MINNESOTA DOCTORS FOR HEALTH EQUITY

February 8, 2021

Governor Tim Walz

Lt Governor Peggy Flanagan

Speaker of the Minnesota House Melissa Hortman

Minnesota Senate Majority Leader Paul Gazelka

Minnesota Department of Health Commissioner Jan Malcolm

Minnesota Department of Human Services Commissioner Jodi Harpstead

Minnesota's COVID-19 vaccination strategy needs a heavy dose of racial and health equity. In the wake of emerging evidence about inequities throughout the Phase 1a & 1b rollout, Minnesota's leaders must recognize that our distribution plans and outcomes directly reflect our implicit and explicit valuation of equity.

Efficiency and speed cannot stand as excuses to push equity aside. Our overemphasis on urgency has contributed to colorblind vaccination strategies which reinforce rather than combat the disparate harms of structural racism evident throughout this pandemic.

As Minnesota continues to rapidly develop our vaccine deployment infrastructure, overreliance on existing health systems, employers, and retail pharmacies is likely to contribute further to inequities in access. To progress forward, equity must be emphasized. Deployment infrastructure must prioritize vaccination of marginalized populations, emphasize data transparency with regard to sociodemographic characteristics of vaccine recipients, and promote community-engaged outreach efforts.

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This moment demands ethical, evidence-based, and equitable action. As community organizations and other entities committed to health justice, we stand in solidarity and urge the following action steps:

1. Race, ethnicity, and language data on vaccine recipients must be made publicly available for immediate review.
2. As with Phase 1a, Phase 1b must provide clear, ethical and equitable guidance on who should be sub-prioritized for vaccination, along with resources for distribution best practices that include:
    a. A vaccine distribution framework that directly engages community leaders, utilizing community centers, churches, temples, mosques, shelters, and other trusted areas as distribution sites.
    b. Individuals working in close quarters such as meat packing plants, living in congregate settings, experiencing homelessness, civilly committed, and incarcerated individuals, are at particularly high risk for contracting and spreading COVID-19, disproportionately hail from historically marginalized communities, and should be prioritized in the response.
    c. The threat of penalty for providers that fail to meet the arbitrary threshold of 90% of doses administered at 3 days should be removed and replaced with a measure that captures, and ideally incentivizes, equitable distribution of vaccines according to the state's updated Phase 1b guidance.
    d. Once distribution sites expand in geographic areas hit hardest by COVID-19, members of those communities should be prioritized. Further,the voices of community leaders must be heeded to apply their own need criteria, rather than allowing outsiders, often with greater resources, to plunder a limited supply.

   e. Vaccine distribution phases must recognize that prioritization by age alone exacerbates disparities and misrepresents the disproportionate toll of COVID-19 among Black, Native American, Asian, and Hispanic populations who are younger on average yet face higher risk of exposure and death.
3. The voices of community leaders must be heeded and uplifted to address vaccine hesitancy. This is especially crucial among communities whose trust has been historically and continually violated by the medical community's reliance on structures rooted in racism and neglect.

Distributing vaccines to millions of Minnesotans is no easy task. However, the disproportionate impacts of COVID-19 have been evident since the pandemic's earliest stages. Minnesota has a critical opportunity to lead with equity in our COVID-19 vaccine distribution strategy while renewing our commitment to transparency and accountability in vaccine outreach and data reporting.

Sincerely,

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