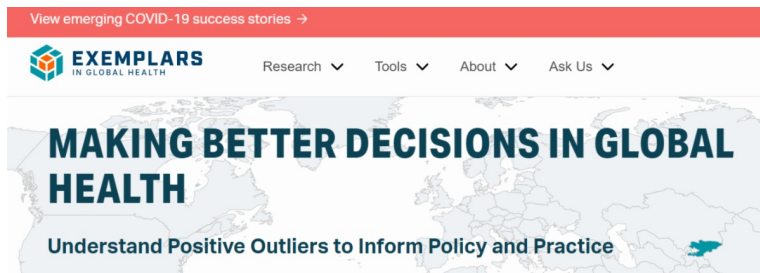


# News from the Collaborative

## Featured Content

***HCGC Vaccine Equity Work  
with Ohio State College of  
Public Health & Futurity  
Highlighted by Exemplars in  
Global Health***



### **Prioritizing those most at risk in the next push of vaccine rollout**

**By: Katie Bollbach, Director, U.S. Public Health Accompaniment Unit (U.S. PHAU), Partners In Health; Evrard Nahimana, MD, MMSc-GHD, Africa Regional Policy and Partnerships Advisor, Partners In Health**

Last month, every adult in the United States became eligible for COVID-19 vaccination. In light of surging cases and evolving variants here and around the world, it was an important step forward. However, it is just as important to highlight that eligibility does not equal access. Throughout Partner In Health's (PIH) work throughout the world, we have seen time and time again that simply making health care available without understanding and eliminating barriers to access perpetuates inequitable outcomes. And given the return to "normal" will only be achieved when the entire globe reaches a 70 to 90 percent vaccination rate, an equity-centered approach is the most direct and just path to reach population immunity, ensuring no one – not in the U.S. and not elsewhere – is left behind. This means that even with open eligibility, epidemiologic evidence and justice both demand we build structures to ensure those most at risk get vaccinated. And learnings – whether they are from successes or failures – must be shared if we want a shot at bringing COVID-19 under control.

In the U.S., based on risk, transmission, and equity, there is a clear case for prioritizing vaccination efforts on older adults, communities of color, and essential workers.

From an epidemiological perspective, vaccination serves two main goals: directly protecting those at highest risk of severe disease outcomes (“risk-based vaccination”) and reducing transmission among those who are most likely to acquire and spread illness (“transmission-based vaccination”). Risk-based data dictate that we must prioritize groups that have experienced higher death and hospitalization rates. In the U.S., this includes those over 65 who have borne more than **80% of COVID-19 deaths**, and Black, Indigenous, and Latinx adults, who have experienced **two- to three-fold higher hospitalization** and death rates from COVID-19 than their white counterparts. Frontline essential workers are also at heightened risk of both contracting and transmitting COVID-19 based on the nature of their work, making them a clear priority for vaccination. The intersection of these groups compounds the risk of poor outcomes.

Racial and social injustice reinforce this epidemiological challenge: historically marginalized groups have disproportionately suffered from COVID-19 and therefore deserve priority protection. In particular, the burden of disease born by communities of color is a pervasive feature of U.S. systems. Our institutions are deeply infiltrated by systemic racism that continues to ensure these communities remain underfunded and undervalued. Additionally, they are further excluded by a lack of recognition of demographic and structural barriers. For example, a focus on mass vaccination sites fails to consider transportation challenges, while strict universal age-based prioritization during the initial vaccine rollout excluded many members of high-risk communities of color who have shorter life expectancies due to **baseline health inequities**. The consequences have been measurable: by May 17, 2021, among 41 reporting states, white people had received at least one COVID-19 vaccine dose at a rate 1.5 times higher than Blacks and 1.4 times higher than non-white Hispanics. Whites also received a **higher share of vaccinations** as compared to their overall share of cases and deaths.

While these challenges can seem insurmountable, it is both possible and vital to concurrently combat the COVID-19 pandemic and the U.S.’ structural inequities. To do so, vaccination programs should focus on three key areas, each of which is more successful if done in concert with the others.

### **First: Improving vaccine demand through community engagement**

Community engagement is an essential and crosscutting part of vaccine programs built on bidirectional communication and collaborative decision-making informed by a nuanced understanding of community needs. Vaccine programs should work with trusted partners who are representative of the communities they serve and who are empowered to openly communicate needs. In the U.S. and internationally, many communities and partners have been hosting informational events (town halls, door-to-door outreach, etc.) aimed primarily at addressing vaccine hesitancy. However, engagement must go further: community members must be able to influence and inform policies and programs, to speak and to be heard, and to make informed decisions regarding vaccination.

