Building Trust in and Access to a COVID-19 Vaccine Among People of Color and Tribal Nations

A FRAMEWORK FOR ACTION CONVENING

EXECUTIVE SUMMARY

The convening's main points of consensus were:

- A woeful history of maltreatment of communities of color and tribal nations by government and the healthcare sector is at the root of higher levels of vaccine distrust within those groups.
- Building trust in and access to the COVID-19 vaccine is urgently needed and necessary to control the pandemic.
- Earning trust requires working with communities of color and tribal nations to use their agency as trusted messengers. Leaders from these communities must have a place at the planning table and be provided with the resources needed to engage their stakeholders in order to facilitate vaccine distribution and administration at the local level.
- The administration and Congress should expand funding to support and strengthen national, state, local, tribal and territorial work on equitable and effective COVID-19 vaccination planning, communications, distribution and administration, including funding to support vaccine distribution at the local level and by community-based organizations.
- The pace of vaccine development, in and of itself a good thing, means that vaccine distribution will begin before vaccine hesitancy has been fully addressed. Those responsible for vaccine distribution and administration need to acknowledge and plan for this reality.
- All vaccine education messaging must be culturally and linguistically appropriate. Messaging campaigns must feature trusted messengers. Education programs should take advantage of existing health communications networks.

As a nation, we are at a pivotal moment in the COVID-19 pandemic. While novel coronavirus transmission continues at alarming rates in communities across the country, the complex task of vaccine distribution and administration is also upon us. It is abundantly clear that the COVID-19 pandemic is impacting communities of color and tribal nations with far greater severity than the white population. This disproportionate impact is largely due to systemic inequities that existed before the pandemic and have been exacerbated by it. Therefore, **it is imperative that there is equitable distribution of and access to the COVID-19 vaccine. We must ensure that leaders in communities of color and tribal communities have the opportunity, resources and cooperation to design and lead strategies to share information, increase vaccine confidence and receptivity, deliver and administer vaccines, and closely monitor and report on results.**

Even with this commitment, the path to widespread vaccination is not simple; it is critical to note that *vaccines* don't prevent disease and save lives; getting people *vaccinated* prevents disease and saves lives.

While the rapid pace of vaccine development has created hope, significant numbers of people are still expressing distrust of a vaccine, or outright reluctance to be vaccinated. Lack of confidence in the vaccine and inequitable access to it are particularly acute in communities of color and tribal communities. This mistrust has evolved over centuries of both historical and contemporary lived experience of structural racism and bias in the design and delivery of healthcare, including previous vaccination efforts and vaccine trials,[1] and in government services.

Failure to earn trust and ensure equitable access to a vaccine will worsen the already disproportionate impact of the pandemic on communities of color and tribal nations. It will also weaken the nation's ability to stop the spread of the virus at large, curtail efforts to fully reopen the economy, and could lessen the public's confidence in future public health emergency responses. Another challenge is that the pace of vaccine development (in and of itself, good news) means that a vaccine will be available for first priority distribution before vaccine education and trust-building programs have had a chance to be implemented and effective. Those responsible for ensuring equitable vaccine distribution and access will have to work within a framework that recognizes that vaccine distrust has not been fully resolved.

Recognizing both the urgency of the moment and the opportunities presented by it, Trust for America's Health (TFAH) hosted a national convening in October 2020 in collaboration with the National Medical Association and UnidosUS. The agenda focused on two vital and related issues: 1) How to earn and build trust and ensure access so that people at highest risk of infection, hospitalization and death—due to structural racism and social, economic and health inequities—are protected; and 2) How to build confidence in the COVID-19 vaccine in communities of color and tribal nations.

Funded by the Robert Wood Johnson Foundation and Kaiser Permanente, the convening was designed to generate specific, actionable steps to be taken by policymakers both before and after the vaccine becomes available. It included more than 40 experts in racial justice and equity, community engagement, public health, healthcare and science to identify critical issues and actions. The fact that every one of these organizations—many working on the frontlines of the pandemic and combating racial injustice—immediately replied "yes" to the invitation reinforced our conviction that this conversation was both necessary and urgent.

