COVID-19 Vaccine Equity Strategy

The rollout of COVID-19 vaccines will require unprecedented collaboration between governmental agencies across NYC to make sure vaccine access, uptake and outcomes are anti-racist, equitable, ethical, and directly address racism and other systems of oppression by dismantling these systems wherever possible. These systems have stopped Black, Indigenous, Latino/a, Asian and other people of color; people who are LGBTQIA+; people with disabilities; people who are undocumented; veterans; people with a history of criminal justice involvement; people who have faced religious persecution, oppression and intolerance; and older adults from accessing the resources they need to maintain their health and well-being. The COVID-19 vaccination program must confront historical and current abuses rooted in racism and other intersecting systems of oppression within the fields of research, medicine and government, including experimentation, exclusion and disinvestment. Ethical and equitable[1] COVID-19 vaccination strategies[2] must be grounded in dismantling deep-rooted institutional and structural oppression, and include multiple areas of the emergency response. Equity is not the job of just one person, office or role.

Equity Principles

The following equity principles were identified by the Taskforce on Racial Inclusion & Equity Vaccine Equity subcommittee and reflect the City's commitment to making sure equity is at the center of the COVID-19 vaccination program. These principles are woven throughout this strategy and will serve as a guide for accomplishing the strategies described below.

1. **Compassion and trust:** Reach for justice by prioritizing communities hardest hit by the COVID-19 public health emergency, as well as people who face current and historic health inequities and systemic oppression. Acknowledge the need for healing, and amplify the voices and experiences of people who have been oppressed.
2. **Inclusiveness:** Approach vaccine engagement from a place-based, community-centered and intersectional perspective by recognizing New Yorkers belong to multiple communities, including those defined by neighborhood as well as identity.
3. **Transparency:** Build trust with communities through honest, open and clear communication delivered by messengers who are trusted by their communities.
4. **Autonomy:** Make sure all New Yorkers, regardless of their housing status or criminal justice involvement, access needs, age, use of social services or the languages they speak, can get the information they need to make an informed decision about the COVID-19 vaccine.
5. **Accountability:** Take advantage of the historic opportunity to build new, equitable policies, systems and power structures. Use data and community feedback to measure the impact of the COVID-19 vaccination program.

[1]Ethics and equity require anti-racism, accountability, transparency, shared decision-making, community engagement, health justice, supervision of scarce resources, trust, and systematic and data-driven and -informed approaches.

[2]Special thanks to the NYC Test & Trace Corps Community Advisory Board, NYC Department of Health and Mental Hygiene Staff, Taskforce on Racial Inclusion & Equity Vaccine Equity subcommittee and others for providing input and feedback during the development of this strategy.

Access

Implement the following strategies to help reduce inequities in deaths and negative health conditions caused by COVID-19, and give back to groups that accept a higher risk of getting COVID-19 in the service of others. While access by itself is not enough to achieve equity, it is a necessary step toward equitably vaccinating all New Yorkers who want to get vaccinated.

1. Use federal, state and other advisory guidance, public input with an emphasis on prioritizing contributions from the most marginalized communities, and quantitative and qualitative data about inequities to guide distribution decision-making to help reduce exposure and transmission, deaths and negative health conditions caused by COVID-19, and negative societal impacts (including social and economic impacts). As needed, recommend including specific groups for consideration in prioritization categories.
2. Prioritize populations with the highest risk of death and negative health conditions due to COVID-19, with a focus on neighborhoods identified as having experienced greater burdens during the COVID-19 public health emergency as a result of systemic racism. System racism has led to chronic diseases, crowded living conditions, social inequities, higher levels of employment in service and essential occupations, exclusion from formal support and benefit systems, and higher COVID-19 rates in these neighborhoods.
3. Make vaccine allocation plan and other key decisions publicly available and accompanied by ethical and equitable justification appropriate to convey key decision points and decision tools.
4. Throughout planning for vaccine access and uptake, endorse the social model of disability,[3] which focuses on eliminating the external barriers that prevent people with disabilities from engaging fully with their environment. Acknowledge that, throughout this public health emergency and during times of resource scarcity throughout history, people with disabilities have been deprioritized on the basis of their disability.[4] Ensure that people with disabilities are not deprioritized because of disability.
5. Establish ongoing partnerships and collaborations with the community to collect feedback. Incorporate multiple voices and identities, particularly with groups and individuals that we typically do not reach, to guide vaccine access and uptake planning. Feedback can include where New Yorkers want to receive the vaccine, what New Yorkers need to know in order to feel confident receiving the vaccine, who New Yorkers trust to share vaccine information, what messaging and communications strategies should be used, and how vaccine distribution should be prioritized.[5] Incorporate this information into vaccine allocation, logistics, messaging, public health education and community engagement planning. Develop and maintain ways to address community input.

