May 11, 2021

Via Electronic and Letter Mail

Governor Andrew Cuomo
Governor of New York State
NYS State Capital Building
Albany, NY 12224

Mayor Bill de Blasio
Mayor of the City of New York
City Hall
New York, NY 10007

RE: Ensuring Equitable Distribution of COVID-19 Vaccine in New York

Dear Governor Cuomo and Mayor de Blasio:

On behalf of the NAACP Legal Defense and Educational Fund, Inc. (“LDF”), we call on you to take immediate steps to eliminate the stark racial disparities in New York’s distribution of COVID-19 vaccinations. COVID-19 is a public health crisis that affects the entire New York State community but has disproportionately impacted communities of color. Ensuring vaccine equity through prioritization of those most vulnerable to COVID-19 protects and benefits everyone.

Since the onset of the coronavirus pandemic, communities of color have borne a disproportionate burden of COVID-19 infections, hospitalizations, and deaths.\(^1\) Black communities, in particular, have been ravaged by COVID-19, dying at nearly twice the rate of white people nationwide,\(^2\) and at disproportionately higher rates than white people in New York City.\(^3\) Black and Latinx individuals often hold frontline essential and service industry jobs,\(^4\) which prevent them from working from home, and disproportionately experience social and healthcare inequities, all of which contribute to increased risk of COVID-19 exposure. Nevertheless, Black and Latinx individuals nationwide are receiving the COVID-19 vaccine (“the vaccine”) at significantly lower rates than white individuals. As of May 6, 2021, more than 149 million people nationally have received at least one vaccine dose, however, racial and ethnic data is available for only approximately 55% of recipients.\(^5\) Of those, only 8.8% of doses have thus far been administered to Black people and 12.6% to Latinx people.\(^6\) In contrast, 63.2% of those vaccine doses have been administered to white people nationally.\(^7\) Black residents in New York City are likewise underrepresented in vaccine distribution even though they should be especially targeted due to their disproportionately higher rates of serious illness and death from COVID-19: across New York state, only 11% of Black residents have received the first dose of the vaccine despite comprising 17% of the state’s population, compared to 73% of white residents who make up 70% of the state’s population.\(^8\) Similarly, in New York City, only 19% of Black residents have received
the first dose of the vaccine despite making up 27% of the city’s population, compared to 50% of
white residents who make up 53% of the population.9 These figures cannot be explained by so-
called “vaccine hesitancy” among Black residents. In fact, polls indicate that Black people have
no greater vaccine hesitancy than white people.10

As New York’s leadership, it is your responsibility to ensure equitable vaccine distribution
and protect your most vulnerable residents from increased risk of COVID-19 infection,
hospitalization, and death. Barriers to vaccine access, such as vaccine deserts, lack of digital
access, and inattention to unhoused and incarcerated communities, unduly burden communities of
color and limit their ability to obtain the COVID-19 vaccine.11 This disparate treatment directly
threatens the rights of Black and Latinx New York City residents in possible violation of Title VI
of the Civil Rights Act of 1964, as well as the safeguards afforded under the Equal Protection
Clause of the Fourteenth Amendment and Article I § 11 of the New York Constitution. On April
2, 2021, the United States Department of Justice (the “DOJ”) issued a statement making clear that
“[t]he Civil Rights Division, together with other agencies throughout the Federal government, will
continue to monitor civil rights issues related to COVID-19 and vigorously enforce civil rights
laws.”12 Quite simply, “[c]ivil rights protections and responsibilities still apply, even during
emergencies. They cannot be waived.”13 As a result, we urge you to review the following factors,
among others, that contribute to vaccine inequity and immediately implement our
recommendations, specified below, to remedy the racial inequities in your vaccination distribution
methods.

A. Vaccine Deserts and Vaccine Tourism

Due to racial segregation, redlining, and other effects of structural racism, predominantly
Black communities are often housed in areas with little to no healthcare infrastructure and few, if
any, healthcare resources.14 This means Black residents are significantly more likely than white
residents to live at least a mile away from the nearest quality pharmacy, clinic, hospital, or
healthcare center.15 Thus, when local governments primarily rely on preexisting health care
infrastructure and providers for vaccine administration, many Black individuals have few, if any,
options for receiving the vaccine in their own communities—creating “vaccine deserts.”16 Further,
vaccine deserts are largely concentrated in low-income communities of color, which commonly
lack transportation or rely on public transport.17 Thus, the populations with high vulnerability to
COVID-19 infection and death are the same populations excluded from vaccine access and
distribution.18