We recognize and remind those in government at all levels—as well as the pharmaceutical industry, healthcare sector and public health community—that trust must be earned. The context and considerations explored in this brief underscore the breadth of strategies needed, from validation of a vaccine's safety, to safe and equitable access, to culturally relevant and linguistically appropriate communication, and more. This is not only about convincing communities that a vaccine is safe; it is also about following the lead of communities to deliver what is most needed in this moment to earn and rebuild trust and ensure that the benefits of a vaccine will be felt where the need is most acute.

STRUCTURAL RACISM ELEVATES EXPOSURE, ILLNESS AND DEATH FROM COVID-19

As people across the nation—and around the world—continue to grapple with the worst pandemic in a century, it is undeniably clear that people of color and tribal communities are largely the hardest hit. The data in the table below was released by CDC on November 30, 2020, comparing COVID-19 rate ratios for different racial/ethnic population groups to the rate ratio for white non-Hispanic persons.[2]

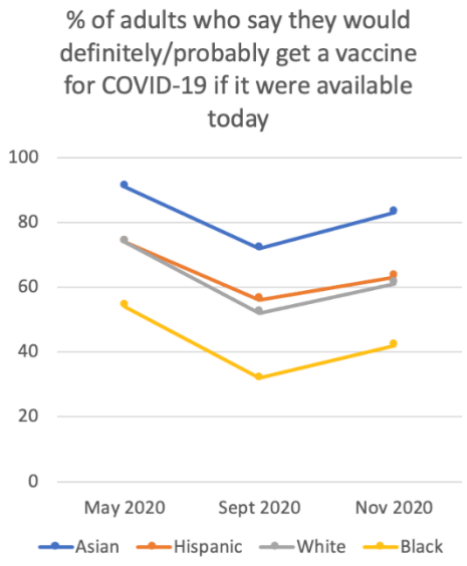
Rate ratio compared to white, Non-Hispanic persons	American Indian or Alaska Native, Non-Hispanic persons	Asian, Non-Hispanic persons	Black or African-American, Non-Hispanic persons	Hispanic or Latino persons
Cases	1.8x	0.6x	1.4x	1.7x
Hospitalizations	4.0x	1.2x	3.7x	4.1x
Deaths	2.6x	1.1x	2.8x	2.8x

In addition, the UCLA Center for Health Policy Research reported on December 13, 2020, that the COVID-19 case rate for Native Hawaiians and Pacific Islanders (NHPI) is 4.5 times higher than for white persons, and the death rate for NHPI persons is 8.5 times higher.[3]

The disproportionality in COVID-19's impact is the direct result of centuries of structural racism. Unjust social, economic and environmental conditions have led to a higher incidence of underlying chronic disease and other risk factors among people of color and tribal communities, resulting in higher rates of illness, hospitalization and death due to COVID-19. Practices and policies that force people of color into denser living conditions and increased exposure to environmental hazards, such as fine particle pollution, further elevate risk.[4] People of color and tribal communities are more likely to work in front-line healthcare, transportation, food service or other essential jobs that increase exposure to the virus,[5] and are less likely to have access to quality healthcare. Beyond the impact of structural racism, when intersectional issues, also shaped by racism, such as homelessness, incarceration, disability, lack of access to paid sick leave, and immigration status are also at play, the disparities gap widens further.

