadelphia highlights the local partnerships between medical centers and African American churches that helped vaccinate 5,000 Black residents in one day.<sup>22</sup> Another example from Fort Worth, Texas, provides a “tale of three communities,” (see sidebar) highlighting the importance of having a local champion with authority and community reach, authentic engagement and connecting in trusted spaces.<sup>23</sup>

A few key elements that lead to success include:

- » **Ensuring that community leaders participate routinely in advising city and state officials about allocation strategies and events.** One way this can be accomplished is by working with community leaders to host listening sessions that are open to the entire community. These sessions should also include local leaders, trusted

### Spotlight on Community-Based Vaccinations: A Tale of Three Communities In Fort Worth, TX

#### Community A: Hispanic Population

- » Community groups worked with an engaged and enthusiastic councilmember who helped to drive the vaccine event including using social media channels.
- » Community members were able to get their vaccines and talk with the councilmember about other issues in their community.
- » Event was held at the local community center.
- » 335 people were vaccinated.

#### Community B: Hispanic and Black Population

- » Community groups were not engaged in the vaccine clinic.
- » No local officials attended, and turnout was low.
- » Event was held at a local fire station.
- » 39 people were vaccinated.

#### Community C: Black Population

- » Event led by a local church congregation.
- » Church leaders attended and promoted the event heavily.
- » Event was held at the church.
- » 757 people were vaccinated.

health care professionals, and other influential stakeholders (for example, business leaders or faith leaders) who are members of the community and who can advocate on its behalf. Local leaders representative of BIPOC communities should be engaged in advisory groups and task forces.

» **Asking community members what they need from the public health response and being prepared to meet those needs.**

People implementing vaccine efforts must be open to engaging authentically with communities and addressing the range of issues they identify. For example, these needs could include access to transportation, language services, personal protective equipment (PPE) and timing of vaccine allocations. This ground work will help to maximize uptake and confidence, and it can contribute to a comprehensive approach that addresses longstanding inequities.

» **Leveraging partnerships with community-based organizations to achieve common goals that address community needs.**

For example, the Faith in Vaccines initiative in Washington, D.C., includes a federally qualified health center where vaccines are stored, area churches, and an organization that administers shots and provides mobile units.<sup>24</sup> Another example of nontraditional public health partnerships involves Emergency Management Services (EMS) helping staff vaccine events or vaccinating people who are homebound.<sup>25</sup>

» **Ensuring that people who get vaccinated are from the communities of highest need, and**

**managing expectations of non-community**

**members who seek vaccination.** To protect lives in an environment of vaccine scarcity, vaccination strategies must prioritize communities with the highest need and others who are vulnerable. Some successful strategies involve organizing community members and sharing specific registration codes with them, or establishing sign-up lists. Success with these approaches has varied, and other approaches are needed even as vaccine supply increases. Setting up phone banks has been helpful in addressing the limitations of online registration systems, and it is central to an approach that takes into account limited internet access. Phone banks may also be useful in focusing resources on specific communities.

Vaccines are also flowing directly from the federal government to local communities, some of which specifically focus on distribution to at-risk communities. For example, the Health Center COVID-19 Vaccine Program<sup>26</sup> is prioritizing health centers serving people hardest hit by the pandemic including people experiencing homelessness, residents of public housing, migrants, seasonal agricultural workers, or patients with limited English proficiency, among others. Other examples of federal to local efforts include those from the Department of Veterans Affairs (VA)<sup>27</sup> and the Indian Health Service (IHS).<sup>28</sup> State partners note that these federal to local efforts have been some of the most successful collaborations to date in terms of getting shots into arms in an equitable manner. Additionally, in rural areas, partners have found that independent pharmacies are central to distribution.

### 3 BRING VACCINES TO SAFE AND FAMILIAR SPACES

By using place-based solutions, leaders can bring vaccines to communities that need them most both during short supply and as supply increases. These efforts have included hosting a vaccine clinic in a local school gymnasium ([Virginia State University](#)),<sup>29</sup> bringing mobile units into communities ([Farmworkers in California](#)),<sup>30</sup> coordinating with local tribes ([Alaska](#)),<sup>31</sup> and providing needed transportation while ensuring that people who need it can be vaccinated in their homes ([Baltimore County](#)).<sup>32</sup> Local and state leaders need to be flexible and creative with vaccine dissemination.

