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2 Health Inequities in the U.S. Coronavirus Disease 2019 Pandemic and Response
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III. Sponsorship

- a. Epidemiology Section

IV. Collaborating Units

- a. American Indian, Alaska Native, and Native Hawaiian Caucus
- b. Asian & Pacific Islander Caucus for Public Health
- c. Black Caucus of Health Workers
- d. Caucus on Homelessness
- e. Disability Section

V. Endorsements

- a. Community Health Planning and Policy Development Section
- b. LGBTQ Health Caucus
- c. Maternal and Child Health Section
- d. Public Health Social Work Section
- e. Pharmacy Section

VI. Summary

Coronavirus Disease 2019 (COVID-19) was first detected in the United States in January 2020. As a respiratory pathogen, non-pharmacologic measures such as physical distancing, sheltering-in-place, and mask wearing were deemed important early interventions while treatments and vaccinations were being developed. While these interventions are effective for some, many people across the United States do not have the luxury or ability to physically distance from one another because of their housing and place of employment. Based on available data, individuals belonging to historically underserved communities are experiencing disproportionate rates of COVID-19 infection and mortality. COVID-19 has exacerbated health inequities among People of Color, persons with home and food insecurity, persons with underlying health conditions, persons living with disabilities, and persons living in other underserved communities. Due in part, to a lack of sufficient data collection, capturing demographic characteristics, testing to identify affected individuals, and community-specific response delays, COVID-19 has continued to spread widely across the United States. Federal, state, tribal, and local officials must prioritize comprehensive and transparent COVID-19 data collection, effective contact-tracing, widely accessible and accurate testing, and employ culturally appropriate and community-based public health interventions that address underlying health inequities.

VII. Relationship to Current APHA Policy Statements

- a. 20189: Achieving Health Equity in the United States

- 1 b. 20177: Improving Working Conditions for U.S. Farmworkers and Food
- 2 Production Workers
- 3 c. 20166: Opportunities for Health Collaboration: Leveraging Community
- 4 Development Investments to Improve Health in Low-Income Neighborhoods
- 5 d. 20158: Preventing Occupational Transmission of Globally Emerging Infectious
- 6 Disease Threats
- 7 e. 201015: Securing the Long-Term Sustainability of State and Local Health
- 8 Departments Policy Statement
- 9 f. 20091: Support for Community Health Workers to Increase Health Access and to
- 10 Reduce Health Inequities
- 11 g. 200412: Support for Community Based Participatory Research in Public Health
- 12 h. 200311: Opposition to Eliminating or Compromising the Collection of Racial and
- 13 Ethnic Data by State and Local Public Institutions
- 14 i. 20017: Research and Intervention on Racism as a Fundamental Cause of Ethnic
- 15 Disparities in Health
- 16 j. 20015: APHA Position Paper on the Health Status of American Indians and
- 17 Alaska Natives
- 18 k. 20005: Effective Interventions for Reducing Racial and Ethnic Disparities in
- 19 Health

20 **VIII. Rationale for Considering**

21 Coronavirus Disease 2019 (COVID-19) has resulted in high morbidity and mortality across the

22 United States (U.S.) and globally. Warnings about expected disproportionate impacts on

23 communities were issued early on even before COVID-19 surveillance documented them. The

24 United Nations has urged their member states to consider the needs of Indigenous peoples in

25 their COVID-19 response. Despite weeks of surveillance system delays, disproportionate

26 impacts of COVID-19 on diverse and underserved communities throughout the U.S. are evident.

27 These impacts have steadily increased and remain prominent in scope and magnitude. While this

28 policy statement is not addressing a public health issue previously identified by JPC and APHA,

29 the COVID-19 pandemic is a new and evolving crisis, and the need to reconcile health inequities

30 in the U.S. COVID-19 response is urgent. As of this writing, specific attempts by Congress to

31 designate emergency supplemental funding to mitigate COVID-19 transmission and illnesses and

32 to slow down suffering and death in these communities have failed. Yet, the communities who

33 are disproportionately impacted by COVID-19 are already chronically impacted by health

34 inequities. Enhanced, coordinated public health responses need federal funding and technical

35 support through the Department of Health Human Services. State, tribal and local public health

36 departments also need funding and technical support to respond in impacted communities. These

37 continue to be lacking. Inadequate, delayed and sporadic efforts continue as health agencies

1 struggle to redirect existing resources to communities at high risk. As public health
2 professionals, we cannot ignore this unfolding crisis. We have a responsibility to clearly call for
3 meaningful actions that advance health equity and empower all communities with a full measure
4 of tools to prevent and reduce more suffering and deaths.

