



# Toward a Racially Equitable COVID-19 Vaccine Distribution in DC

## A Framework by the Council Office of Racial Equity

*This report examines racial equity in the District's vaccination rates and practices. It was written at the request of Ward 5 Councilmember and Chair Pro Tempore, Kenyan McDuffie.*

**March 2021**

### Introduction

As vaccine data becomes available, it is evident that vaccinations are not equitably reaching District residents by race and location. This report aims to illuminate structural and institutional barriers to having a racially equitable vaccine distribution. This report also recommends best practices the District can take to ensure a racially equitable process exists moving forward.<sup>1</sup> To accomplish this, the report examines best practices from jurisdictions throughout the country, analyzes successful and less successful frameworks, and pulls from available DC Health data.<sup>2</sup>

The start of the District's vaccination process enabled the whitest and wealthiest neighborhoods to have exponential vaccination rates, leaving the rest of the District with low vaccination rates.<sup>3</sup> Since the roll out, demand has outweighed supply. Residents continue to experience long waiting lines and there is confusion about how and where to register. In some instances, distributors find themselves throwing away unused vaccines when they close for the day. It is against this backdrop that this report aims to provide guidance on how the District can proceed forward in a strategic and inclusive way.

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<sup>1</sup> [The Office of the District of Columbia Auditor also released a COVID-19 Special Report](#). Their report focuses on all COVID-19 mitigation policies, their impacts of demographics, and regional mobility in DC. Our report focuses on the vaccine, best practices, and a racially equitable framework.

<sup>2</sup> DC Health's vaccination data is available at [coronavirus.dc.gov/data/vaccination](https://coronavirus.dc.gov/data/vaccination). Data is subject to change daily. For data referenced in this report, the date is referenced.

<sup>3</sup> [DC reports improvements in equitable access to coronavirus vaccine](#); Washington Post.



## The District's Vaccination Trends

DC Health manages the District's vaccination process. The vaccine was first rolled out the week of December 14<sup>th</sup>.<sup>4</sup> It quickly became evident that there were gaps in ensuring an equitable distribution. For context, the COVID-19 vaccine is administered in two doses. For the purposes of this report, individuals that have received both doses will be referred to as *fully vaccinated*.

At the beginning of the vaccination rollout, DC followed a phased approach that prioritized appointments by age, occupation, ward, and zip code. During this time, doses were primarily available for residents age 65 or older and front-line employees working in the District.

As of February 20<sup>th</sup>, the District administered [139,516 COVID-19 doses](#). DC Health also reported that as of February 20<sup>th</sup>, [22,073 residents have been fully vaccinated](#). Given the transient nature of DC, approximately [24,838 non-residents have been fully vaccinated](#).

### **Vaccination doses are not equitably administered by race and ethnicity.**

It has become apparent that vaccinations are not being equitably accessed by all racial groups. The Centers for Disease Control and Prevention report that this is the nationwide trend.<sup>5</sup> Tables one and two illustrate the District's vaccination data by race as of February 20<sup>th</sup>. About 9,611 people who received the vaccine did not report their race.

As of February 20<sup>th</sup>, DC Health reported that for vaccination trends by race, a total of 32,487 people received their first dose of the vaccine. Of this group, about nineteen percent of those vaccines were administered to Black people.

**Table 1. Race of people that received at least one vaccination dose, as of February 20<sup>th</sup>**

RACE	RECIPIENTS OF AT LEAST ONE DOSE	ESTIMATED PERCENT OF RECIPIENTS*
Black	10,165	19%
White	14,486	27%
Other	20,297	37%
Race not reported	9,611	18%

\*rounded to the nearest percentage point; percentage out of 54,559 residents that received at least one dose. Races reported in the table above are based on based on [DC Health's data](#) as of February 20<sup>th</sup>, which is not disaggregated for Asian, Native American, and Pacific Islander residents. It also is not disaggregated for residents that are more than one race.

<sup>4</sup> The COVID-19 vaccine is administered in two doses. For the purposes of this report, individuals that have received both doses will be referred to as fully vaccinated.