In addition to vaccinating people at easily accessible, familiar locations, states should ensure that vaccines are free to everyone regardless of immigration status,<sup>f</sup> that vaccination sites are accessible on weekends and outside traditional business hours, and that documentation is not required to be vaccinated. Leaders should also pay close attention to barriers faced by specific populations, such as people with disabilities, people with limited English proficiency, and immigrants. As noted by the National Immigration Law Center, “[...]documentation requirements, data sharing fears, discrimination, technology, worries about their status, and misinformation all are making it harder for immigrants to get vaccines.”<sup>33</sup> Officials should eliminate these barriers whenever possible.

### 4 WORK WITH THE COMMUNITY TO SIGN PEOPLE UP AND PROVIDE A SMOOTH VACCINATION EXPERIENCE

As was widely reported in the news, online options for scheduling vaccination appointments have not worked well for many and are exacerbating disparate access to vaccines.<sup>34, 35, 36</sup> To ensure that individuals from prioritized communities are able to make appointments, state and local leaders should consider other strategies for signing people up, such as using texts, toll-free phone numbers, and door knocking, as well as enlisting the help of local business leaders and other community health champions (including community health workers and promotoras). It is also important to make available translation and interpretation services, and written resources in multiple languages (where indicated), to help people throughout the process — from navigating the appointment system to getting the vaccine.<sup>37, 38, 39</sup> Walk-in sites are essential in some communities.

While community-based vaccination sites are essential, transportation to otherwise inaccessible locations is needed. Some initiatives are starting to fill this gap. For example, ride hailing providers are collaborating with community partners and payers. One example is from CVS, Lyft and the YMCA who have partnered to provide free or discounted rides to vaccination appointments. Additionally, they are launching their own mobile vaccination vans and community-based vaccination sites starting in March and April 2021.<sup>40</sup>

*By using place-based solutions, leaders can bring vaccines to communities that need them most both during short supply and as supply increases.*

<sup>f</sup> The Centers for Disease Control and Prevention [has made it clear](#) that vaccines are free for individuals regardless of their immigration or insurance status.

## 5 REMAIN FOCUSED ON EQUITY: HAVE THE POLITICAL WILL TO SAY “NO”

Informed decision-making, coupled with resolute leadership and clear communication, are needed when vaccine supplies are limited. Political leaders should be transparent about their goals and the importance of equity-based distribution. A recent episode of the podcast [Tradeoffs](#),<sup>41</sup> echoed repeat observations from state partners: Local and state leaders need to review the data, prioritize equity and stand by those decisions. “I say no 100 times a day right now to a lot of providers, communities, individuals, about all things related to vaccine. I have to say no so that we can say yes to these [equity] initiatives,” says Chicago Commissioner of Public Health Allison Arwady.<sup>42</sup>

The bully pulpit and political will can set the tone and shift the dynamic to prioritizing equity. Officials may face challenges in this regard, such as the concern that equitable strategies will slow down vaccination progress, or that confidence is a major barrier for BIPOC (discussed in more detail on page 7). Policymakers who are committed to saving lives, addressing disparities in COVID-19-related outcomes, and addressing longstanding inequities in the health care system should be empowered to say no to efforts to pressure them to shift away from equitable responses. The data clearly support this approach. Doing so is a public health necessity and tackling real or perceived complexity in an equity-based approach is a vital step in addressing longstanding inequities.

## 6 CONTINUE FOCUSING ON EQUITY AS VACCINE SUPPLY INCREASES

The increasing vaccine supply and the loosening of criteria for vaccine eligibility do not mean that the focus on equitable distribution should end. Infectious disease expert and former Biden COVID-19 advisor, Mike Osterholm recently cautioned: “I am very concerned about the number of states that are opening up completely all of their vaccine eligibility...I am really concerned about the fact that many of these states...actually have vaccine available that should be going to high-risk people in those states that are not getting vaccinated...[State leaders are] saying ‘let’s just open it up to everybody knowing that we are missing high risk people.’<sup>43</sup>” In fact, state and local leaders will need to continue to ensure that vaccines are getting to communities that need them, quickly, so that infections rates stay low or decrease from the recent surge we are seeing in some states.<sup>44</sup>

### Reflections on Vaccine Confidence

While BIPOC have some concerns and questions about vaccines due, in part, to the role of institutional racism, almost universally, state partners report that the demand from BIPOC communities for vaccines far outweighs hesitancy to get vaccinated. State partners point out that claims of refusal due to historical atrocities<sup>45</sup> are exaggerated in some cases and are being used as an excuse to provide fewer vaccines to these communities when supply is low. In fact, data suggest that the groups most likely to refuse the vaccine identify as Republican, live in rural areas, and

*State partners report that the demand from BIPOC communities for vaccines far outweighs hesitancy to get vaccinated.*

are non-health care essential workers.<sup>46</sup> According to the Kaiser Family Foundation polling, there are varying levels of refusal and rapid progress may be made in the hesitant or “wait and see” group.<sup>47</sup>

Misinformation is another critical piece to vaccine confidence. A study focused on vaccine acceptance in the U.S. and the U.K. found that exposure to misinformation reduced an individual’s intent to receive a COVID-19 vaccine.<sup>48</sup> Anecdotes of misinformation vary—including a fear from older White people that the vaccine would put a chip in their arm, to Black college students believing that a healthy lifestyle will protect them from contracting COVID-19. All of this suggests that public health messaging must be tailored to individuals and communities need.