- Exemplar: in Chicago, bolstered by the Chicagoland Vaccine Partnership – a community coalition formed to aid the push for equitable vaccination – the city launched an **initiative** to dedicate vaccine resources to 15 vulnerable neighborhoods. As part of the Partnership, PIH developed a training program to equip local leaders with resources for engaging community members in dialogue, ensuring relevant vaccine information reaches everyone, including public health planners. Thus far, over 113 organizations and 266 members have become a part of the initiative, a diverse and adaptive community network with broad health and social aims and a mandate for long-term system improvement that will last beyond the pandemic.

### **Second: Ensuring adequate vaccine supply through equitable resource allocation and site operations**

In order to achieve coverage for all, but especially disadvantaged people who are most in need, we must ensure priority communities have an adequate supply of vaccines when and where they are needed. As such, vaccination programs must collect disaggregated coverage data to grasp the full extent of the local landscape. But many communities continue to lack this information. As of May 19, 2021, the **CDC reported** that race/ethnicity was known for only 56.1% of those who had received at least one vaccine dose.. To understand disparities in access, innovate and operationalize “last mile” strategies, and monitor progress

toward outcomes, this data must be available so vaccine allocation and distribution can break down common barriers to access: limited hours of operation, complex scheduling and registration systems, inaccessible sites, and language barriers. Equity demands that instead of blanket tactics like mass vaccination, which may be less resource intensive but are also less effective in reaching historically oppressed communities, we invest in strategies that reach those most in need.

- Exemplar: in Ohio, using collaborative spatial mapping, community, government, and academic partners comprehensively document and visualize available resources and vaccination needs of communities most vulnerable to COVID-19. Through census tract-level analysis, the team identifies gaps in coverage and insufficiencies in public transportation. Four major health systems and two local health departments are now using recommendations based on this mapping to place mobile and pop-up clinics. The mapping will also inform the deployment of Community Health Workers (CHWs) to provide vaccine education, assist clients to locate and register for appointments, and furnish transportation assistance.

[Click to read full article](#)

## Insights from the HCGC Blog

### Central Ohio Pathways HUB Joins Statewide Network of Certified Pathways HUBs



### Ohio Network of Certified Pathways Community HUBs

In Ohio, there are currently 10 Pathways

Community HUB Institute Certified HUBs (HUBs). These HUBs have created a statewide network in order to support, grow, and sustain their model, with the goal of achieving health equity for all people in Ohio.

- HUBs are built for and by the communities each serves. Regional organizations work to receive certification, then act as that area's HUB.
- The HUB model is an evidence-based system that helps trained Community Health Workers (CHWs) perform field work in vulnerable communities to identify and eliminate characteristic barriers to clients' good health outcomes. Typical obstacles include food insecurity, lack of transportation access, and housing instability.
- Outside health care agencies partner with regional HUBs to benefit from CHW training and certification, field support, and data.

### Member HUBs:

**Better Health Pathways HUB**  
Cleveland, OH

**Bridges to Wellness HUB**  
Tuscarawas County, OH

**Central Ohio Pathways HUB**  
Columbus, OH

**Community Action Pathways HUB**  
Canton, OH

**Community Health Access Project**  
Mansfield, OH

**Health Care Access Now**  
Cincinnati, OH

**Mahoning Valley Pathways HUB**  
Youngstown, OH

**Northwest Ohio Pathways HUB**  
Toledo, OH

**Pathways HUB Community Action**  
Akron, OH

**Stark County THRIVE**  
Canton, OH





## Partner News and Events

[Stopping the Other Pandemic: Systemic Racism and Health](#)

[Resources:COVID-19 Vaccines and Racial and Ethnic Minority Populations](#)

[The Virtual National Health Equity Summit](#)

[United Way of Central Ohio: COVID-19 Impact Survey--please complete!](#)

[Enhancing the Capacity of Local Health Departments to Address Birth Equity: The Institute for Equity in Birth Outcomes](#)



## Monthly Meeting Resources

Following each Monthly Meeting and Regional Learning Session, the agenda, speaker information, slide deck and other relevant resources are uploaded to the HCGC website for your reference. [View resources.](#)

For a Calendar of Events visit:  
<http://www.hcgc.org/events.html>

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