<sup>5</sup> [Demographic Characteristics of Persons Vaccinated During the First Month of the COVID-19 Vaccination Program](#); CDC.

This trend continues for vaccination rates by ethnicity. It is important to note that about 24,448 people that received the vaccine did not report their ethnicity. Table 2 shows that only about three percent of vaccines were administered to Hispanic or Latinx people as of February 20<sup>th</sup>.

**Table 2. Ethnicity of people that received at least one vaccination dose, as of February 20<sup>th</sup>**

ETHNICITY	RECIPIENTS OF AT LEAST ONE DOSE	ESTIMATED PERCENT OF RECIPIENTS*
Hispanic	1,789	3%
Non-Hispanic	23,322	43%
Ethnicity not reported	29,448	54%

\*rounded to the nearest percentage point; percentage out of 54,559 residents that received at least one dose. Ethnicities reported are based on [DC Health's data](#) as of February 20<sup>th</sup>, which is not disaggregated for Indigenous populations.

### **Vaccination doses are not equitably administered across wards.**

In relation to ward, the trend of inequity continues. Out of the 30,545 residents that received their first vaccination dose, Ward 3 makes up twenty-five percent of first dose vaccinations as of February 14<sup>th</sup>. DC Health reported that this covers [about fifty percent of Ward 3 residents age 65 years or older](#).<sup>6</sup> On the other end, Ward 8 makes up just 5 percent of first dose vaccinations as of February 14<sup>th</sup>. DC Health reported that this covers [about twenty-one percent of Ward 8 residents age 65 or older](#).<sup>7</sup>

**Table 3. First vaccination doses of residents age 65 or older, as of February 14<sup>th</sup>**

WARD	RECIPIENTS OF AT LEAST ONE DOSE (65 OR OLDER)	ESTIMATED PERCENT OF RECIPIENTS*
1	2,632	9%
2	3,510	11%
3	7,511	25%
4	5,484	18%
5	3,518	12%
6	3,697	12%
7	2,543	8%
8	1,650	5%

\*rounded to the nearest percentage point; percentage out of 30,545 residents

<sup>6</sup> This coverage data was provided by DC Health as of February 14<sup>th</sup>. Table 3 does not include coverage data. Instead, it includes percentages based on residents that received a first vaccination dose as of February 14<sup>th</sup>. As of February 27, 2021, the DC Health website no longer shows first dose vaccination coverage by Ward (though it was previously reported in early February).

<sup>7</sup> Ibid.

Out of the 16,310 residents that are fully vaccinated, Ward 3 makes up twenty-three percent. That covers [just over four percent of Ward 3 residents](#). Ward 8 makes up five percent of fully vaccinated residents, [covering less than one percent of Ward 8 residents](#).

**Table 4. Fully vaccinated residents, as of February 14th**

WARD	FULLY VACCINATED RESIDENTS	ESTIMATED PERCENTAGE OF VACCINATED RESIDENTS*
1	2,111	13%
2	2,436	15%
3	3,669	23%
4	2,142	13%
5	1,830	11%
6	2,316	14%
7	1,007	6%
8	799	5%

\*rounded to the nearest percentage point; percentage out of 16,310 fully vaccinated residents

## Barriers to Equitable Vaccination Rates

So, what explains these inequities? Through various roundtables held by the Committee on Health, District community members have testified about the barriers they observe and face in the COVID-19 vaccination process. This information can help to highlight opportunities for the District to revisit its approach.<sup>8</sup>

Based on the testimony provided during the hearing and some common themes revealed, there are at least four primary barriers to racially equitable vaccination process. They include:

1. Availability of vaccines;
2. The registration processes;
3. Access to vaccination sites; and
4. Policy barriers.

While the District has demanded a higher allocation of vaccines, several barriers continue to persist.<sup>9</sup>

<sup>8</sup> See Committee on Health Public Oversight Roundtable on “[The District’s COVID-19 Vaccination Process](#),” Monday, February 1, 2021, chaired by Councilmember Vincent C. Gray.

<sup>9</sup> [Coronavirus Vaccination Appointments Canceled in DC Region as Health Officials Confront Scarce Supply](#); Washington Post.