5 **IX. Problem Statement**

6 Physical distancing, shelter-in-place, and mask wearing are essential non-pharmacologic
7 prevention measures for Coronavirus Disease 2019 (COVID-19). In addition, widespread testing
8 and contact tracing are effective strategies to identify and isolate COVID-19 positive persons,
9 and their contacts.¹ However, in the United States (U.S.), the implementation of and funding for
10 these strategies vary widely by state and regional authorities.² The lack of a national strategy for
11 safe physical distancing, testing, and contact tracing has significantly dampened the ability of
12 states, tribes, and local communities to stop COVID-19 transmission. Underserved communities
13 who face endemic systemic, institutional racism, and poverty are experiencing disproportionately
14 high morbidity and mortality from COVID-19.³ In an examination of 1,320,488 laboratory-
15 confirmed COVID-19 cases in the U.S. between January and May of 2020, 33% of cases were in
16 Hispanic and Latinx persons of any race, 22% of cases were in non-Hispanic Black persons, and
17 1.3% of cases were in non-Hispanic American Indian and Alaska Native persons. In contrast,
18 Black, Hispanic and Latinx, and American Indian/Alaska Native communities make up 13%,
19 18%, 0.7% of the U.S. population respectively.⁴ This study also demonstrated the frequency of
20 missing data; 45% of cases did not report race and ethnicity.⁴ Often, race and ethnicity data are
21 left blank on reports to public health. Lacking incentives, health care systems irregularly collect
22 and report these data. There are also significant data delays, which continue to leave decision-
23 makers and communities unable to understand the scope of the problem.⁵ This policy statement
24 aims to identify underserved populations at elevated risk for COVID-19 morbidity and mortality,
25 describe delays and missing information impacting COVID-19 prevention and containment, and
26 advocate for action steps to meaningfully address health inequities in the U.S. COVID-19
27 pandemic and response.

28 **Underserved populations by race and ethnicity**

29 *Impact on Black Americans:* In the U.S., Black Americans are facing systemic “racism,
30 segregation, and economic disinvestment” which contribute to disproportionate levels of poverty
31 and chronic disease compared to non-Black Americans.⁶ Black Americans represent 13% of the

1 U.S. population but by April 2020, represented 34% of all deaths from COVID-19.⁷ Black
2 Americans are less likely to be screened for COVID-19 due to implicit bias and lack of access to
3 healthcare resources and insurance.⁷ In a cross-sectional study examining COVID-19
4 surveillance data in the greater Houston, Texas area, 20,228 persons were tested and 1,551 tests
5 were positive. Of persons testing positive for COVID-19, 22% were Black Americans. The odds
6 of testing positive in the non-Hispanic Black population was 2.23 times that of the non-Hispanic
7 white population. The authors attribute the higher risk in Black Americans to be associated with
8 lower socioeconomic position and higher population densities found in Black communities.⁸

9 *Impacts on Hispanic/Latinx Americans:* Reports show a disproportionate impact of COVID-19
10 cases and death on Hispanic and Latinx communities. An analysis of 79 counties in the United
11 States with COVID-19 hotspots found that Hispanic persons were the largest population group
12 living in a COVID-19 hotspot. This disproportionate impact is possibly due to employment in
13 essential industries, multigenerational and multifamily households, and social inequities
14 contributing to chronic disease and environmental exposures.⁹

15 *Impact on Indigenous Americans:* Indigenous people in the U.S. and its Territories, include
16 American Indian and Alaska Native (AI/AN), Native Hawaiian (NH) and Pacific Islander (PI)
17 populations. Often, AI/AN, NH and PI race and ethnicity is limited, missing, or misclassified in
18 federal, state and local reportable disease and health data systems including COVID-19.^{10,11}
19 Frequently, these data are not reported publicly by federal, state and local health departments and
20 researchers because of statistically small numbers.¹⁰ Yet, early on, AI/AN communities
21 experienced sustained, widespread outbreaks, and from limited data, researchers noted
22 laboratory-confirmed incidences of COVID-19 among AI/AN persons 3.5 times higher than
23 among non-Hispanic white persons.¹¹