These disparities are particularly stark in New York City neighborhoods such as Eastern
Queens,19 East Harlem,20 and Washington Heights21 which have all experienced noticeably fewer
vaccination sites. The consequence is that Black and Latinx residents live much farther, on
average, from the closest vaccination site than white residents. Residents in vaccine deserts must
shoulder additional costs of finding transportation to vaccine centers outside of their
neighborhoods while juggling employment obligations, childcare responsibilities, declining
health,22 and other consequences of living in racially segregated neighborhoods that are deprived
of healthcare resources. As a result, those residents who are most vulnerable and marginalized
must spend more time and money to obtain the vaccine. This trend cannot continue. We strongly
urge you to implement the following recommendations to eliminate these inexcusable barriers and
racial disparities in New York City’s vaccine access and distribution methods. Even when additional vaccination sites are created to support residents in vaccine deserts, those residents may still be excluded from vaccine access due to vaccine tourism. For example, when the Armory in Washington Heights began vaccinating residents, staff members noted that “the majority of people being vaccinated were not from the low-income predominantly Latino neighborhood.”\textsuperscript{22} Relatively, more than a fourth of those who received vaccines in New York City reported not residing in the five boroughs.\textsuperscript{23} Accordingly, we recommend you implement the following recommendations to ensure broad vaccine access and avoid vaccine tourism.

- **Prioritize the establishment and expansion of vaccination sites, such as mobile healthcare centers, clinics, and other healthcare facilities, in underserved communities hardest hit by COVID-19 and those located in vaccine deserts.** Ensure vaccination sites consider the targeted community’s specific challenges, such as access to healthcare facilities, limited internet access, lack of transportation or limited mobility, limited English language proficiency, limited hours of availability due to work or childcare, and limited income, and provide solutions that circumvent these challenges.

  - Review and analyze geographic data, such as ZIP Codes and census tracts, to ensure that investments in public health infrastructure prioritize healthcare and vaccination of populations that are underserved or most vulnerable to COVID-19 infection, including frontline essential and service industry workers.\textsuperscript{24} Place new vaccination sites in accessible public spaces within underserved communities, \textit{e.g.}, near or within churches, community centers, public housing residences, public schools, and parking lots.

- **Collaborate with and rely on community-based organizations, religious institutions, stakeholders, leaders, and activists within communities most impacted by COVID-19, before, during, and after implementing all efforts to combat vaccine inequity.** Because vaccine inequity overwhelmingly impacts vulnerable communities of color, all efforts to ensure equitable vaccine access should center around meaningful engagement with Black and Latinx communities, particularly elders and those residing in vaccine deserts. These engagement efforts should be conducted in partnership with, or led by, grassroots organizations, local activists, clergy, and other key community stakeholders to achieve increased vaccine distribution and reduce vaccine hesitancy in vulnerable communities of color.\textsuperscript{25}

- **Take action to guard against vaccine tourism.** Frequently, when vaccination centers are brought to underserved communities to increase vaccine access for vulnerable residents, the targeted vulnerable residents are still unable to access the vaccines because more affluent people from outside areas, who have the resources and connections to learn of and travel to the new vaccination site, “skip” ahead of underserved residents to receive a vaccination—commonly labeled “vaccine tourism.”\textsuperscript{26} To avoid vaccine tourism, elected officials should work with the targeted community’s stakeholders and leaders to ensure members of the targeted community are prioritized for vaccine resources.\textsuperscript{27} There should also be a public campaign to condemn vaccine tourism and discourage more privileged constituents and people outside your constituency from depriving vaccine access to those more vulnerable to COVID-19 infection, serious illness, or death, which creates greater burdens and harms for everyone.
• In coordination with trusted community-based organizations, stakeholders, leaders, and activists representing Black, Latinx, and other communities of color, create easily accessible public education campaigns that target, reach, and inform vulnerable and underserved populations, including unhoused and incarcerated populations, about vaccine eligibility, safety, efficacy, distribution sites, and emphasize the absence of any cost associated with vaccination.

All public education campaigns should directly address vaccine hesitancy in communities of color, in a manner that validates and takes seriously the concerns, acknowledges the healthcare industry’s history of racial discrimination and experimentation on Black communities, clarifies that the COVID-19 vaccine will not replicate those practices, and provides accessible resources and data showing the safety of the vaccine.