## **The District continues to face a limited supply of vaccines.**

DC's unique relationship with Maryland and Virginia increased the gap between vaccine supply and demand. The federal government provided DC vaccines but failed to consider that DC's resident population did not include essential workers that commute into the District. Because of this, a majority of essential workers who received the first shots were not DC residents.<sup>10</sup> To help, Maryland and Virginia gave DC doses to vaccinate essential workers and DC has requested more vaccines since the roll out.<sup>11</sup> The limited supply emphasizes the need for a racially equitable vaccination process.

## **Residents struggle to register for a vaccination appointment.**

There are several registration paths for residents interested in the COVID-19 vaccine. Most appointment slots are scheduled through a hospital, healthcare center, or the [DC registration portal](#). DC Health reserves vaccination slots via phone and the portal. Offering two methods to reserve a vaccination slot gives residents the opportunity to pick the method most accessible to them. However, this also perpetuates disparities because it requires time to wait in long phone queues and internet access. Nationally, white households are more likely to have internet access.<sup>12</sup>

Long wait times on the phone and burdensome online registration forms have caused residents to struggle with the existing system. Residents register for an appointment and often find that there are no appointments by the time they finish the registration form. If they want to try to get an appointment again, they have to restart the process and fill out the same registration form to attempt to get an appointment. While some residents have help to navigate the registration process, that is not the case for all residents. The current process may exclude those that do not have access to the online portal, along with those that have a limited amount of time to stay in a queue on the phone.

## **Vaccination sites are not equitably distributed throughout the District.**

As mentioned earlier, the District has a variety of locations to administer the vaccine. The number of vaccination locations varies week by week. Vaccinations are typically available at [major hospitals](#), [health centers](#), grocery stores, and retail pharmacies. Considering these possible locations, there are forty-five estimated vaccination sites, excluding mobile clinics and pop-up events. Out of those forty-five estimated vaccination sites, about nine are in Wards 7 and 8, [despite the high number of lives lost in these Wards](#).<sup>13</sup>

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<sup>10</sup> [Nearly Half of DC's Vaccine Doses Have Gone to Non-Residents](#); NBC Washington.

<sup>11</sup> [Mayor Defends DC's Vaccine Allocation Process While Calling for More Doses](#); NBC Washington.

<sup>12</sup> [Smartphones Help Black People and Hispanics Close Digital Gap with White People](#); Pew Research.

<sup>13</sup> [Vaccination Appointment Guide](#); DC Health.

Even further, hospitals and healthcare centers are encouraged to prioritize serving existing patients. While healthcare centers focus their services on vulnerable residents, hospitals do not necessarily reach the District's most vulnerable residents. For hospitals, prioritizing vaccine registration based on an existing relationship may help those being treated for chronic conditions. However, this plan also perpetuates geographic and economic disparities by inherently deprioritizing those who may not have an existing relationship with a hospital for various reasons, including health insurance or other economic resources to regularly visit hospitals for care.

### **DC pharmacies are facing policy barriers.**

As the Biden administration addresses the COVID-19 vaccination guidelines through its new Federal Pharmacy Program, most states have seen an increase of vaccines sent directly to pharmacy stores.<sup>14</sup> Despite DC Health pleading for more vaccines, the District has unfortunately been excluded from the push of vaccines directly to pharmacies as of the week of February 8<sup>th</sup>.<sup>15</sup>

Another layer to this policy barrier is that independent pharmacies, which tend to be deeply connected with the communities they serve,<sup>16</sup> are not currently listed under the new Federal Pharmacy Program. This is shocking considering that independent pharmacies have excelled at COVID-19 vaccine distribution.<sup>17</sup> While independent pharmacies can register to provide the vaccination, the current program guidelines might exclude them for getting vaccines directly based on the program's specifications as of February 12<sup>th</sup>.<sup>18</sup>

These layers also intertwine with a third policy barrier – the provider status of pharmacists in the District. The states that are leading in vaccine distribution, such as West Virginia, New Mexico, and California have also granted pharmacists provider status. This status allows pharmacists to have the availability to provide services such as vaccination and to be reimbursed for their time. Given that independent pharmacies may not have the same level of support as a pharmacy that is a part of a large chain such as Giant,<sup>19</sup> this status could further incentivize independent pharmacies to seek out participation in the original COVID-19 vaccination process.