VACCINE HESITANCY BORNE OUT OF EXPERIENCE

As development of a vaccine for COVID-19 has progressed, several researchers have noted troubling rates of vaccine hesitancy. The *STAT* and Harris Poll from October 2020 found that only 59 percent of people in the United States were likely to get vaccinated when the COVID-19 vaccine is generally available, down from 70 percent just two months earlier.[6] The decline was even more pronounced among Black Americans, whose likelihood to be vaccinated had dropped from 65 percent to 43 percent.[7] In September 2020, Pew Research Center found similarly dramatic drops in likelihood to be vaccinated among communities of color, as reflected in the chart at right. Although Pew's November survey found a rebound in vaccine receptivity across all four population groups surveyed, the percentage indicating they definitely or probably would be vaccinated is still lower for all four groups than it was in May 2020.[8]



No data have been found showing receptivity to the vaccine among Native Americans in general or in specific tribes, nor among Native Hawaiians or Pacific Islanders. This underscores the ongoing racial gaps and invisibility in data collection and disaggregation among certain racial and ethnic groups.

Hesitancy to be vaccinated is problematic since the vaccine will only provide population-level protection if enough people want it and can get it. And while hesitancy in the population at large is certainly a concern, the higher level of hesitancy in some communities of color and tribal communities is particularly alarming given the disproportionate impact of COVID-19.

However, a person's receptivity to the vaccine is not necessarily permanently fixed. Overcoming hesitancy and building trust requires acknowledging and taking steps to address the historical and present-day context of race and racism, discrimination and bias in this country. While these conditions existed long before the pandemic, COVID-19 has cast them in a stark light.

As referenced above, people's willingness to receive the COVID-19 vaccine has rebounded somewhat this fall but confidence in the vaccine continues to be lower in Black communities. A November 2020 Pew Research Center poll found that between spring and fall 2020 there was an increase in the number of Americans intending to be vaccinated, but also documented continuing lower levels of vaccine confidence among Black individuals as compared to whites and other racial and ethnic groups.[9]

This hesitancy has deep roots. It is impossible to overstate the impact of centuries of egregious medical experimentation without informed consent, forced sterilization, the weaponization of disease, and other attacks against people of color and tribal communities. These historical injustices have long legacies and add to generational mistrust in government and medical research.

A few examples include:

- From 1932 to 1972, CDC and the U.S. Public Health Service told Black men in Tuskegee, Alabama, with syphilis that they were receiving free healthcare; instead, they were given placebos while researchers studied the progression of the disease as the men succumbed to blindness, mental illness or death.[10]
- Johns Hopkins University harvested the cells of Henrietta Lacks, a Black woman being treated for cancer, without her or her family's consent. After her death, her cells were used in genetic and medical research for more than 40 years without acknowledgement, consent or compensation.[11]
- Between the 1930s and the 1970s, approximately one-third of Puerto Rico's women of childbearing age were sterilized, the highest rate in the world, to "control the population and decrease the high level of poverty and unemployment." Sterilization was presented as free and reliable family planning; women were not provided complete information and many later regretted being sterilized.[12]
- In the 18th Century, North American colonists intentionally gifted blankets contaminated with smallpox to Native Americans, killing at least 30 percent of the Native population on the Northwest coast of North America.[13]
- Infectious diseases, like smallpox, whooping cough, dysentery, tuberculosis, influenza and measles, along with refusal to provide care, decimated thriving Native Hawaiian and Pacific Islander populations throughout history.
- People of color and members of tribal communities have also experienced a long history of lack of access to healthcare, a lack of culturally and linguistically appropriate care and providers, and a

lack of respectful and equitable treatment, which continues in the present day. Many people of color and tribal communities say they have personally experienced discrimination when going to a doctor, hospital or health clinic because of their identity. Notably, nearly one-third (32 percent) of Black Americans and at least one-in-five Native Americans (23 percent) and Latinos (20 percent) say they have experienced racial discrimination when going to a doctor, hospital or health clinic.[14]

Other current-day experiences further erode trust. For example:

