Beyond the COVID-19 Emergency

Sustaining and Expanding Vaccine Equity

20 Recommendations from Public Health and Equity Leaders

Supported by

The Rockefeller Foundation

School of Public Health
BROWN UNIVERSITY

Equity-First
Vaccination Initiative

Beyond the COVID-19 Emergency

Sustaining and Expanding Vaccine Equity

Executive Summary

Mistakes plagued the response to the Covid-19 pandemic. But among the successes were programs that improved vaccine uptake, disease prevention and treatment follow-through in communities of color and among low-wage Americans.

In recent months, these gains have slipped, and the hard-won equity lessons of Covid-19 risk being forgotten or ignored. This statement is intended to reaffirm these real-world teachings and urge the United States to maintain effective community-based programs and safeguard vital progress for its most vulnerable and marginalized citizens.

At a Glance: 20 Action-Steps to Ensuring Vaccine Equity

Community Leadership

1. Engage diverse community representatives in policy making and rollout
2. Ensure community members are leaders and designers at all points of initiatives

Trust Building

3. Build a collaborative communications infrastructure
4. Build misinformation resilience with trusted messengers and trusted community organizations at the center

Access

5. Bring vaccines to wherever people are and work with existing community infrastructure
6. Unlock funding and other support
7. Designate community workers as “essential workers”
8. Build for the long term

Capacity Building

9. Invest in communities and CBOs for sustained engagement
10. Build, sustain, and entrench public health capacity over the long term
11. Combine support for evaluation of community work with trust

Data Availability

12. Support equity-centered data collection
13. Publish and share public health data
14. Fund data infrastructure modernization for health settings at the federal, state and local levels
15. Ensure timely and high-quality data is accessible to various stakeholders across the health system, including community members

Effective Governance

16. Activate diverse funding streams tailored to the needs of community-based organizations
17. Co-creating with community organizations also means understanding their funding needs
18. Advocate for political leaders to highlight needs of vulnerable groups

Healthcare, Public Health and Community Readiness

19. Clinical research and trials must reach communities of color
20. Leverage trusted health workers

Introduction

Across the nation, federal, state and county government agencies are moving Covid-19 management and treatment into the U.S. healthcare system as part of their transition from pandemic response to recovery. The national Covid-19 Public Health Emergency (PHE) will end in 2023, and so will key drivers of more equitable outcomes that were enabled by the PHE and other emergency measures, such as free vaccinations, free tests and free therapeutics.

As people in underserved communities often can not afford or access the nation's healthcare delivery system, there are essential equity challenges to address in this transition phase:

- The significant progress that has been made over the past 18 months in closing vaccination gaps and improving Covid-19 outcomes for people of color must be sustained and become part of the new normal.

- The lessons learned from achieving Covid-19 vaccine equity must be applied to improve vaccine and health equity more broadly and save lives in America's most vulnerable communities.

Already, funding and other resources and efforts are dwindling as new gaps in Covid-19 booster vaccination rates are emerging. Experts are anticipating a spillover of anti-vaccine sentiments and activism to future, non-Covid pediatric and adult immunization initiatives.

Failing to protect communities of color and low-wage Americans at this critical moment risks undoing the groundbreaking progress that has been made in reducing Covid-19 vaccination and treatment gaps for these populations.

It is no longer a question of if these efforts can be effective, but a question of if there is a true commitment to sustaining and expanding evidence-based equity initiatives that save lives.

ILLUSTRATION BY PAWEL MILDNER

In this statement, members of the Rockefeller Foundation's **Equity Advisory Council** – a group of 13 public health and equity experts representing diverse communities – call on government authorities and Congress to make available the funding, technical expertise and political support required to make the recent progress on vaccine equity a permanent feature of the new normal.