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<sup>14</sup> [Pharmacies Participating in the Federal Retail Pharmacy Program for COVID-19 Vaccination](#); CDC.

<sup>15</sup> [Vaccines at Pharmacies; Where Can I Get a COVID Vaccine](#); WUSA9.

<sup>16</sup> District of Columbia Citywide Rx Coalition; Howard University School of Pharmacy.

<sup>17</sup> [Small Pharmacies Beat Big Chains at Delivering Vaccines](#); Washington Post.

<sup>18</sup> [Pharmacies Participating in the Federal Retail Pharmacy Program for COVID-19 Vaccination](#); CDC.

<sup>19</sup> Giant is a part of [Retail Business Services, LLC](#). As of early February, Retail Business Services, LLC was the only pharmacy organization listed on the [Federal Retail Pharmacy Program](#) as a potential provider of the additional vaccine allotment for DC.

## **Mistrust towards medical institutions compounds on structural barriers in Black and Brown communities.**

While communities of color do have reason to mistrust medical institutions, this mistrust does not explain the structural barriers responsible for low vaccination rates in Black and Brown communities. However, understanding this history paints an important picture. Scientific racism in the US has targeted communities of color since the inception of this country. Experiments targeted Black, Puerto Rican and Japanese Americans for generations.

In 2018, the Agency for Healthcare Research and Quality found that forty percent of their health quality measures were worse for Black people than whites.<sup>20</sup> This finding, paired with the nation's long history of medical racism, adds to the existing barriers to vaccination access for people of color nationwide.<sup>21</sup> While access to vaccination registration, sites, and other barriers are important, we must recognize the historical context of these racial inequities.

## **The Tuskegee experiments did not seek informed consent and withheld treatment from Black men.**

One of the most recognizable cases of scientific racism in America, is the Tuskegee syphilis experiment. Beginning around 1932, the United States Public Health Service began non-therapeutic experimentation on Black men infected with syphilis. The experiments targeted poor sharecroppers in the small-rural town of Tuskegee, Alabama. For over forty years, medical doctors and researchers studied the evolution of untreated syphilis in Black men under the direction of the Federal government. They ended with a lawsuit filed against the US government.

According to legal counsel and civil rights activist Fred Gray, “More than half of the 623 men had syphilis; the others, a control group, did not.”<sup>22</sup> What resulted became one of the most egregious examples of racial injustice in American history. The study was done without informed consent, effective treatment was knowingly and systematically withheld, and the experiments lasted well after penicillin had been discovered as a proven treatment.<sup>23</sup> Although legislative and regulatory reforms were put in place, the damage, trauma and harm experienced by the Black community cannot be quantified.<sup>24</sup>

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<sup>20</sup> [2018 Annual Report](#); Agency for Healthcare Research and Quality.

<sup>21</sup> [Why Some Black and Latinx People Are Reluctant to Get the COVID-19 Vaccine](#); Healthline.

<sup>22</sup> [The Tuskegee Syphilis Study: An Insider's Account of the Shocking Medical Experiment Conducted by Government Doctors Against African American Men](#); New South Books.

<sup>23</sup> [Bad Blood: The Tuskegee Syphilis Experiment](#); Free Press.

<sup>24</sup> Ibid. *The Tuskegee Syphilis Study*.