- Misinformation and disinformation about the vaccine and the virus, as well as inflamed or overblown political rhetoric about the vaccine development and clinical trial process.
- Lack of clear, consistent culturally relevant information about the vaccine and the virus in appropriate languages and cultural contexts and aligning with health literacy best practices.
- Lack of consistent, accurate and timely data collection, disaggregation and reporting to show the full impact of the pandemic across racial and ethnic populations and subpopulations, which could render some communities of color and tribal communities invisible in allocation and distribution plans.
- Shortcomings of the federal and state governments to prioritize and deliver sufficient quantities of personal protective equipment (PPE), COVID-19 testing, healthcare services, paid sick leave and pandemic relief funding have had a disproportionate impact in communities of color and tribal communities. In addition, employers have not always fully met their obligations to protect essential and front-line workers.
- Ongoing failure to deliver on treaties and other governmental agreements with sovereign tribal nations and U.S. territories, including the lack of basic health infrastructure, lack of funding for health services, failure to release pandemic relief funding, abandonment during other disasters, and exclusion from previous vaccine programs.[15]
- The long-standing lack of investment in public health infrastructure and lack of coordination of the COVID-19 response between the federal and state/local governments are two additional barriers to a successful vaccination program.

This historical context combined with current lived experience are likely at the root of many concerns about a COVID-19 vaccine. For example, despite reports from many of the pharmaceutical companies of racial diversity within their vaccine development trials, lived experiences has undoubtedly generated concerns that COVID-19 vaccine trials may not adequately include communities of color and tribal communities—and, therefore, that the vaccine's safety and effectiveness in these communities will be unknown. Such experiences may drive additional concerns that planning has not considered the unique factors affecting tribal nations, territories, Freely Associated States and small island communities with distinct leadership and decision-making structures (American Samoa, Guam, Hawaii, The Republic of the Marshall Islands, Commonwealth of the Northern Mariana Islands, Republic of Palau, Federated States of Micronesia, Puerto Rico and U.S. Virgin Islands).

It is also important to note the ongoing racism being directed at Asian American and Pacific Islander communities as a result of xenophobic framing by government leaders and others about the origins and spread of COVID-19. Asian Americans are reporting a surge in racially motivated hate crimes, including harassment and physical violence since the beginning of the pandemic.[16] About four in 10 adults in the U.S. say it has become more common for people to express racist views toward Asians since the pandemic.[17]

Organizations that attended the convening are doing vital work to redress these inequities and ensure representation in vaccine planning. They are advocating for communities; addressing systemic inequities; ensuring representation in testing, data collection and vaccine clinical trials; countering misinformation; and advocating that resources be directed to these communities for planning, decision-making and action. But these efforts must become a national priority, not solely the work or responsibility of individual organizations.

Ultimately, it is not the responsibility of people of color and tribal communities to find a way to trust the COVID-19 vaccine. Rather, it is the responsibility of governments at all levels, the public health sector, the healthcare sector and the pharmaceutical industry to develop and equitably disseminate a safe and effective vaccine in ways that are deserving of trust. It also requires acknowledging, respecting and resourcing the power and agency of communities of color, tribal communities and those who serve them in the development of, dissemination of, and communication about a vaccine that is worthy of trust.

PRINCIPLES FOR BUILDING TRUST AND EQUITABLE ACCESS

Insights gleaned from convening participants coalesced into four principles that are essential in guiding decision-making and action to earn and build trust and ensure access to a COVID-19 vaccine in communities of color and tribal communities.

Agency

Communities of color and sovereign tribal governments must have the opportunity and resources to ensure full and authentic participation and leadership in all steps of the vaccine development, distribution and monitoring process. This includes adequate time, information and resources to engage their stakeholders and communities according to their own practices and protocols, and opportunities for impact-making roles in program planning and decision-making.

An asset-based approach that relies on communities identifying and leveraging their assets will be much more effective than one that relies on external, top-down strategies reflecting a paternalistic, hierarchical, "problem-solving" approach.

Transparency

The methodology and findings in the vaccine development process, as well as plans for disseminating the vaccine, must be transparent. Members of communities of color and tribal communities must be involved in development, implementation, monitoring and communication during each step.