24 In April 2020, data suggested that in six Western U.S. areas, the NH/PI COVID-19 case rates
25 were higher than other racial/ethnic groups.¹² NH/PI COVID-19 rates in California were 217.7
26 cases per 100,000 persons while the statewide overall rate was 62.43 per 100,000 persons.¹²
27 NH/PIs have some of the highest rates of essential workers in California and Hawaii. A high
28 percentage of NH/PIs live in multigenerational homes and a significantly large percentage of the
29 NH/PI community is uninsured and underinsured.¹²

1 *Impacts on Asian Americans:* One analysis examined COVID-19 hotspots and found that
2 although Asian Americans are not commonly living in counties with COVID-19 hotspots, they
3 are overrepresented in cases compared to their population proportions.⁹ Asian American
4 communities vary extensively, however most COVID-19 data are reported in aggregate. Without
5 data disaggregation, community-specific needs cannot be identified. The high prevalence of
6 underlying health conditions is a large contributing factor. Asian-Americans face xenophobia
7 and one third of Asian Americans have limited English proficiency, which can create a
8 substantial barrier to accessing routine health care.¹³ Asian Americans, like PI, also make up a
9 large proportion of essential workers in nursing, medicine, manufacturing, and retail.¹³

10 **Underserved communities and their intersection with determinants of health**

11 Health inequities are a result of institutional racism that continues to impact living conditions,
12 working conditions, political voice, power and self-determination. Health inequities worsen the
13 prevalence of chronic diseases and contributes to low levels of poverty, and environmental
14 exposures.¹⁴

15 Persons living and working in congregate setting

16 *Living conditions and housing practices:* Due to explicit government actions to enforce racial
17 segregation, underserved communities are more likely to live in densely populated housing.
18 Structural racism in housing was propelled by red-lining, exclusionary zoning, gentrification,
19 racism, restrictive covenants, and lending practices.¹⁵ As a result, housing negatively influences
20 health due to the biological and chemical hazards in these areas.¹⁵ Persons living in densely
21 populated housing struggle to maintain physical distancing and have challenges isolating sick
22 family members from non-sick individuals.¹⁵ Black American, Latinx, and low income persons
23 are 1.7 to 2.2 times more likely to live in low-income and under-invested neighborhoods.¹⁵

24 *Persons experiencing housing insecurity:* Persons experiencing homelessness have high rates of
25 chronic mental and physical health conditions and large barriers to medical care.¹⁶ Underserved
26 communities are also overrepresented among people experiencing homelessness, and those who
27 lack housing are at greater risk of contracting infectious diseases.¹⁶ One study examined 2,729
28 patients who presented to Boston Medical Center with COVID-19 and found that one in six
29 persons were experiencing homelessness.¹⁷

1 *Persons living in institutional settings:* Persons living in institutional settings such as skilled
2 nursing and group home facilities are at significant risk for COVID-19 due to congregate living
3 and elderly residents. Several studies indicate disproportionate morbidity and mortality in these
4 residents and their staff members.^{18,19}

5 *Persons living with disabilities:* One study in New York found that those living in institutional
6 facilities or group homes with disabilities were more than five times as likely to contract
7 COVID-19 with congregate settings being the primary risk factor. Individuals with disabilities
8 have an elevated risk of chronic disease and other underlying health conditions, which can
9 worsen severity of COVID-19.²⁰ Individuals with disabilities are also facing unprecedented
10 discrimination regarding resource allocation. One filed complaint in Tennessee describes how
11 the state's crisis standards of care initially discriminated against people with disabilities by
12 preventing the allocation of ventilators to this population in times of scarcity.²¹

13 *Persons who are incarcerated:* Persons who are incarcerated have increased prevalence of
14 infectious and chronic diseases and persons of color are overrepresented in incarcerated settings
15 due to systemic racism and discriminatory policing policies.²² Due to crowded living conditions
16 that prevent adequate physical distancing as well as poor ventilation, restrictions on hygiene
17 products, and an increasingly aging population, incarcerated persons remain at high-risk for
18 COVID-19.²³ Preliminary COVID-19 data among state and federal prisons indicate that the
19 prevalence of COVID-19 cases and mortality were 5.5 times higher than the U.S. population
20 rate.²⁴