The Council provides 20 evidence-based recommendations that grew out of the basic understanding that vaccine equity starts at the community level, and that efforts to build vaccine confidence and demand need to be prioritized as much as efforts to create vaccine supply. To do this, federal, state and local governments need to invest in communities and CBOs for sustained engagement, ensure community leaders are included as leaders and designers in initiatives, support equity-centered data collection, and build communications teams that include community leaders who can consistently adapt messages to meet local cultures and needs. Federal officials also need to do a better job of acknowledging uncertainty, telling stories, and using visuals.

The Council's recommendations, alongside other in-depth readouts from the Rockefeller Foundation's Equity-First Vaccination Initiative, serve as a roadmap for how to consistently build vaccine and health equity into public health,

healthcare and civic society responses broadly – and why we must do so.

About the Equity Advisory Council

The recommendations in this statement are based on 15 months of work by the Rockefeller Foundation's Equity Advisory Council, a group of 13 public health and equity experts representing diverse communities. The Foundation convened the group to assess the state of vaccine equity at each pandemic moment, and inform the Foundation's grantmaking during its Equity-First Vaccination Initiative (EVI). Combining data, community knowledge, and learnings from the EVI, the Council gained a nuanced understanding of how complex, systemic drivers of inequity played out in vaccination efforts – and where and how community leadership was able to break the cycles of inequity.

>>SEE PAGE 13 FOR A FULL LIST OF COUNCIL MEMBERS

About the Equity-First Vaccination Initiative

Launched in spring 2021 to demonstrate and scale hyper-local, community-led programs, the $20 million Equity-First Vaccination Initiative brought resources, technical support and programmatic autonomy to over 90 community-based organizations across five U.S. cities. Over the course of one year, EVI community partners were able to make nearly 15 million connections with members of vulnerable communities to provide accurate, engaging information about vaccines, deliver assistance to get vaccinated over 150,000 times, and vaccinate over 60,000 people at community events, bringing the protection of vaccines to some of the hardest to reach Americans.

About the progress made on Covid-19 vaccine equity

Investments by federal, state and local governments as well as philanthropic organizations supporting efforts such as the EVI, the Made To Save coalition and similar work carried out by thousands of community leaders across the country led to a significant shift in Covid outcomes for communities of color: By early 2022, vaccine confidence had increased in people of color, and by summer 2022, more than 18 months after the start of the U.S. vaccine rollout, primary series vaccination gaps were finally closing for Hispanic, Black, Native Alaskan and American Indian communities. In turn, hospitalization and death rates for these populations began to no longer be so disproportionately high.

The Recommendations: 20 Steps to Achieving Vaccine Equity

COMMUNITY LEADERSHIP

Building and maintaining infrastructure and mechanisms that allow true community leadership and participation is a core component of an equitable crisis response. The U.S. is a diverse society in which power is not shared equally, and top-down crisis response efforts have failed to reach all Americans equally, and instead contributed to damaging disparities that shape the lived experiences of millions.

Engage diverse community representatives in policy making and rollout

When policy shifts are made and rolled out with representatives of diverse communities at the table, they are more likely to succeed. During the course of the pandemic, Federal authorities often made policy decisions and announcements with little to no warning to state and local leaders. As a result, some policies led to inequitable outcomes (e.g. not offering child care or sick day support for those who experience side effects from the vaccine which disproportionately impacts low-wage workers who can't afford to take time off). Top-down policy making also resulted in mixed messaging, confusion, and delays in implementing policy and public health guidelines.

Partnering with community members, early, consistently and improving communication and coordination between federal, state, local and community leaders ensures a policy making process that is both timely, actionable and equitable. It allows state, local and community leaders to request assistance and clarification as needed – prior to policy changes being announced – and to become partners in implementing and communicating new policies and practices well.

Ensure community members are leaders and designers at all points of initiatives

Rather than asking for community participation in externally defined crisis response efforts, state and local authorities and funders must focus on amplifying, supporting, and leveraging emerging and existing community-led strategies.