Candid communication must reiterate that the vaccine—while a critical tool in the fight against the spread of COVID-19—is not a guarantee of protection due to a variety of factors from efficacy to vaccination rates to unknowns about how the virus will behave over time; other preventive practices (e.g., masks, physical distancing and handwashing) will need to stay in effect for some time. Risks associated with the vaccine, including potential side effects, efficacy for children younger than 16 and pregnant women (about whom the current trials will not yield sufficient data) must also be transparently communicated in such a way to allow people to accurately understand risks.

As has been acknowledged elsewhere in this paper, while trust and trust building cannot be rushed, a COVID-19 vaccine will be in at least limited distribution before this trust-building process has been given

time to take root. This makes it all the more important that the trust-building process begin immediately and be given heightened focus and attention. Managing expectations will be a critically important part of the trust-building process.

Relevancy

Data—disaggregated by race, ethnicity and other demographics at the sub-population level—must be community-informed, consistently and accurately collected, reported and used (with consent) in a timely manner to guide planning and decision-making.

Engagement with communities of color and tribal communities must recognize that these communities are not monolithic. A one-size-fits-all approach to community engagement, planning, communication, and vaccine distribution and administration will be unsuccessful. The historical context and current lived experience of communities of color and tribal nations must be acknowledged and respected in developing and disseminating the vaccine.

Accountability

Government at all levels, the public health sector, the healthcare sector and pharmaceutical companies must hold themselves—and be held by others—to the highest standards of ethics, transparency and integrity. Commitments must be honored. When mistakes are made, they must be promptly acknowledged and corrected.

POLICY RECOMMENDATIONS

The following recommendations, all an outgrowth of the October convening, specifically address actions to earn and build trust and to ensure vaccine access—including removing cost barriers—within communities of color and tribal communities. These recommendations include a call for funding grassroots involvement in the vaccine development, trust building and distribution process. These recommendations also call for actions at a much broader level to provide protection to priority populations while advancing public health at large. This underscores the fact that protecting the entire population must begin with action where the risk, need and benefit are greatest.

These recommendations have been vetted by a review team of convening attendees. They represent the joint expertise of the participating public health and health equity organizations.

Ensure the scientific fidelity of the vaccine development process.

- The U.S. Department of Health and Human Services (HHS) and vaccine developers should ensure that all COVID-19 vaccine trials include representation of race, ethnicity, age, disability and chronic conditions at levels that reflect the increased COVID-19 disease risk and burden these factors create. Vaccine developers should release data about the demographics—including both race and ethnicity—of all clinical trial populations. Ensuring diversity in all clinical trials should be a priority for the industry and the Food and Drug Administration (FDA) moving forward.

- Because of the pace of vaccine development and the levels of public distrust of the process, it is vital that additional steps be taken to create transparency and engage with communities of color and tribal communities, elected and community leaders, public health officials, and healthcare

providers about the safety and efficacy of COVID-19 vaccines. Any perception of bypassing safety measures or withholding information could derail a successful vaccination effort.

- The White House and HHS must clarify and communicate the roles and responsibilities of CDC, FDA and other federal agencies in the vaccine development and vaccination process. The White House must not interfere, or give any appearance of interfering, with FDA's ability to act independently and follow the science in review and approval of the vaccines. There must be transparency and uniformity in federal messaging from the White House, CDC, FDA and the National Institutes of Health (NIH) to ensure message clarity, avoid confusion and build trust.

- HHS and vaccine developers should release all available vaccine data at frequent and regular intervals to improve transparency and increase confidence in the vaccine evaluation process. Leadership at FDA and HHS must commit to advancing any vaccine only after it has been validated based on established federal and scientific protocols. Programs to monitor for adverse events must also be in place and transparent.

- FDA should engage health and public health professional societies, particularly those representing healthcare providers of color and tribal healthcare providers, local public health officials, as well as other stakeholders with a role in vaccination, and allow these groups to validate all available data, review the vaccine development and approval process, and issue regular updates on data to their patients, members and the public.