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[3]Towards a Common Language for Functioning, Disability and Health, The International Classification of Functioning, Disability and Health, World Health Organization. https://www.who.int/classifications/icf/icfbeginnersguide.pdf.

[4]Kendall et al. (2020) Immediate and Long-Term Implications of the COVID-19 Pandemic for People With Disabilities. American Journal of Public Health. https://ajph.aphapublications.org/doi/10.2105/AJPH.2020.305890. Haque and Stein. (2020) COVID-19 Clinical Bias, Persons with Disabilities, and Human Rights. Health and Human Rights Journal. https://www.hhrjournal.org/2020/11/covid-19-clinical-bias-persons-with-disabilities-and-human-rights/.

[5]Within the New York City Department of Health and Mental Hygiene, this happens via community partner engagement, the Health Opinion Poll, the Test and Trace Community Advisory Board, the External Partner Engagement Coalition, and staff.

6. Work with community-based partners to determine where to set up COVID-19 vaccination sites for New Yorkers to easily access vaccines. Use public input to identify any unique needs that should be addressed in identifying COVID-19 vaccination sites.
7. Leverage flu and other existing vaccination pathways to enable COVID-19 vaccination, particularly in neighborhoods that experience low uptake. Prepare for decreases in vaccine uptake as COVID-19 disease rates decrease, as seen during H1N1. Leverage and expand communications and community engagement infrastructure at the early signs of decreasing vaccinations to encourage continued vaccinations.
8. Proactively review New York City-run vaccination sites to ensure that vaccination sites are safe and accessible for all. Individuals whose safety and accessibility needs are often overlooked include people with disabilities, people who do not read or speak English, people who are undocumented, people who have experienced criminal justice exposure, people with mental illness, people with substance use disorders, people who are homebound, and people experiencing homelessness or housing instability. This list will continue to be expanded with input. Provide messages and communications in plain language in different modes and languages, including using technology as needed, especially for individuals with vision impairments and who are deaf or hard of hearing. Ensure that signage and staffing, including interpreters where appropriate, meet the cultural and linguistic needs of the community, and that staff are properly trained and prepared. Carefully plan the look and feel of sites to ensure that sites are welcoming for all.
9. Widely distribute information about locations of COVID-19 vaccination sites, what to expect during the vaccination process, costs of getting vaccinated, insurance coverage, known side effects, what to expect after receiving the vaccine, number of doses required, the need to maintain key prevention measures (such as wearing a mask when in public) even after receiving the vaccine, what data is collected, how privacy and confidentiality are maintained, how to report a problem with accessing vaccination and/or side effects after vaccination, and that being vaccinated will not impact immigration status. This information will be made available in multiple languages.

Uptake

Strategies to achieve population immunity and reduce transmission will address misinformation and concerns about vaccine safety and will promote transparency and trust. The strategies aim to shift attitudes around vaccine hesitancy by partnering with and mobilizing trusted messengers to give New Yorkers the information they need to make an informed decision about the COVID-19 vaccine. Uptake strategies recognize the right of all New Yorkers to make an informed decision about whether and when to receive a COVID-19 vaccine and acknowledge that hesitancy is rooted in rational, valid concerns about efficacy and safety, as well as distrust due to medical racism.

1. Communications and community engagement efforts will build trust[6] and address historic and current systems of oppression and institutional betrayal.[7] By working with diverse stakeholders, this work will acknowledge the historical and contemporary harms perpetrated

[6]Altevogt, Bruce. Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report. https://www.ncbi.nlm.nih.gov/books/NBK219958/pdf/Bookshelf_NBK219958.pdf.

[7]Freyd, Jennifer. Institutional Betrayal and Institutional Change. https://dynamic.uoregon.edu/jjf/institutionalbetrayal/index.html.

by research, medical, and government systems on Black, Indigenous, Latino/a, Asian, and other people of color, people who are of LGBTQIA+ experience, people with disabilities, people who are undocumented, veterans, people with exposure to the criminal justice system, people who have faced religious persecution, oppression, or intolerance, and older adults. These harms have resulted in rational distrust in the systems on which the public is expected to rely when determining whether a vaccine is safe and effective, and this distrust is a root cause of COVID-19 vaccine hesitancy.