## **The eugenics movement propelled forced sterilization of low income, Black, and Brown populations.**

The US eugenics movement began in California and became popular in the early 1900s.<sup>25</sup> Around this time, Charles Davenport created the Eugenics Record Office (ERO).<sup>26</sup> Serving as the starting point for Hitler's regime, the US eugenics movement focused on maintaining the "purity of the white race."<sup>27</sup> The guiding principles of the movement were put into US legislation, which led to the forced sterilization of thousands of Americans.<sup>28</sup>

## **The secret Puerto Rico birth control pill trials led to deaths and negative health effects.**

Following the Spanish American War of 1898, US imperialism gave way to American racism and exceptionalism.<sup>29</sup> This laid the groundwork for medical racism in Puerto Rico, which continued into the 1950s with the Puerto Rico Birth Control Trials. Puerto Rican women were a part of birth control trials without their informed consent.<sup>30</sup> Women in the poorest areas of San Juan were targeted to participate.<sup>31</sup> According to researchers, three women died during the trials, but their deaths were not investigated further.<sup>32</sup> Women who took the drug knew that it prevented pregnancy but were not given safety information about the product. Several women experienced serious side effects such as blood clots and nausea. This instance reflects how medical racism was used to control women's bodies, particularly through legislating control over their sexuality and reproduction.<sup>33</sup>

## **Henrietta Lacks' regenerating cells have been used in research for decades—without her permission or compensation.**

The painful pattern of medical research without consent continued with Henrietta Lacks, a Black mother who lived in the United States in the 1900s.<sup>34</sup> Lacks' cells were taken as part of a biopsy—and then used for countless medical experiments around the world without her permission.<sup>35</sup> After she died in 1951, her family was not asked—or told—either.<sup>36</sup> All the while, Lacks' cells were used to develop vaccines, power research, and create profit.<sup>37</sup> Her family was involved in decision-making about the use of her cells only recently.<sup>38</sup>

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<sup>25</sup> [The Horrifying American Roots of Nazi Eugenics](#); The History News Network.

<sup>26</sup> [Human Testing, the Eugenics Movement, and IRBs](#); Nature Education.

<sup>27</sup> Ibid. *The Horrifying American Roots of Nazi Eugenics*.

<sup>28</sup> Ibid. *Human Testing, the Eugenics Movement, and IRBs*; for further background, also see [ICE is accused of sterilizing detainees that echoes the U.S.'s long history of forced sterilization](#); The Washington Post.

<sup>29</sup> *Reproducing Empire: Race, Sex, Science, and US Imperialism in Puerto Rico*; University of California Press, page 15.

<sup>30</sup> [The First Birth Control Pill Used Puerto Rican Women as Guinea Pigs](#); History.

<sup>31</sup> Ibid.

<sup>32</sup> Ibid.

<sup>33</sup> *Forging Diaspora: Afro-Cubans and African American In a World of Empire and Jim Crow*; University of North Carolina Press.

<sup>34</sup> [NIH finally makes good with Henrietta Lacks' family -- and it's about time, ethicist says](#); NBC News.

<sup>35</sup> Ibid.

<sup>36</sup> Ibid.

<sup>37</sup> Ibid.

<sup>38</sup> [Deal done over HeLa cell line](#); Nature.

## **DC Health’s program begins to address the history of unethical medical trials.**

To begin to address these concerns, DC Health launched the [Faith in the Vaccine](#) program, which includes the Pennsylvania Avenue Baptist Church as a new vaccination site. There are also pop-up events and mobile clinics to vaccinate residents and front-line employees that do not live in DC. Lastly, the District holds vaccination clinics at DC Housing Authority locations, further pushing the District to embrace a community-based approach.

While DC Health’s new program is a step in the right direction, perhaps there are other innovative approaches the District can take to intentionally disrupt the inequitable rollout. To gain a better sense of the possibilities, the following section outlines successes in jurisdictions across the country.

## **Proven Frameworks and Other Vaccination Approaches**

At the beginning of the COVID-19 vaccine rollout, many jurisdictions opted to follow the CDC’s federal guidelines for distribution and administration. These guidelines allowed jurisdictions to decide on who should be vaccinated first and how residents can receive vaccines.<sup>39</sup> Since the rollout began, there have been several examples of successful frameworks and practices throughout the nation.