This goes beyond the typical model of working with communities, which usually includes consultation of community members and local organizations to obtain knowledge and experience while interventions are ultimately led by authorities, external groups or funders. Community members need to be established, empowered, and trusted to act as leaders and designers in initiatives.

The EVI tested this model with great success, letting community partners drive all aspects of the work. Community-based organizations (CBOs) are the most knowledgeable about how to support their communities and address ongoing challenges and opportunities. They know what it looks like to be in solidarity with community members and work toward a shared goal. They have a deep knowledge of people's assets, concerns, questions, challenges and how to meaningfully engage them with a cultural lens. The full inclusion of people with direct lived experience strengthens trust and improves access and investments.

COMMUNICATIONS AND TRUST

Build a collaborative communications infrastructure

Clear, culturally relevant, accessible and timely communication is key to equity. Too often throughout the pandemic, crucial messages did not reach the most marginalized populations, for example because they were delivered by messengers or voices unknown or disconnected from the community, disseminated in spaces and on platforms that weren't popular, or were pre-empted by well produced misinformation and disinformation targeting communities of color. Communications from authorities and agencies were often inaccessible, confusing, too technical, and/or politicized.

While the communications challenges are of national and global proportions, effective solutions are often local. Community leaders, as trusted

messengers, know how to reach and listen to their community members, how to meaningfully engage (rather than simply instruct) in vaccination information with people and what drives change locally.

Funders, public health authorities and policy makers need to invest in building infrastructure and models for creating partnerships with community members and leaders to work collaboratively on clear communications strategies and outputs. They need to invest in equitable access to quality and timely information, and allow local leaders to own and target messages and approaches as they see fit.

The EVI program highlighted that "trust is the single most important determinant of attitudes towards vaccination - trust in the vaccine itself, trust in the system developing and delivering the shot, trust in those sharing information about the vaccine – but also, trust in government and institutions, trust in local leaders and community, trust in healthcare, and trust in each other."

Community leaders and organizations are key to building trust.

Build misinformation resilience with trusted messengers and trusted community organizations at the center

Mis- and disinformation thrive in the absence of accessible information and of trusted messengers. Mis- and disinformation resilience requires the presence of both of these.

Community organizations are able to cut through the noise of a chaotic information ecosystem by crafting messaging and community touchpoints based on a deep understanding of the lived experiences that align with the values, priorities and realities of their communities. By providing unconditional support and assistance, organizations build and maintain meaningful relationships with community members, signaling their trustworthiness and proving themselves as sources for reliable and relatable information.

Empowering trusted messengers and community leaders is particularly important to effective communications in communities of color and systematically oppressed populations. The scientific and health communities need to work closely with trusted messengers in these communities to provide insights about the latest scientific evidence, and engage in community-based research to document effective communications practices. Then, by ensuring CBOs are well invested, and have the funds, technical capacity and staff, they can tailor communications about new scientific developments, policies and interventions to truly engage their audiences.

As highlighted by the EVI program, "trusted messengers" can be found everywhere: the individuals or organizations that people rely on for information about their health may not be "official" or an "expert". For example, in some communities members of the clergy have become key trusted messengers during the pandemic. Public health organizations should not necessarily require formal expertise and should widen the circle of who they view as a trusted messenger, while providing the tools and resources for messengers to be knowledgeable communicators to their neighbors, transferring power and voice to individuals who, as one community member phrased it, "speak from the heart and with authority".

CBOs and organizations like the Indian Health Service (IHS) used communication strategies that harnessed the power of community relationships and aligned with their values. For example, many American Indian/Alaskan Native communities decided to first vaccinate members who are central to their ways of life, such as tribal elders, council members, knowledge keepers, Indigenous-language speakers, and tribal health providers. Vaccinated elders became role models and the community-oriented strategy built trust for tribal members.