• Eliminate additional barriers to vaccine access.
  - Increase community-based vaccination sites in vulnerable zip codes and—to prevent vaccine tourism and limited vaccine access for those targeted and vulnerable communities—encourage proof of residency within the targeted area prior to vaccination. However, because proof of residency requirements typically place additional burdens on low-income residents and communities of color, all proof of residency requirements should be broad and include identifying documents beyond government-issued identification, such as current mail (not limited to utility bills), statements from others residing in the community, school records, individual attestation of residency in targeted district, and more.
  - Eliminate all fees and co-pays associated with an individual’s COVID-19 vaccination, including hospital and clinic administrative fees, even if reimbursable.
  - Create free, COVID-19 sanitized, wheelchair-accessible methods of public transportation to and from vaccination centers and underserved areas, racially segregated neighborhoods, and vaccine deserts for residents needing transportation assistance.

B. Lack of Digital Access & Difficulties with Online Platforms

State and local governments nationwide rely primarily on online platforms to disseminate crucial public health information about the safety and efficacy of the vaccine; vaccine appointment eligibility and registration; and location of vaccination sites. However, for many Americans nationwide, reliable broadband internet access is a luxury beyond reach—this includes the 32% of Black and 33% of Hispanic New Yorkers without home internet. This digital divide disproportionately impacts the elderly, low-income residents, and those in rural communities. Lack of digital access is also more prevalent in communities of color with over 80% of white Americans owning a computer as compared to just 58% of Black Americans and 57% of Latinx Americans. Even residents who have technology devices and dependable internet access must contend with complex registration processes, multi-step verifications, and numerous platforms as they search for the few available vaccine appointments. New Yorkers have reported extensive difficulties when searching for vaccine information and ultimately securing an appointment. This complicated registration process further limits vaccine accessibility for those who lack digital
proficiency or the time or capacity to review various websites. The digital divide and complicated registration systems should not prevent your constituents from receiving the vaccine. As such, we recommend you take the following steps:

- **Permit all vaccine sign-up and registration, waiting in line, and distribution processes to be completed in-person and by telephone, as well as online and via SMS messaging.**

- **Streamline the registration process by placing details about vaccine appointment availability on a single website.** Centralizing this information will increase user confidence and avoid confusion arising from users navigating multiple websites. Also ensure that vaccination telephone hotlines and in-person registration systems are equally streamlined so that all necessary information can be obtained from a central source. Make all information about the vaccine and vaccination sites available in the most common languages used by your constituents.

- **Implement outreach methods from prior successful public education campaigns, such as the use of mobile sign-up units that travel to residences and frequent high-traffic locations in underserved communities, to ensure vulnerable communities easily receive vaccine and appointment information.** Coordinate with local community-based organizations, religious institutions, elected officials, activists, and other leaders to identify additional reliable methods of broad transmission about vaccine and appointment information with considerations of language proficiency.

C. **Inattention to the Unhoused and Incarcerated Populations**

COVID-19 vaccination plans must prioritize those experiencing housing instability and homelessness. Black people, particularly those who are older or have poor health, are disproportionately represented in unhoused communities, making them even more susceptible to severe COVID-19 infection and death. Communities of color are also more likely to face housing insecurity due to the economic toll of the pandemic. Black and Latinx households are more than twice as likely to report being behind on housing payments than white households. In fact, Black people represent just 21% of all renters, but 35% of all defendants on eviction cases during the pandemic. With a population of nearly 80,000 unhoused individuals, New Yorkers are particularly vulnerable to contracting COVID-19. Although vaccination eligibility now extends to unhoused populations, many unhoused New Yorkers are still vulnerable to COVID-19. Often unhoused individuals have less access to information about the vaccine, as they may not have reliable medical care, access to the internet, or the ability to view public service announcements. Unhoused communities also often rely on congregate settings such as homeless shelters or outdoor communities, where they are in poorly ventilated spaces and are unable to engage in the practices necessary to slow the transmission of the virus, such as social distancing, regular cleaning, and frequent handwashing.