### **Successful frameworks focus on communities that are constantly mistreated by health care institutions and policies.**

Cities such as Portland, Oregon and San Antonio, Texas<sup>40</sup> have made great progress addressing racial inequities exacerbated by COVID-19. Both cities have implemented rapid response<sup>41</sup> and recovery toolkits<sup>42</sup> to guide those responsible for crisis response work. Their resources highlight how Black and Brown communities are mistreated and disadvantaged by health care policies and institutions. They also recognize that these communities are hesitant to get vaccinations due to historical events such as the Tuskegee Trials.<sup>43</sup> Lastly, they emphasize that policy leaders have a responsibility to commit to a recovery that especially benefits communities of color and those living in or near the poverty line.<sup>44</sup>

Several states are leading the nation in vaccination rates and successful distribution practices. Many of these jurisdictions have also created successful and comprehensive frameworks. A common practice among these states is the activation of non-federal channels for vaccine administration, such as independent and local pharmacies, volunteers, and retail locations.

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<sup>39</sup> [COVID-19 Vaccine Rollout Recommendations](#); CDC.

<sup>40</sup> [Office of Equity](#); City of San Antonio.

<sup>41</sup> [COVID-19 Equity Framework and Rapid Response Tool](#); City of San Antonio.

<sup>42</sup> [Equity Toolkit for COVID-19 Community Relief and Recovery Efforts](#); City of Portland.

<sup>43</sup> See [Tuskegee Experiment: The Infamous Syphilis Study](#); History.

<sup>44</sup> In DC, twenty-six percent of Black residents and twenty-three percent of persons of color live below the poverty line.

## **West Virginia focuses on community relationships with local pharmacists.**

[West Virginia](#) decided to utilize 250 local pharmacies [instead of the federal distribution program](#). This approach emphasizes the roles and relationships that neighborhood pharmacists have with residents. When residents get vaccinated, they are already comfortable with the pharmacist. In this model, the pharmacists pick up their vaccines or the national guard delivers materials to participating pharmacies.<sup>45</sup>

## **Connecticut partners with pharmacies to administer leftover vaccines.**

Similar to the District, [Connecticut](#) has targeted long term care facilities for the first phase of vaccinations. As of January 31<sup>st</sup>, Connecticut's long-term care facilities have vaccinated between ninety to one hundred percent of residents. As a result, Connecticut has seen COVID-19 infection rates decrease for long term care facilities. When there is an excess left over from the vaccine allocations for nursing homes, Connecticut partners with Walgreens, CVS, hospitals and retail stores to administer the vaccine to other residents.

## **Maryland uses the Medical Reserve Corps and mass vaccination sites.**

Maryland's distribution plan emphasizes a community-focused approach by allowing its Medical Reserve Corps volunteers to administer the vaccine.<sup>46</sup> The [Medical Reserve Corps](#) (MRC) is a national volunteer network that focuses on community-based response to public health needs, including natural disasters and disease outbreaks. Maryland is one of a handful of states that has expanded the scope of their MRC to include vaccine administration, along with Virginia.<sup>47</sup> In addition to the MRC, Maryland is also offering mass vaccination sites at the Baltimore Convention Center, Six Flags America in Prince George's County, and the M&T Bank Stadium.

## **North Dakota expanded its guidelines, educates providers, and stores vaccines in a state warehouse.**

North Dakota departed from federal guidelines for vaccination phase two, to now include people age 65 and older, adults with at least two high-risk conditions, and front-line workers in schools or childcare.<sup>48</sup> The state also has a provider education partnership with the North Dakota State University Center for Immunization Research and Education.<sup>49</sup> The partnership allows the university to hold weekly office hours and manage a COVID-19 vaccine email inbox where providers can ask questions about the vaccine.

North Dakota also operates a state warehouse to store and handle its COVID-19 vaccines. The warehouse allows them to break down COVID-19 vaccine shipments into smaller quantities to get vaccines to rural areas of the state, where many healthcare providers are located.

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<sup>45</sup> [West Virginia Leads in COVID-19 Vaccination Distribution With Local Strategy](#); NBC Washington.

<sup>46</sup> [Governor Hogan Announces Expansion of COVID-19 Vaccine Eligibility for Marylanders 65 and Over](#); The Office of Governor Larry Hogan.

<sup>47</sup> [Virginia Medical Reserve Corps Recruiting Volunteers for Vaccine Distribution](#); WJLA.