ACCESS

Bring vaccines to wherever people are and work with existing community infrastructure

Equitable access to vaccines means bringing vaccines to wherever people are. A hands-off, market-driven approach to vaccination distribution has shown to reinforce and recreate the structures of inequity. Making vaccinations, tests, and

therapeutics available predominantly through existing structures has highlighted the barriers inherent in distribution systems and strategies overall. For example, pharmacy deserts and hospital closures disproportionately affect rural and poor communities and thus limit access for people in those communities. Similarly, prior negative experiences with healthcare (e.g. surprise billing, medical debt, physician bias) can make even a nearby vaccination site inaccessible.

Community-led efforts that meet people in the places where they live their day to day lives and in spaces where community comes together and residents feel connected have shown to be most effective in overcoming access challenges and minimizing the hidden costs. This can include providing vaccinations after a Sunday church service or employers providing paid time off for vaccination appointments for employees and their families.

Accordingly, vulnerable people can also be reached where they already receive care and social services. Vaccination programs are often established in isolation, without considering synergies with effective, pre-existing programs such as substance use programs and those providing care to LGBTQIA+ individuals. Indeed, many HIV services and community clinics were shuttered during the pandemic, creating a double health burden for their users instead of building on their existing structures of access and trust. Instead, vaccination programs and other pandemic responses should leverage existing effective health programs - including HIV services and community clinics - to support access for high risk patients and support ongoing services.

Unlock funding and other support

To ensure equitable access, vaccination programs require sustainable funding and support from a range of governmental and non-governmental bodies to succeed, particularly to support community-based organizations serving vulnerable communities. Investments from The Rockefeller Foundation and other non-governmental organizations (NGOs), as well as the Biden Administration, have made a difference, and need to be sustained to ensure access to mobile clinics, community health centers, and appropriate public health information, and other preventive strategies.

Designate community workers as “essential workers”

Community health workers and the staff of community-based organizations supporting vaccination initiatives should be designated as “essential workers,” and given priority for vaccines, testing, and therapeutics to support the durability of these programs and resources.

Build for the long term

Vaccination programs built on durable infrastructure and long-term funding and staffing horizons have been much more effective than those set up as short-term, “band-aid” interventions.

The pandemic exposed the inadequacy of community health infrastructure across the United States, particularly in the absence of a robust federal initiative to support community-level programs from the start. Such a program could also have allowed for the exchange of best practices, enabling improved outreach to hard to reach populations - including those with limited or no access to the internet - through improved understanding of “last mile” challenges inhibiting access for the most vulnerable.

Vaccine rollout and other pandemic response programs have been established as short-term initiatives addressing a time-limited episode. Given the ongoing pandemic threat - from Covid-19, MPV (monkeypox), and other diseases or crises - state and federal governments and non-governmental funders must instead invest in sustainable capacity building to support community resilience to infectious diseases and other public health threats.

CAPACITY BUILDING

Invest in communities and CBOs for sustained engagement

Authorities and funding agencies must invest in the infrastructures, capacity support and relationships that will truly allow communities to lead. CBOs should not be seen as a stop gap measure for crisis response during an emergency; but rather need to be incorporated into the public health system for the long term and adequately supported, with both

funding and technical assistance. Too often in this pandemic, community health workers and CBO staff were undercompensated and not prioritized for PPE, vaccines and tests as they were not formally recognized as part of the healthcare/public health workforce.

Investing in community-based infrastructure will be essential for addressing inequities beyond vaccinations. A key finding from the EVI is the advantage of engaging a broad range of partners in critical vaccination work: Only about 14% of the nearly 90 community organizations funded through the EVI are considered part of the traditional healthcare or public health sectors. The overwhelming majority consists of organizations supporting individuals and families in a variety of ways including food pantries, civic engagement activists, churches and youth organizations such as Black Girls Vote, Legal Services for Prisoners with Children, East Harris Empowerment Council, Illinois Coalition for Immigrants & Refugee Rights and South Ward Children's Alliance.

