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U.S. House of Representatives Select Subcommittee on the Coronavirus Crisis Briefing:
"Ensuring Equity in Coronavirus Vaccinations"

Written Testimony of
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Chairman Clyburn, my name is Frankie Miranda, and I am the President of the Hispanic Federation. On behalf of the network of more than 300 Latino-led community-based nonprofits that we serve and represent, thank you for the opportunity to address you and the distinguished members of the House Select Subcommittee on the Coronavirus Crisis.

For 30 years, Hispanic Federation's work has centered on building power and capacity in Latino and immigrant communities and in the nonprofits that serve them through institutional development, policy advocacy and programs in the areas of education, immigration, health, civic engagement, and economic and community development. In response to the grave challenges presented by the coronavirus pandemic, we created the most far-reaching Latino Covid-19 Relief Fund in the nation, investing $16 million dollars partnering with nearly 300 nonprofits in 30 states and Puerto Rico to provide care and hope to severely impacted families and communities. We recently launched our VIDA initiative to provide one million dollars in support to 15 community health centers that serve low-income Latinos across the country struggling without adequate funding to administer COVID vaccine programs.

For nearly a year now, this deadly disease has wreaked havoc and left a trail of destruction through the very heart of our communities. According to the CDC, as of Feb. 18, 2021, Latinos have been hospitalized at a rate three times that of Whites and have second highest rate of death after Native Americans due to COVID-19.[1] Latino children are losing more ground than their peers because of school shutdowns, and Latino workers have been devastated by disproportionate pandemic job losses.

[1] Centers for Disease Control (CDC) Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity. Accessed 2/18/21 https://documentcloud.adobe.com/link/track?uri=urn:aaid:scds:US:934354a5-dbb1-4dab-bd34-27476346b0c1

The work that you and your Select Subcommittee are doing here today, and have done since your creation, is vital to our country's future. But to fully grasp the challenge that lies before you, it is important that we turn first to the past. The unique challenges faced by Latinos in this crisis, are grounded in a history of exclusion, neglect, and racism that has deep roots in the United States.

We have spent the better part of a year listening to public health professionals and physicians warn us about how the coronavirus feeds off the underlying conditions of patients. I want to propose another framing, that the coronavirus feeds off the underlying conditions of the nation.

The fact is that the historical, systemic, and structural barriers and inequities that Latinos, Blacks, Native Americans, and immigrants face in health care, housing, education, and the labor market have served as an accelerant for Covid-19 to spread like wildfire throughout our nation's communities of color. Here are just some of the ways in which the separate and unequal realities that define life in America have exacted a deadly toll for far too many of our people.

Lack of access to quality education and high-paying jobs, along with discriminatory housing policies and practices, have forced large majorities of Latinos and Blacks to live in segregated neighborhoods with limited access to health care, healthy foods, clean air and water, and equitably funded public education. These neighborhoods are marked by substandard and overcrowded housing environments. Together, these conditions not only help to promote the spread of the coronavirus in our communities, they leave our people more susceptible to the underlying health conditions (such as asthma, hypertension, diabetes, obesity, and heart disease), also known as "social determinants of health" that make Covid-19 particularly deadly.[2]

Latinos are disproportionately represented in occupations with less stability, lower wages, and where the lack of labor protections, such as paid sick days, means they have little choice but to go to work. These jobs – which our nation has finally come to acknowledge as essential during this pandemic – in agriculture, healthcare, food preparation, sanitation, and delivery services often require Latino and immigrant workers to work closely with others, leaving them much more vulnerable to Covid-19 infection. According to a September 2020 McKinsey report,

[2] The list of four examples is drawn from "Health equity considerations and racial and ethnic minority groups." (n.d.). Accessed February 14, 2021, from https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html#print

Latinos are "overrepresented in nine of the ten lowest-wage jobs that are considered high contact and essential."

Latinos account for the largest share of the nation's undocumented immigrant population. Our communities are home to millions of men, women, and children who have spent the last four years in constant fear of family separation through enhanced immigration enforcement activities and in fear of seeking essential government services for fear of having it counted against them. [3] They have limited options for medical care due to a lack of work benefits like health insurance, lack of access to affordable health insurance through the ACA marketplace, limited access to health care facilities.

These social determinants of health are further exacerbated by a historic trust gap between communities of color and the medical field. Health care and racism have often intersected in our nation's history. Indeed, they have often informed and encouraged one another. The examples are many and, I am certain, many are well known to you and the members of this subcommittee.

Latino communities have also been the subject of medical racism, deception, and coercion. Our stories, like so much of our history in this country, are less well-known but no less important. Some of those examples include the "gasoline baths" of Mexican migrant laborers at the border in the early 20th century which sparked riots and inspired the Nazis[4], followed by "fumigation" using deadly DDT of millions of Mexican laborers brought to work legally in the US agricultural fields (1942-1964).[5] Other examples include the hundreds of Puerto Rican women being treated as unknowing guinea pigs in the first large scale human experiment for the development of the pill as a contraception method in the 1950s.[6] Allegations last year of non-consensual sterilization of immigrant women in private detention facilities echoed the *Madrigal* case from 1970s Los Angeles, where medical personnel systematically coerced Spanish-

[3] Sara A. Quandt, Natalie J. LaMonto, Dana C. Mora, Jennifer W. Talton, Paul J. Laurienti, Thomas A. Arcury. (2021) COVID-19 Pandemic Among Immigrant Latinx Farmworker and Non-farmworker Families: A Rural–Urban Comparison of Economic, Educational, Healthcare, and Immigration Concerns. *NEW SOLUTIONS: A Journal of Environmental and Occupational Health Policy* 20, 104829112199246.