21 *Work settings:* Persons belonging to underserved populations are at-risk for COVID-19 due to
22 working conditions. Between April and May 2020, in 239 meatpacking plants, 87% of COVID-
23 19 cases were persons belonging to racial and ethnic minority groups.²⁵ In Utah between March
24 and June of 2020, 58% of COVID-19 cases occurred in manufacturing, wholesale trade, and
25 construction sectors. Hispanic and non-white workers make up 24% of Utah workers but
26 accounted for 73% of workplace outbreaks.²⁶ The U.S. Department of Homeland Security
27 identifies essential jobs needed for economic sustainability, many of these positions are filled by
28 persons in underserved communities.²⁷ These jobs often involve prolonged interaction with the
29 public or lack the potential for physical distancing. In addition, 24% percent of the U.S civilian

1 workforce does not have paid leave. A lack of paid time off may promote attendance at work
2 despite sickness or recent illness exposure.²⁸

3 *Frontline Healthcare Workers:* Frontline patient care and non-patient healthcare workers are
4 disproportionately impacted by COVID-19. Initial reports suggest critical shortages of personal
5 protective equipment (PPE) for the medical community and despite an increase in capacity, some
6 personnel report limited PPE availability.²⁹ One study found that frontline healthcare workers'
7 risk of reporting a positive COVID-19 test was 3.4 times higher than the general community.
8 The same study found that Black, Asian, and other underserved healthcare workers' risk was
9 4.88 times that of the non-Hispanic White population.²⁹ Many case-reporting platforms across
10 the U.S. do not report occupation or healthcare worker status. CDC suggested that data
11 informing of healthcare provider status is missing in 84% of reported cases.³⁰

12 *Persons living in rural communities:* Rural communities experience greater barriers to access
13 care as indicated by fewer physicians across specialties. These communities are marked by aging
14 populations, higher disability, greater uninsured rates, and reduced internet access.³¹ Rural
15 communities may lack sufficient local resources and must wait for state and federal resources to
16 address limits in testing and treatment for COVID-19. Lower number of healthcare providers and
17 facilities may delay treatment. In addition, limited internet access may prevent individuals from
18 working from home and may impact feasibility of implementing telehealth services.³¹

19 *Persons identifying as Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ):* Individuals
20 who identify as LGBTQ have higher rates of chronic diseases and cancer putting them at greater
21 risk for significant morbidity and mortality related to COVID-19. Reduced access to healthcare
22 services will worsen the impact.³² Persons identifying as LGBTQ also have higher rates of
23 mental illness and suicidality due, in part, to societal discrimination and stigma and COVID-19 is
24 predicted to worsen these effects.³² However, the true impact of COVID-19 on the LGBTQ
25 community is unknown as those data are not collected.

26 *Immigrant and undocumented persons:* Immigrants persons constitute another underserved
27 group impacted by COVID-19. While U.S. citizens have uninsured proportions of less than 10%,
28 23% of immigrants with legal status are uninsured. That number increases to 45% for
29 undocumented immigrants in the U.S.³³ Furthermore, language barriers, lack of paid-sick-leave,
30 and the cost of seeking medical care impact the health of immigrant communities.²⁸ Immigrant

1 persons fear legal and deportation repercussions for seeking care or enrolling in health insurance
2 and reimplementing of the Public Charge Rule perpetuates these fears and concerns.

3 **Intersectionality**

4 In many instances, affected persons share more than one of the above characteristics and
5 identities, which may amplify the effects. There are also populations inadvertently missing from
6 this statement where the data are emerging. This includes pregnant women of reproductive age
7 who are at an increased risk for severe COVID-19 infection.³⁴ Missing and incomplete data for
8 COVID-19 cases make it challenging to identify every impacted population. More research and
9 better data are needed to explore the impact of intersectionality on COVID-19 risk and identify
10 all individuals at an increased risk based on determinants of health and discrimination.

11 **U.S. COVID-19 surveillance**

12 COVID-19 reporting: Federal public health spending continues to decrease while state public
13 health workforces are chronically underfunded and overburdened.³⁵ As such, state, tribal, and
14 local public health response work for COVID-19 are hampered. Concerns consistently raised
15 about data collection include reporting delays, incomplete reporting, and reports missing
16 sociodemographic elements. These issues limit public health understanding about the burdens of
17 COVID-19 and contributes to gaps in response capacity especially for those underserved
18 populations.^{9,24,26,30} Basic epidemiological data dashboards are insufficient to answer simple
19 community questions about COVID-19. For example, what percent of COVID-19 cases and
20 deaths come from specific underserved communities? Among essential workers, those with
21 chronic illnesses, and older people, what are the COVID-19 incidences and prevalences and
22 trends? Cumulative reporting provides no information about gaps and successes within
23 communities and it stigmatizes hard hit communities. More granular data, such as patient zip
24 code, neighborhood, occupation, and location density are needed for allocating resources,
25 tailoring interventions to fit the community needs, and empowering impacted communities to
26 respond.³⁶