Strategies to address vaccine confidence must center on the community that is being engaged, must reflect community concerns with cultural humility, and answering questions with an evidence-informed approach. Public health communicators should also speak to people as informed consumers and avoid pre-conceived notions about requests for additional information. Actively engaging local leaders and partners (as in the examples above), using data to understand supply and demand, and identifying any health literacy or other barriers are other useful approaches.

## Spotlight on Tailored Communication

### The Conversation: Between Us, About Us

*A [campaign video series](#) to answer questions about the COVID-19 vaccines that “dispels misinformation and provides accessible facts to help Black people with this important decision.”<sup>49</sup>*

## Broader Public Health Tools for Ensuring a More Equitable Response to COVID-19

With the spotlight on COVID-19 vaccines, it’s important that state leaders not lose sight of the public health tools that will bolster successful vaccination campaigns and protect against harmful variants.

1. **Testing:** Testing should be free and accessible, especially in the hardest hit communities, such as those identified by the CDC’s Social Vulnerability Index and through listening sessions.<sup>50</sup> Diagnostic, antibody, and surveillance testing will all be essential as we move into new stages of the pandemic. Similarly, contact tracing and quarantining will remain major elements of public health response strategies. Some locations are forgoing testing to make way for vaccination sites.<sup>51</sup> States need to ensure that they make resources available to do both.
2. **Public Health Infrastructure:** In just a few short weeks, vaccine supply has increased and vaccination campaigns ramped up.<sup>52</sup> States and communities need to build the infrastructure and partnerships, particularly at the community level, now to handle the coming supply of vaccines. States will also need this community-driven infrastructure to achieve the ultimate goal of herd immunity. According to Anthony Fauci, we will reach herd immunity when 75%-85% of the population has immunity either from a vaccine or natural infection.<sup>53</sup>
3. **Support services for low-income individuals:** Low-income people, especially those in communities hardest hit by the pandemic, will continue to need support services such as financial assistance to quarantine if necessary, in-home services and supports such as food delivery, and continued access to free testing and treatment of COVID-19.

## 4 Tools to Ensure a More Equitable Vaccination Response to COVID-19



### Testing

Make free and accessible to hard hit communities



### Infrastructure

Build for sustainable public health response



### Support Services

Provide support services for low-income individual



### Genomic Surveillance

Monitor all communities for new variants

4. **Equitable genomic surveillance:** The CDC reports that some of the COVID-19 “variants of concern” are in fact more transmissible and more deadly than the original strains that the U.S. has fought over the past year.<sup>54</sup> Leading vaccine manufacturers are developing booster shots to augment immune response in the face of variants, but the impact of the new strains is unclear. Moving forward, an equitable national genomic surveillance plan with a representative sample of Americans is a critical component of the coronavirus response. Equitable genomic surveillance is essential to tracking variants across communities. And it is only with a robust effort to track genetic mutations that we will be able to understand how and where mutations are happening in the U.S. and around the world.<sup>55</sup> A March 2021 Rockefeller report<sup>56</sup> highlights the need for this work so that the country can stay on top of any mutations and attempt to ward off the devastating health and economic impacts that the country has experienced over the past year.

## Conclusion

The issue of equitable vaccine distribution may seem like a short-term problem that will quickly be fixed as the vaccine supply increases. This is a shortsighted assumption that doesn’t take into account the longstanding racial and economic inequities in this country. It also ignores the likelihood of more public health crises on the horizon and the critical need to build resilience in these communities.

A mass vaccination campaign built on a health system rife with inequities will likely lead to more inequities. Underserved and forgotten communities will continue to be underserved and forgotten unless political leaders address the underlying causes of this disenfranchisement. And BIPOC who face health and economic barriers will continue to be at greater risk for infection, illness, and death.

Supplies of the vaccine are growing, meaning states need to redouble their commitments to equity and develop distribution plans that respond to community needs. Through developing responsive distribution plans, states can draw on these creative and successful strategies centered on equity to build a more just health care system for the future.

## Endnotes

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