<sup>48</sup> [The COVID-19 "Vaccination Line": An Update on State Prioritization Plans](#); Kaiser Family Foundation.

<sup>49</sup> [Most Successful Vaccine Rollouts in US: 4 State Strategies](#); Becker's Hospital Review.

## **A racially equitable COVID-19 response involves the community in strategic planning.**

A racially equitable COVID-19 response requires rethinking traditional approaches to solving social and economic problems. An equitable framework begins with collaborative strategic planning. This planning must involve both the executive and legislative branches, amplify the voices of community stakeholders, and involve the District's most marginalized communities. An equitable framework:

1. Centers racial equity;
2. Puts people first;
3. Invests in community infrastructure;
4. Builds an equitable economy; and
5. Protects and expands community voice and power.

An important requirement to an equitable COVID-19 response is to ensure that marginalized community members are given meaningful opportunities to engage in budget and policymaking processes.<sup>50</sup> When community members are directly involved in decision making, more inclusive choices are made. Greater accountability ensures resources reach those who need them the most.<sup>51</sup>

An equitable framework to addressing the COVID-19 emergency does not wait for crisis to hit in order to involve community leaders in policy making. Instead, an equitable framework is one that already invests in building robust platforms for community participation before crisis hits.<sup>52</sup> Cities that have invested in community engagement and explicit racial equity work prior to the COVID-19 pandemic, have found it easier to repurpose existing community tables to solicit feedback on COVID-19 response and recovery plans.<sup>53</sup>

If community members, including Black and Brown residents, local pharmacists, local health clinics, ANCs, civic associations, and community-based organizations, were given an opportunity to engage in decision-making processes, many of the challenges now facing communities due to COVID-19 would have been properly prepared for. Specifically, protecting people living in institutional settings or other facilities, such as jails and prisons, mental health-care facilities, and homeless shelters, where an outbreak can spread rapidly has been a key challenge in most cities.<sup>54</sup> Therefore, it is important that State and local governments be well-positioned to support residents and partner with communities to ensure the 90,000 people who are economically insecure in the District emerge from this crisis stronger.

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<sup>50</sup> [Inclusive Processes to Advance Racial Equity in Housing Recovery: A Guide for Cities during the Covid-19 Pandemic](#); PolicyLink.

<sup>51</sup> Ibid.

<sup>52</sup> Ibid.

<sup>53</sup> COVID-19 & Race Principles for a Common-Sense, Street-Smart Recovery: Complete Set; Policy Link.

<sup>54</sup> Ibid.

## Looking Ahead

The District requires an equitable approach to vaccine distribution, appointments, policies, and community awareness. The existing barriers to a racially equitable distribution stem from system processes that fail to prioritize a racially equitable and resident-centered approach. While this report highlights disparities in vaccination rates to date, it also leaves us with questions:

- What are the vaccination rates for Asian, Native American, and Pacific Islander residents, along with residents that are more than one race in the District?
- How many people attempt to make an appointment and give up during the registration process?
- How many are traveling to vaccination sites outside of their ward of residence to get a vaccine? For those traveling, how far are they going and why?
- How many vaccination appointments are missed in a day? How many of those reserved vaccines are distributed to nearby residents and how many are simply disposed of?
- How are different providers tracking vaccination data? Are they being provided with standard guidance?

Answering these questions requires detailed data from the registration platform, which is currently not available to the public. That data could help the District better understand how each layer of the COVID-19 vaccine distribution contributes to the disparities we see today. If the current vaccination trends continue, racial and ethnic disparities will widen as the District continues into each phase of recovery.

While this report is focused on COVID-19 vaccination in the District, the public health pandemic is interacting with racial equity in other ways as well. To ensure we are responding in a proactive and racially equitable way, the Council should continue to apply a racial equity lens in reviewing how COVID-19 impacts cost-burdened renter households, minority-owned businesses, education, childcare, real estate, employment, behavioral health, and income inequality.<sup>55</sup>

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<sup>55</sup> This is the first of two reports to be created by the DC Council Office of Racial Equity (CORE). CORE will build out this report to focus on a racially equitable economic recovery in the District.