Similarly, vaccination plans must prioritize incarcerated people. COVID-19 outbreaks in carceral facilities have been rampant, with one in five state and federal prisoners testing positive for coronavirus, a rate more than four times greater than the general population. Like those in other congregate settings, individuals in jails, prisons, and detention centers are housed in poorly
ventilated facilities and are unable to socially distance, have limited access to personal protective
equipment and cleaning supplies, and lack adequate health care resources to prevent and treat
COVID-19 infections.\textsuperscript{49} Additionally, the constant movement between carceral facilities and
outside communities by both carceral staff and residents increases the likelihood of community
spread of the virus from carceral facilities to outside communities.\textsuperscript{50} Across New York, increasing
jail populations threaten to exacerbate the spread of COVID-19 both within prisons and jails and
to the broader community.\textsuperscript{51} Given the challenges in protecting incarcerated people from COVID-
19, it is encouraging that New York state guidelines and a court order have included incarcerated
people in vaccination efforts.\textsuperscript{52} We urge you to urgently prioritize incarcerated persons for vaccination to avoid the \textit{shared} increased risk of infection between staff and incarcerated persons,
creating an additional vector for spreading COVID-19 among communities and burdening the
healthcare infrastructure.\textsuperscript{53} Furthermore, it remains unclear whether vaccination of carceral staff
prevents their transmission of COVID-19 to others; therefore, simultaneous vaccination of those
living and working in carceral facilities is necessary to meaningfully reduce transmission rates
both within carceral settings and the surrounding community.\textsuperscript{54}

Housing insecurity and incarceration should not be death sentences. Accordingly, we ask
that you take the following efforts:

- \textbf{Provide targeted information to unhoused and incarcerated populations about vaccine eligibility, safety, efficacy, distribution, and lack of cost} with special consideration of the unique concerns and hesitancies of these populations.

- \textbf{Prioritize the unhoused and incarcerated populations in vaccination plans} given their greater susceptibility to infection within congregate settings and greater risk of serious illness or death given their higher rates of comorbidities.\textsuperscript{55} At a minimum, these populations should be vaccinated simultaneous to staff working with them.

- \textbf{Employ mobile vaccination clinics to reach unhoused communities and individuals}, including those residing outside of shelters and simultaneously offer free and COVID-safe forms of transportation (\textit{e.g.}, designated buses, free taxis, shuttle service) to vaccination sites.

\section*{D. Collection and Publication of Demographic Vaccine Data}

In addition to the above barriers to vaccine equity, there is a nationwide lack of public
vaccine distribution data, disaggregated by key demographics, such as race, ethnicity, age, sex,
disability, English proficiency, and geographic location.\textsuperscript{56} These gaps in data hinder the public
from tracking and evaluating the racial equity of vaccine distribution nationally and within specific
localities. Both New York city and state have maintained publicly available data on COVID-19
infections and the status of vaccination efforts.\textsuperscript{57} We applaud this effort and recommend that you
continue to collect and publish vaccine administration data at the county, city, and state level,
disaggregated by race, ethnicity, age, sex, disability, English proficiency, geographic location,
including residency of those vaccinated, and other relevant demographics. Additionally, New York
city and state publish consistent data on the number of unhoused and incarcerated people who have been vaccinated.
To rectify the stark racial disparities in New York’s vaccine distribution and halt the spread of COVID-19, you must ensure that New York centers racial equity as a key principle in vaccine distribution plans and efforts. Without this critical intervention, your most vulnerable constituents will remain largely unvaccinated and will continue to disproportionately fall ill from the virus or die, creating greater risks of community spread within your entire constituency and further burdening your overstretched healthcare infrastructure. Communities of color have already disproportionately borne the weight of this unprecedented public health crisis. You now have a critical opportunity to reverse this trend by ensuring racial equity in vaccine distribution.

During this unprecedented public health crisis, residents of New York, including residents of color, are looking to you for the bold leadership and swift action that is desperately needed at this time. We thus encourage you to meet this moment by implementing the above recommendations and making clear your firm commitment to racial equity for all. Thank you for your time and consideration, and please do not hesitate to contact Katurah Topps at ktopps@naacpldf.org or Kaydene Grinnell at kgrinnell@naacpldf.org if you have any questions or concerns.

Sincerely,

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CC:

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5 *Demographic Characteristics of People Receiving COVID-19 Vaccinations in the United States*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://covid.cdc.gov/covid-data-tracker/#vaccination-demographic (last visited May 7, 2021) (reporting that Hispanic/Latinx, Black non-Hispanic, and Asian non-Hispanic populations are all being vaccinated at disproportionately lower rates, while the white non-Hispanic population is being vaccinated at higher rates).