2. Collaborate with community-based, faith-based, and other organizations that serve as trusted messengers in their communities to lead bidirectional engagement aimed at ensuring that community members have the information they need, including risks, benefits, and alternatives, to make an informed decision about the COVID-19 vaccines.
3. Track high-profile topics related to a COVID-19 vaccine that may impact uptake. Develop and disseminate messaging that directly and honestly addresses these topics. Examples include concerns around providing identifying information, government-mandated or employer-mandated vaccination, vaccine side effects and vaccine costs.
4. Develop media campaigns, messaging and other materials to disseminate COVID-19 vaccine information that is anti-racist, culturally and linguistically appropriate, and tailored to the needs of communities across NYC. Implement accountable community-informed processes to ensure that public input guides communications material development and dissemination.
5. Identify and account for common experiences within and across communities. Note that some communities will be diverse in race and ethnicity but have some shared experience (for example, immigrants, people who are pregnant or lactating). At the same time, recognize that people within racial and ethnic groups do not all have the same needs and interests. Many people will hold multiple intersecting identities.
6. Within New York City agencies, recognize staff as a community unto themselves whose feedback is essential to an equitable vaccine strategy. Staff serve as an important resource for disseminating information to the public and as trusted messengers within their own communities. Collect feedback from all levels of staff to inform vaccine planning and logistics. Make information and strategies to build vaccine confidence and misinformation available to all staff, particularly staff who reside in priority neighborhoods.

Outcomes

The effectiveness of COVID-19 vaccine equity strategies must be measured using vaccination and infection data and community feedback to ensure that efforts to encourage vaccine uptake are building, not destroying, trust.

1. Use racial equity[8] and public health ethics tools[9] and frameworks[10] to evaluate the vaccination program to ensure equitable, anti-racist and ethical implementation, distribution and impact.
2. Create vaccine data dashboards, including public-facing versions, to track uptake and inform vaccination program decisions. Vaccine uptake and coverage will be analyzed based on geography and available demographics to track uptake and coverage in high-risk areas and populations, with close attention to geographic areas and populations identified for

[8]Government Alliance on Race and Equity. Racial Equity Toolkit. https://www.racialequityalliance.org/resources/racial-equity-toolkit-opportunity-operationalize-equity/.

[9]Centers for Disease Control and Prevention. Public Health Ethics Resources. https://www.cdc.gov/os/integrity/phethics/resources.htm.

[10]Kass, Nancy. An Ethics Framework for Public Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446875/.

prioritization in the vaccination allocation tool and community input.

3. Collect real-time individual and community feedback from people who are vaccinated across New York City to address the issues around vaccine access and uptake when they arise.
4. Monitor COVID-19 indicators alongside COVID-19 vaccination rates, especially in priority neighborhoods. Communicate with the public about when high vaccine rates can be expected to correspond to reduced infection and death rates and about the need to maintain key prevention measures. Prepare to address perceived or real failures of vaccination efforts to reduce COVID-19 infection rates and deaths.
5. Adverse events can reduce trust in research, medicine and government, even when adverse events cannot be definitively tied to a vaccine. Monitor vaccine safety reporting trends and prepare to respond to trends.
6. Throughout planning and implementation, ensure appropriate post-incident response, learning and improvement. Post-incident response should include collecting feedback from communities to identify changing needs as vaccines become widely available, planning for the return to nonemergency vaccination infrastructure, and gathering information about the impact of the vaccination program.

Dismantle

The unparalleled scope of the COVID-19 vaccination efforts offers a unique opportunity to identify and dismantle oppressive systems and generate the sustained, long-term changes required to eliminate health inequities even after the public health emergency.

1. Promote changes to the ways that health care systems collect, document and share the race, ethnicity, and gender identity data that is essential to guiding equitable distribution of resources. This will include communicating with health care providers about the importance of giving patients the opportunity to self-report their demographic data, supporting health care providers in communicating with patients about the value of demographic data, and providing technical assistance to health care providers to adapt their workflows to integrate demographic data documentation.
2. Improve health literacy by developing trusted pathways to share information about health and wellness with communities that have historically faced restricted access to information. Embed these pathways into broad public health education efforts to ensure that those pathways persist after the public health emergency ends.
3. Leverage broad engagement with the health care sector to expand training on anti-racist health care practice, addressing structural racism within our hospital and health care systems.
4. Continue to support the Mayor's Racial Inclusion and Equity Taskforce in convening across agencies to address structural inequities and advocate for their work to be formalized as a permanent body.
5. With recognition that racism is a public health crisis, move forward with Take Care New York: The Roadmap to Health Equity, beginning with listening sessions to engage marginalized communities, and finishing with setting our health equity agenda for the next four years. We will pay particular attention to the factors — including City infrastructure, structural racism, and poverty — that led to such unequal impacts of the COVID-19 public health emergency.