Working in partnership with state and local officials and health systems, CBOs have demonstrated how critical they are to implementing public health interventions successfully.

Build, sustain, and entrench public health capacity over the long term

Vaccine rollouts have been most effective when they could draw on existing human capacity rather than requiring hiring and training an entirely new workforce. When the Covid-19 pandemic arrived in the United States in 2020, it was met by a skeleton public health workforce at all levels.

Rapidly standing up adequate capacity to meet the acute needs of a novel pandemic is an immense challenge, placing enormous strain on staff, and causing high rates of burnout across all partners of the response – from healthcare providers to community and social workers to public health practitioners in state and local health agencies.

Funders and legislative leaders must look to sustain and augment community-based health capacity developed over the course of the Covid-19 pandemic for the long term. This will require a flexible and expansive view of capacity building. In the absence of novel acute threats, public health capacity can be deployed to improve preparedness efforts and/or tackle longstanding public health challenges.

Combine support for evaluation of community work with trust

Community organizations stepped up to fill the gap in public health capacity, but faced serious challenges. While giving top priority to implementation, community organizations often didn't have the resources to also monitor and evaluate their work, which in turn contributed to difficulties with sustaining funding and programming.

Funders must take into account the limitations faced by grantees, particularly in the early adaptation stages of a response. Funders should consider providing additional and flexible funds and resources to support data reporting, narrative read-outs and evaluation efforts. When doing so, funders should not set the metrics of success but work with community partners on creating meaningful metrics (e.g. instead of measuring how many staff an organization hired, measure how many people showed up for events or were vaccinated.) Communities are eager to understand the impact of their work, which is harder to measure; adequate funding will allow building local partnerships with evaluation experts and building blueprints for evaluating complex community work.

DATA AVAILABILITY AND LIMITATIONS

Public health interventions are only as good as the data on which they are based, as has been apparent throughout the Covid-19 pandemic. Equitable vaccination and other public health interventions require that policy makers and community organizations have timely access to high-quality, disaggregated data to coordinate effective responses to rapidly evolving circumstances.

Support equity-centered data collection

Inadequate data collection prevents accurate assessments of the equity gaps and impedes effective community responses. For most of the pandemic, at least one third of data on cases, deaths, hospitalizations and vaccinations collected

by state and local health departments lacked race and ethnicity data due to incomplete forms from health care sites, outdated data infrastructures, and other reasons. Improvements have been made in some areas, but many gaps remain in collecting accurate, disaggregated data for communities of color, LGBTQIA+, and other underserved populations.

An equity-centered approach to data collection will require investments in data collection infrastructure and technical capabilities in local health departments, as well as the commitment to enforce such data collection. Currently, health data collection, analysis, and reporting is not standardized across more than 3,000 public health agencies in the U.S.. The CDC's Infectious Disease Office has created a core list of the most critical data points that all public health agencies are strongly urged to track and report. Mandating collection and publication of this standardized data would ensure place-based organizations, public health agencies, elected officials, and researchers can draw on adequate data to track disparate health impacts and guide effective equity-oriented action.

Publish and share public health data

Data collection is only effective when it is collected, analyzed and published, and shared with key stakeholders, yet data sharing remains a critical challenge in the United States. Key data is trapped in silos, gathered inconsistently, and shared via a patchwork of technologies (including printed and faxed data spreadsheets). Unlike the US military's command structure, public health is not administered by any single agency or person. Stronger central coordination and investment is needed to improve data sharing and healthcare/public health collaboration.