6 Id.

7 Id.


11 In addition to the factors listed here, a failure to prioritize vaccination of frontline essential workers and individuals 65 years old and older, as the Center for Disease Control (CDC) recommends, contributes to the racial inequalities in COVID-19 infection and vaccine access. See CDC’s *COVID-19 Vaccine Rollout Recommendations* at, https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations.html and the CDC’s Advisory Committee on Immunization Practices’ *Phased Allocation of COVID-19 Vaccines*, at https://www.cdc.gov/vaccines/aacip/meetings/downloads/slides-2020-12/slides-12-20/02-COVID-Doolling.pdf.


13 Id.

had a significantly higher risk than White residents of having a driving distance greater than 1 mile to the closest potential COVID-19 vaccine administration facility”).

15 Id


17 Id.

18 See BERENBROK ET AL., supra note 14, at 4; see also Mackenzie Bean, Black Americans More Likely to Live in Vaccine Deserts, Pitt Study Finds, BECKER’S HOSP. REV. (Feb. 4, 2021), https://www.beckershospitalreview.com/public-health/black-americans-more-likely-to-live-in-vaccine-deserts-pitt-study-finds.html (“About three-fourths of the counties with disparities in vaccine access also had high COVID-19 infection rates, averaging more than 50 new cases per 100,000 residents between November 2020 and January [2021].”).


24 See e.g., Elise Gould & Valerie Wilson, Black Workers Face Two of the Most Lethal Preexisting Conditions for Coronavirus—Racism and Economic Inequality, ECON. POL’Y INST. (June 1, 2020), https://www.epi.org/publication/black-workers-covid/ (noting that Black workers are more likely to be in frontline essential jobs, forcing them to risk their own and their families’ health to earn a living).


27 For example, setting up mobile vaccination centers at various times and locations most accessible to low-income communities of color, such as within a public housing community, in the evening, to account for working families.


measures recommended for use with various forms of transportation, including mask requirements, social distancing guidelines, and cleaning protocols).

30 For example, some cities provide free curb-to-curb service for individuals with vaccine appointments. See Taylor Moore, If You Can’t Get to Your Vaccine Appointment, These Cities Will Drive You, NEXT CITY (Feb. 17, 2021), https://nextcity.org/daily/entry/if-you-cant-get-to-your-vaccine-appointment-these-cities-will-drive-you.

31 PEW RSCH. CTR., Internet/Broadband Fact Sheet, (Apr. 7, 2021) https://www.pewresearch.org/internet/fact-sheet/internet-broadband/?menuItem=2ab2b0be-6364-4d3a-8db7-ae134dbc05cd (noting that for households earning less than $30,000 per year, only 57% have access to broadband internet access at home while 92% of households earning more than $75,000 per year have broadband internet access at home).


34 Id.


38 See CTRS. FOR DISEASE CONTROL & PREVENTION, INTERIM GUIDANCE ON COVID-19 VACCINATION IMPLEMENTATION, https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/vaccination-guidance.html (last updated Feb. 2, 2021) (“Homeless services are often provided in congregate settings, which could facilitate the spread of infection, including infection caused by the virus that causes COVID-19. Because many people who are homeless are older adults or have underlying medical conditions, they may also be at increased risk for severe illness.”).


42 Id.

43 Emily Lemmerman, Renee Louis, Joe Fish & Peter Hepburn, Preliminary Analysis: Who is being filed against during the pandemic?, EVICTION LAB (Dec. 21, 2020), https://evictionlab.org/pandemic-filing-demographics/.

44 Homelessness is a Shared Experience in the New York Metro Area, THE BOWERY MISSION (Nov. 2020), https://www.bowery.org/homelessness/#:~:text=How%20many%20people%20are%20homeless,or%20in%20other%20public%20spaces..


See Kesha S. Moore, LDF Thurgood Marshall Inst., When an Arrest Becomes a Death Sentence: Overpopulation of U.S. Jails Increases the COVID-19 Threat to Every Community, 3-5, 8 (July 2020), https://tminstitutedf.org/wp-content/uploads/2020/07/LDF_07082020_JailsCOVIDTMIBrief-6-2.pdf (“While the risks of exposure to COVID-19 may be higher within jails, the risks do not remain contained within the jails . . . successfully managing the COVID-19 pandemic [] requires successfully managing it in our prisons and jails”).


Id.; see also MOORE, supra note 50.


See Ndugga et al., supra note 3; Press Release, Pamela S. Karlan, supra note 12 (noting that “[c]omplete, consistent, and accurate data collection and reporting on race, ethnicity, disability, and limited English proficient status are essential to our ability to recognize and address disparities and inequality”).