[4] Chakraborty, Ranjani. (July 29, 2019). "The dark history of "gasoline baths" at the border." Vox.

[5] Between 1942 and 1964, 4.5 Mexican laborers were legally brought to work in the US agricultural fields through the federal "*bracero*" program and "fumigated" with deadly DDT. https://thebraceroprogram.weebly.com/dehumanization.html

[6] Quintanilla, Ray. (April 11, 2004). "Puerto Ricans recall being guinea pigs for `magic pill.'" Chicago Tribune. https://www.chicagotribune.com/news/ct-xpm-2004-04-11-0404110509-story.html

dominant mothers in the middle of giving birth via Caesarian-section into submitting to sterilization procedures. These examples of medical racism and coercion perpetrated by the medical establishment on Latina women is not ancient history. Many of these Mexican and Puerto Rican women, and millions of former Mexican *braceros* are still alive and their families - and our communities - still remember.

Against the backdrop of this history, it is not surprising that there is so much unease in Latino communities about the health care establishment especially when it intersects with government practices. This distrust is a symptom of the structural and systemic racism that sustain and engender – and, in fact, are central – to the profound and pervasive health disparities that afflict poor and vulnerable communities. The legacy of this history is compounded by rampant misinformation about the coronavirus and the vaccines developed to combat it, making the pressing and urgent task of confronting the virus, extremely challenging and complicated.

Inequities are now playing out in the ability to receive the potentially life-saving vaccinations. While we marvel at the speed with which these vaccines were developed and the efficacy with which they reportedly combat the virus, we are unsurprised that their distribution has replicated existing inequities. Available data shows a consistent pattern of Hispanic and Black people receiving smaller shares of vaccinations.

As of this week, the CDC reported that Latinos have received only 9% of reported vaccinations administered among the group of people who had received at least one dose of the vaccine and for whom race/ethnicity was known. Nearly two thirds of vaccine recipients were White (63%), 9% were Hispanic, 6% were Black, 5% were Asian.

Latinos make up nearly 1 in 5 of the U.S. population - over 18 percent - yet we represent nearly 33 percent of COVID cases nationwide. We have been dying at rates more than twice as high as the white population. Yet, as of two days ago, we have received 9% of vaccinations for which there is data.

What does this look like?

In Texas, only 20% of vaccinations have gone to Hispanic people, who make up 40% of the population, 42% of COVID cases, nearly half of all deaths (47%) in that state.

In California, Latinos have received just 15% of the vaccine doses administered, less than half the rate of White Californians, although they account for 55% of positive Covid-19 cases and nearly half of the coronavirus deaths in the state.

In New York City, despite having the highest number of coronavirus infections, hospitalizations and deaths, Latinos account for just 15 percent of the total persons vaccinated.[7] By contrast, White New Yorkers account for 48 percent of all persons vaccinated despite having the lowest rates of death and hospitalization. We are seeing the same pattern play out in states and localities across our nation.[8]

Given the history of mistrust between Latinos and government associated medical treatment, we believe that Latino and BIPOC community-based organizations must be funded and engaged to educate, engage, empower, and energize our people to get vaccinated. We will only be able to stem this virus by working together. This will require large-scale government funding targeted at community-based and led nonprofits that are trusted and respected messengers and are leading the way in providing relief and care to vulnerable residents and families in Latino and other communities of color.

We need to do better not only for Latinos but for the health of this country. We know from our own work and from our partners on the ground what the problems are and what needs to happen to address them. You just need to ask us.

I am here today to recommend strategies in three areas that will result in more equitable, targeted, and effective distribution of vaccines:

1. **Accessibility - *Lower Barriers to Access Vaccines***
    - Barriers to access vaccines include language and computer proficiency, lack of transportation, and availability of things people take for granted like having internet or even an email account.
    - Programs that provide vaccination strike teams to go into communities where hard to reach populations live and work must be created for Latino and immigrant communities. Continuing to simply open mega sites shows both a lack of creativity and a commitment to reaching hard to reach populations. You would not open a mega-site to conduct the census.