In addition to setting standards for data collection, federal, state, and local authorities must promote timely and accessible sharing of equity-relevant data, including geographic and racial and ethnicity data. Effective data sharing requires clear guidelines and regulatory pathways, as well as investments in technology and data infrastructure.To support this need, the Kaiser Family Foundation has conducted equity-focused national surveys throughout the pandemic and made this data publicly available. By nature, such national data is aggregated across communities, however, and can mask local trends. Work in EVI communities shows that the national trend of the closing of the vaccination gap between white and Black Americans doesn't hold for all communities in Chicago, for example, where disparities persist. Chicago provides detailed Covid-19 data in transparent and accessible ways in an effort to make such disparities visible, and ramp up efforts to address the underlying structural causes.

Fund data infrastructure modernization for health settings at the federal, state and local levels

Across the United States, Covid-19 response has been significantly limited by public health departments' use of obsolete technology platforms. Necessary investments in health departments' data and IT capabilities can be supported through a range of mechanisms, including public-private partnerships, as well as support from the federal government and funding agencies for data infrastructure modernization initiatives at safety-net hospitals, community health centers, and state, local, tribal and territorial departments. A key area of focus should be to ensure the interoperability of data systems within the public health sector and across the healthcare system to improve the efficiency of communication and execution.

Modernizing health data infrastructure at the federal, state, and local levels will not only improve crisis response but would also help with addressing other public health challenges, e.g. the opioid epidemic.

Ensure timely and high-quality data is accessible to various stakeholders across the health system, including community members

Many hospitals and healthcare systems across the country remain resistant to sharing key data during infectious disease outbreaks (e.g., admission, discharge, and transfer data). Furthermore, even when hospitals or laboratories are willing to share Covid-19 data, they have only reported to the federal Department of Health and Human Services (HHS), and not to local health departments, delaying local decision-making. The EVI and other local examples have shown how timely data sharing with community leaders, CBOs, and community health

workers strengthens community responses and ensures that data is available to inform decision-making and program design.

EFFECTIVE GOVERNANCE FROM CITY, STATE, TRIBAL AND FEDERAL AUTHORITIES

Activate diverse funding streams tailored to the needs of community-based organizations

Covid-19 response funding streams from city, state, tribal, and federal authorities have allowed agencies to direct resources to community-based organizations meeting the most urgent needs in their communities, including general operating support. The Biden administration has made significant efforts to ramp up vaccinations in underserved communities. In addition, philanthropic and corporate organizations like the Ad Council, Direct Relief, and Thrive Global have successfully supported the response, for example by working with organizations like the National Black Nurses Association to appeal to underserved communities to get vaccinated.

Co-creating with community organizations also means understanding their funding needs

Efforts to solicit feedback from implementing organizations have improved funding streams. Federal listening sessions with CBOs have called for additional support for capacity building, for example. In a clear example of how lack of connection to community leaders can lead to inequitable policy, tribal nations were initially excluded from pandemic response efforts and did not receive vaccines, tests, PPE, or funding. After feedback on the Prevent Pandemics Act, 537 tribes have now received funding, though unrecognized tribes continue to have no access to pandemic resources.

Advocate for political leaders to highlight needs of vulnerable groups

Political leaders need to raise the profile of vulnerable groups to improve vaccine access and uptake. For example the Congressional Hispanic Caucus worked to give vaccine priority to agricultural and food workers, whose working conditions require working in close proximity, and urged additional steps to address vaccine inequity.

STRENGTHENING HEALTHCARE, PUBLIC HEALTH AND COMMUNITY COORDINATION AND READINESS

As discussed, the most equitable and effective response efforts are co-created by healthcare institutions and their staff, such as physicians, nurses and other healthcare workers; public health agencies, and the communities they all serve. Too often, healthcare institutions act as single players, instead of partnering with public health and community leaders. Effective engagement between public health and healthcare, and interdisciplinary training for both professional groups, as well as collaborating with community leaders, must be a core component of the education in both disciplines.

Clinical research and trials must reach communities of color

Clinical research, including recruitment for studies and trials of vaccines and therapeutics, has often overlooked communities of color. This oversight results in gaps in our evidence base which can in turn impact these communities as not enough is known about how a new drug or device may work for or impact them. Both data inadequacies and the perception that communities of color have not been engaged in the research and testing of vaccines can undermine vaccine confidence. Recruiting communities of color for clinical trials is critically important.