Equip trusted community organizations and networks within communities of color and tribal communities to participate in vaccination planning, education and delivery. Ensure their meaningful engagement and participation by providing funding.

- Congress should fund CDC and its state, local, tribal and territorial partners to provide training, support and financial resources for community-based organizations to join in vaccination planning and implementation, including community outreach, training of providers, and participation in vaccination clinics. (*See more on need for supplemental funding below*.)

- State, local, tribal and territorial authorities should authentically engage and immediately begin vaccination planning with community-based organizations, community health workers/*promotores de salud*, faith leaders, educators, civic and tribal leaders and other trusted organizations outside the clinical healthcare setting as key, funded partners. This engagement is particularly critical to meet the needs of people at intersections of inequities, such as people of color and members of tribal communities who are experiencing homelessness, are older or who have a disability.

- CDC and NIH should provide guidance and funding to state, local, tribal and territorial partners that supports engagement and outreach with communities of color and tribal communities to inform and deliver effective, culturally responsive and linguistically appropriate messages about COVID-19 and the vaccine.

- These recommendations require short-term emergency funding, but there must also be funding for long-term capacity and infrastructure support to build community-based organizations' ability to engage the community and partner with government on public health needs. Existing community-

based health communications networks should be part of the vaccine education and administration process.

Provide communities with all of the information they need to understand the vaccine, make informed decisions, and deliver messaging through trusted messengers and pathways. This may include details about different types of COVID-19 vaccines, how they are administered, how they work, their effectiveness in specific populations, potential adverse events, and the need to continue using other preventive measures after vaccination.

- Congress should provide at least $500 million to CDC for outreach, communication and educational efforts to reach priority populations in order to increase vaccine confidence and combat misinformation. CDC and NIH should study and develop and work with appropriate outside communication and community action experts to create evidence-based messaging that is effective, clear, consistent, and culturally and linguistically appropriate. Messaging and communication tools will be needed to increase vaccine confidence and reduce misinformation among different subpopulations and disseminate those communications tools to trusted partners in communities. Demographic groups are not monolithic, so public health communication must be culturally and linguistically appropriate and tailored as much as possible to reach diverse populations as well as generations within groups.

- FDA and CDC should initiate early engagement with diverse national organizations and provide funding and guidance for state, local, tribal and territorial planners to engage locally with healthcare providers in communities of color and tribal communities, such as nurses, pharmacists, *promotores de salud*, community health workers, and others to ensure they have the information they need to feel comfortable recommending the vaccine to their patients.

- Congress and HHS should provide funding for training and engagement of trusted non-healthcare communicators to train informal networks, civic and lay leaders, and other trusted community leaders and community-based organizations to answer questions and encourage vaccination. As much as possible, governments and industry should partner with trusted messengers and influencers within communities to shape the messages and serve as the communicators. Trusted messengers may also include community members who have had COVID-19 and/or been vaccinated, *promotores de salud*, community health workers and faith leaders.

- All messaging about the vaccine must be accurate, customized, clear and consistent, and appropriate for all levels of health literacy. Communication should be realistic and clear about timelines and priority groups (and the rationale for these decisions), vaccine effectiveness, types of vaccines, the number of doses, costs and the need for ongoing public health protections. Planners must provide information that meets people where they are (e.g., barber shops, bodegas, grocery stores, places of worship) and ensure that trusted messengers in those places have the information they need to be credible and authentic spokespeople.

- Vaccine messaging spokespersons should be recruited and deployed based on their ability to serve as authentic, welcomed and trusted messengers within specific communities—as identified by communities themselves (e.g., clergy, church and faith leaders, community leaders—formal and

informal—social media influencers, entertainers and professional athletes, especially those with a first-hand experience of COVID-19 and/or have been vaccinated).

- Congress should fund sustained earned, paid/donated, and media and social media campaigns tailored for specific audiences and delivered through appropriate channels and messengers.