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[7] The most recent data on New York City is taken from the New York City Department of Health's COVID-19 Data Webpage at: https://www1.nyc.gov/site/doh/covid/covid-19-data.page

[8] On Colorado, see: https://www.9news.com/article/news/health/coronavirus/vaccine/latinos-colorado-challenges-vaccinated/73-3064f507-b722-42c6-b686-0ad1441fa2cb.
On Louisiana, see: https://bphc.hrsa.gov/emergency-response/coronavirus-health-center-data/la.
On California, see: https://www.latimes.com/california/story/2021-02-08/l-a-latinos-black-seniors-fall-behind-in-covid-19-vaccine-access-compared-to-whites

- Funding should be directed towards partnerships with community-based organizations to create more vaccination sites, including mobile vaccination stations, and to conduct door-to-door outreach in our communities to provide education, address hesitancy, and offer vaccines.
- It should be a bedrock principle of our national vaccination efforts that every person living in the country, irrespective of immigration status, is entitled and encouraged to access vaccination sites and get a vaccine. Understand, that a vaccination site staffed by National Guard is not going to be perceived as welcoming to many Latino and immigrant populations, and may create additional, if unintentional barriers.

2. **Resources - *Unleash Our Community's Greatest Assets***
   - Money must be allocated to community-based non-profits that have the cultural competence to educate and combat the misinformation and distrust rampant in Latino communities, including designing education and outreach programs modeled on successful community-based census programs. That outreach and education must start now – so that we are ready when more vaccines become available as we know they will.
   - There need to be resources for case management personnel with the cultural competence to reach hesitant populations, persuade them to get vaccinated, help them sign up over the phone for the vaccine, and then follow up to ensure they go back for their second dose. Providing the vaccines is not enough.
   - Nonprofit Health Care Navigators who assist people in signing up for the ACA and disaster case managers should be repurposed (or additionally purposed) to provide case management assistance to people in low-income and high health disparity neighborhoods who need help in signing up for and getting vaccinations.
   - Empower Federally Qualified Community Health Centers (FQCHCs) and provide them with adequate resources to do comprehensive vaccinations programs. The Biden announcement to ship more vaccines to FQCHCs is welcomed, but much more support is needed to truly leverage the ground-level expertise and access that these community health centers provide for our communities.
   - The federal government should allocate dedicated funding for a nationwide public education campaign that employs trusted community and health care messengers

to provide clear, consistent, and linguistic and culturally relevant messaging about vaccine safety and the importance of getting inoculated against the coronavirus.

3. **Equity and prioritization - *Guidelines, Consistency, and Oversight Are Key***
   - Federal distribution guidelines must be created to target need and impact. There must be priority guidelines, guardrails to prevent abuse and jumping the line, and oversight - especially while shortages remain.
   - Policies must be developed and prioritized for hard to reach, disproportionately impacted communities in mind. For example, blanket age-based vaccination priorities deepens distribution inequities for Latinos who have the highest numbers of deaths among younger age-groups. Almost half of all COVID-related deaths in the 35-44 age range are Latino (48.9 percent), compared with 27.3 percent of Black people and 15.5 percent of whites.[9] With more than half of the country's second largest population group under the age of 54, concerns run high that many Hispanic COVID-19 survivors in that age group may be facing tough recoveries and long-term poor health.[10] This has the potential to reverberate negatively throughout the country and the economy for years to come. Latinos have the greatest share of deaths in age groups under 54, according to the CDC.
   - The CDC must require states to collect and report of data disaggregated by race and ethnicity. We cannot effectively develop solutions for problems for which we lack inadequate data. We urge you to support initiatives like the Equitable Data Collection and Disclosure on COVID-19 Act of 2020.
   - Puerto Rico and the territories must also be included in data collection. Even the Biden White House Task Force has been conducting state-by-state weekly analysis of the pandemic and issuing reports with specific recommendations to all state governments – but have left Puerto Rico (and other territories) out of those reports. This is not in the public interest of getting this pandemic under control.

[9] Center for Disease Control and Prevention COVID Data Tracker https://covid.cdc.gov/covid-data-tracker/#demographics (accessed 12/29/20)

[10] Margarita Martin-Hidalgo Birnbaum, "Doctors Worry About COVID's Effects on Hispanics," WebMD, accessed December 23, 2020, https://www.webmd.com/lung/news/20200727/doctors-worry-about-covids-effects-on-hispanics

We cannot open the economy on the backs of brown, black, undocumented, and low-income workers who continue to suffer disproportionately high infection rates, economic hardship, and death. They must be valued and treated as essential, with adequate compensation, paid family and medical leave, childcare coverage, and protections from family separation.

But the immediate need is to provide equitable access to vaccines. We are not asking for equity for the sake of equity. Continuing to give low priority to Latinos and immigrants is not merely unfair; it is terrible public and economic policy. This country will not recover as quickly as it needs to if Latinos and immigrants continue to be treated as disposable, made invisible in policy discussions, or are left behind in the life-saving race to provide vaccines.

Chairman Clyburn let me conclude by acknowledging that the work ahead of us is difficult. The health-related problems that beset a significant part of the Latino community are long standing and reflect a confluence of historic social, economic, and political factors. These are not circumstances that Latinos have brought upon themselves. They are the products of decades, and in some cases more than a century, of systematic racism, discrimination, and exclusion. But the scope of the problem cannot distract us from the urgency of a solution. There will be time enough for analysis in the future; today we must focus on actions. Our lives hang in the balance. Help us. There is no more time to waste. Thank you for asking us how together we can do better for our communities, our country, and our future.