Leverage trusted health workers

Community health workers and other “non-traditional” providers such as dentists played a key role in the vaccine rollout in communities of color. However, these non-traditional providers were not appropriately prioritized for training for new roles - including reporting requirements - and were often unable to access funding or reimbursement for their work due to narrow reimbursement policies.

Efforts should anticipate and fund the important role that these "non-traditional" providers can play.

A WAY FORWARD

Across the nation, key lessons have been learned during the Covid-19 pandemic about outdated approaches and structural factors that stand in the way of an equitable response to a new infectious disease threat. While the pandemic isn't over, government agencies at all levels are transitioning out of the active response phase and working to integrate Covid-19 management into existing public health and healthcare structures. Congressional support to adequately fund and coordinate this transition is lacking, and states and local jurisdictions are largely on their own in figuring out how to move forward.

It's a shift that has a significant impact on equity: Support provided by the federal government such as the availability of free tests, therapeutics and vaccines has been essential to reaching vulnerable populations with life-saving measures. Similarly, the Covid-19 equity support that was provided by government and philanthropic institutions to community-based organizations has enabled innovative, effective delivery of services in communities hardest hit by the pandemic.

How federal agencies, states and communities move forward in this next phase will set the stage for overall community resilience, health and wellness for years to come.

It is tempting to fall back on pre-pandemic structures and approaches and move to "endemic" Covid management. Existing infrastructures, however, are known to disadvantage marginalized populations, who often lack access to care and face bias and discrimination in healthcare. Endemic diseases, such as HIV/AIDS, already disproportionately affect communities of color and vulnerable populations.

In addition, in a moment of collective burn-out after 2.5 years of rapid response work, the risk of even more of the response work falling back on exhausted community organizations and community health workers without adequate support is high. Compounding this situation is an increasing awareness of how anti-vaccine activists (through newly expanded, empowered, and well-funded anti-vaccine organizations) are preparing for a post-Covid world and have set their sites on targeting all pediatric and adult vaccinations.

Failing to apply the lessons learned and rebuild systems to become more equitable overall will inevitably lead to a return of Covid-19 disparities and inequities, and exacerbate other existing health disparities. It risks further driving down immunization rates and enabling the return of Covid and other vaccine-preventable illnesses, such as measles, pertussis, and polio.

A new way forward is needed, and the recommendations in this statement serve as a starting point. The Equity-First Vaccination Initiative and other programs have shown how equity-focused initiatives improve outcomes. They deliver a blueprint for how to scale this essential work. Comprehensive reports by EVI Partners on Community Leadership and Vaccine Demand and EVI Impact and Lessons Learned provide concrete approaches and best practice examples for how to implement these recommendations.

Communities of color have confronted an unacceptably disproportionate burden in this pandemic. Coordinated efforts and especially community-led initiatives have shown that there are effective and accessible ways to right this wrong. It is imperative that we learn from, invest in and scale these efforts to ensure that the pandemic recovery phase and the new preparedness systems we build are centered in equity.

Equity Advisory Council Members

NAME	ORGANIZATION
Carly Bad Heart Bull	Native Ways Federation
Carmen Orozco-Acosta	Community Change Action
Denise Smith	National Association of Community Health Workers
Elena V. Rios	National Hispanic Medical Association
Georges Benjamin	American Public Health Association
Jay Brown	Human Rights Campaign Foundation
Marjorie A. Innocent	National Association for the Advancement of Colored People
Jamal R. Watkins	National Association for the Advancement of Colored People
Loretta Christensen	Indian Health Service
Peter Hotez	Baylor College of Medicine
Rhea Boyd	The California Children's Trust
Rita Carreón	UnidosUS
Millicent Gorham	National Black Nurses Association