- HHS must conduct ongoing communication that responds in real time, including if adverse experiences arise. This transparency is critical not only to the success of the COVID-19 vaccination effort, but also to future vaccination and pandemic response efforts. HHS, in collaboration with local leaders, must plan for communication around vaccination rates in different communities, efficacy and emerging mis/disinformation.

- HHS should design and implement a phased communication strategy that follows Advisory Committee on Immunization Practices (ACIP) guidelines for equitable vaccine distribution, prioritizing frontline health workers, essential or critical infrastructure workers who face increased risk and who are more likely to be people of color and members of tribal communities—and who in turn can help share information and build trust among people considering the vaccine.

Ensure that it is as easy as possible for people to be vaccinated. Vaccines must be delivered in community settings that are trusted, safe and accessible to communities of color and tribal communities.

NOTE: *The convening participants support vaccine distribution guidelines that are grounded in equity and delivering the vaccine on a priority basis to those places and/or people at the highest risk of infection, such as those outlined by the National Academies Science, Engineering and Medicine (NASEM) and Advisory Committee on Immunization Practices (ACIP) frameworks.*

- We urge the administration and Congress to appropriate the resources necessary to expand and strengthen federal, state, local, territorial and tribal capacity for a timely, comprehensive and equitable COVID-19 vaccination planning, communications, distribution and administration campaign, including funding to support vaccine distribution at the local level and by community-based organizations.

- Planners should ensure that vaccination sites are located in areas that have borne a disproportionate burden of COVID-19, especially leveraging community-based organizations, such as Federally Qualified Health Centers, community health centers, rural health centers, schools and places of worship. Mobile services will be particularly important in rural areas.

- Planners should prioritize congregate living facilities, such as long-term care, prisons and homeless shelters. In addition, some families, displaced by the COVID-19 economic fallout, may be living with relatives. Planners should ensure vaccination sites have services that meet the Americans with Disabilities Act (ADA) and HHS Office for Civil Rights (OCR) standards for disability and language access.

- Congress and HHS should allocate funding to increase access to vaccination services to ensure that people seeking to be vaccinated do not experience undue increased exposure to the virus as

they travel to, move through, and return home from vaccination sites. Flexibility in funding is needed to enable transport of people to vaccination sites, increase accessibility to people without cars, and promote safety and minimize exposure at vaccination locations. Funding should also be provided to health and community-based agencies to assist those for whom transportation or child-care costs are an obstacle to being vaccinated.

- Federal, state, local, tribal and territorial officials must guarantee and communicate with the public that immigration status is not a factor in people's ability to receive the vaccine, and that immigration status is not collected or reported by vaccination sites/providers. Similarly, the presence of law enforcement officers or military personnel could be a deterrent for vaccination at locations, so planners should consider other means of securing sites.

- In the initial phase, as communities vaccinate healthcare workers, planners must be sure to prioritize home health, long-term care, and other non-hospital-based healthcare workers, who are more likely to be people of color or members of tribal communities. Other essential workers that comprise large numbers of workers who are people of color or members of tribal communities and should be classified as vaccination priority groups are the food service industry, farmworkers and public transportation employees.

- Government entities should require that existing agreements with vaccine distribution sites (e.g., pharmacies, urgent care facilities) include locations within and serving communities of color and tribal communities and meet other ADA and OCR standards for accessibility. Requirements for retail sites should also include both independent and chain pharmacies in both rural and urban parts of the country.

Ensure complete coverage of the costs associated with the vaccine incurred by individuals, providers of the vaccine, and state/local/tribal/territorial governments responsible for administering the vaccine and communicating with their communities about it.

- Congress, the Centers for Medicare and Medicaid Services, and private payers must guarantee that people receiving the vaccine have zero out-of-pocket costs for the vaccine, related health care visits, or any adverse events related to the vaccine, regardless of their health insurance status.
- HHS must ensure that municipalities, tribes, territories and community-based organizations providing the vaccine to their communities will not bear any costs associated with delivering the vaccine (e.g., administration, ancillary supplies, PPE, vaccine supplies, storage and refrigeration, staffing).

Congress must provide additional funding and require disaggregated data collection and reporting by age, race, ethnicity, gender identity, primary language, disability status and other demographic factors on vaccine trust and acceptance, access, vaccination rates, adverse experiences and ongoing health outcomes.

- CDC and state, local, tribal and territorial authorities should include leaders from communities of color and tribal communities to plan on-going data collection, interpret data, add cultural context, share data with communities, and determine implications and next steps.

- CDC and state, local, tribal and territorial authorities should use these data to inform ongoing prioritization of vaccine distribution and rapidly address gaps in vaccination that may arise among subpopulations by race, ethnicity, neighborhood or housing setting.

CONCLUSION

Race, ethnicity and socioeconomic status should not be barriers to accessing to the COVID-19 vaccine. Work needs to be done to make this statement a reality.

It is essential that the United States develop and equitably distribute a vaccine that is safe, effective and accessible to everyone. Furthermore, we must monitor for—and address—any inequities or barriers in the delivery of and access to the vaccine in communities of color and tribal nations, which are bearing the brunt of the current pandemic. Equally critical is a vaccine development and distribution process that has earned the trust of the American people through fidelity to the scientific process, transparency, and well-planned and executed communications and public education.

The pace at which COVID-19 vaccines have been developed (thanks to unprecedented levels of investment and scientific innovation and cooperation) makes distribution planning and trust-building even more critical. As a nation, we are facing a situation in which a safe and effective vaccine could be made ineffective because large numbers of people do not trust the vaccine or do not have access to it. The challenge for the vaccine distribution and administration process is to acknowledge and work within an environment in which vaccine hesitancy has not been fully addressed.

While urgency is certainly called for in addressing the spreading pandemic, a process that is rushed—leaving inadequate time for communities to fully and authentically participate in the development of customized dissemination plans—runs the risk of increasing distrust among communities of color and tribal communities that would almost certainly increase vaccine hesitancy. Lack of trust in the vaccine—or a vaccine that is not delivered equitably—will weaken efforts to end the pandemic, could further undermine the public health sector, and make future vaccination efforts even more difficult.

The damage of centuries of structural racism and the recent erosion of trust in the public health sector cannot be undone overnight. But everything done now to develop and deliver a safe and effective vaccine worthy of trust and accessible to communities of color and tribal communities will be central to not only ending the pandemic but also rebuilding trust in the nation's public health system.

In this moment of crisis, we must find new ways to harness community power to drive broad-based engagement in public health that is focused on saving lives, especially the lives of those who have been especially hard hit by the COVID-19 pandemic. Governments at all levels, the public health and healthcare sectors, and the pharmaceutical industry must listen, learn from others, value and fund local expertise, address longstanding systemic barriers, and partner in new ways. In so doing, they will earn trust, increase rates of vaccination, and allow for significant progress to be made in fighting the COVID-19 pandemic.

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Trust for America's Health (TFAH) is a nonprofit, nonpartisan public health policy, research and advocacy organization that promotes optimal health for every person and community, and that makes the prevention of illness and injury a national priority.

The **National Medical Association (NMA)** is a national professional and scientific organization representing the interests of more than 50,000 African American physicians and the patients they serve. A nonprofit organization, NMA is the leading force for parity and justice in medicine and the elimination of disparities in health.

UnidosUS, previously known as NCLR (National Council of La Raza) is the nation's largest Hispanic civil rights and advocacy organization. Through its unique combination of expert research, advocacy programs, and an Affiliate Network of nearly 300 community-based organizations across the United States and Puerto Rico, UnidosUS simultaneously challenges the social, economic and political barriers that affect Latinos at the national and local levels. For more than 50 years, UnidosUS has united communities and different groups seeking common ground through collaboration, and that share a desire to make our country stronger.

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ENDNOTES

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