27 Access to testing and treatment: Historically, People of Color are underrepresented in clinical
28 trials. Emerging data for COVID-19 treatment shows that studies are being conducted in
29 majority white participants.³⁷ Data are also needed on the distribution of COVID-19 treatment,
30 the effectiveness of COVID-19 contact tracing, and COVID-19 testing availability for

1 communities of color. In New York, data suggested that COVID-19 testing frequency was
2 highest in predominantly white communities. However, the highest number of positive tests
3 identified was recorded in non-white neighborhoods.³⁸

4 **X. Evidence-based Strategies to Address the Problem**

5 **1) Comprehensive COVID-19 public health surveillance, research, and evaluation:**

6 Comprehensive data collection, analyses, and evaluation about COVID-19 related interventions,
7 care, supplies and system capacity need to be transparent and readily available to community
8 leaders, public health workers, and the public.³⁹ Data collection must include race, ethnicity,
9 neighborhood, housing status, disability, sexual and gender identity, industry and occupation,
10 and other social and environmental determinants of health. The frequency of sociodemographic
11 information collection is inadequate. One systematic review found that of the 13 studies
12 evaluated, only one contained any indicator of socioeconomic position.⁵ The authors attribute
13 this lack of data collection to the World Health Organization standard for case-reporting and
14 clinical processes at many public health and healthcare institutions.⁵ However, integrating
15 COVID-19 data collection with electronic health records, integrated health data exchanges, and
16 existing public health surveillance systems can help gather these needed data.⁴⁰ Data dashboards
17 created for data transparency during COVID-19 must also contain robust case information about
18 the social determinants of health.⁴¹ Few current COVID-19 dashboards provide such important,
19 specific data, only showing cumulative data by race, ethnicity and other special populations.³

20 Mandating the collection of these data through legislation may be effective. Though not
21 comprehensive, federal agencies, such as Centers for Medicaid and Medicare Services and
22 Health Resources and Services Administration have begun to require and incentivize health care
23 entities to systematically collect and report race and ethnicity.^{42,43} Several states have enacted
24 legislation which requires providers to collect specific sociodemographic data for each COVID-
25 19 patient encounter which is anticipated to help bolster each state's COVID-19 response.⁴⁴
26 Canadian health organizations found that asking patients to self-report these demographic data
27 was a successful means to collect these data.⁴⁵

28 **2) Actively address health disparities and disparities created by COVID-19:** All stakeholders
29 must actively address health disparities and access to care among underserved populations in the
30 COVID-19 response. COVID-19 testing should be freely available for all workers, including

1 persons living and working in institutional facilities. The evidence suggests that testing
2 frequently, especially in communities with dense living like skilled nursing facilities, can detect
3 circulating disease in asymptomatic persons and reduce disease transmission.^{18,19} Employers
4 must also ensure the availability of PPE for those at increased risk of contracting COVID-19 at
5 work. Concurrently, paid sick-leave and physical distancing measures must be implemented to
6 support persons who work in at-risk settings and live in dense housing.⁶ Extensions on
7 moratoriums for evictions and foreclosures, access to clean water and healthy food, and
8 advocacy for legislation that promotes clean air can help reduce existing health disparities.⁶
9 Focusing on employing trained community health workers, expanding Supplemental Nutrition
10 Assistance Programs, enhancing school lunch programs, and ensuring universal broadband
11 access can also narrow disparities and build community resilience.⁴⁶

12 **3). Empower all communities in public health practice and research decision-making:** A
13 core component of public health work is empowering the community from design to
14 implementation, evaluation, and dissemination to find feasible evidence-based solutions. Public
15 health must enhance efforts to engage with local community leaders and organizations to provide
16 critical messaging about COVID-19 infection and to collaborate for community-based testing
17 and contact-tracing. Seeking community input and partnership is necessary for community
18 uptake and can help ensure credible information is distributed across neighborhoods. One study
19 suggests that when community engagement and culturally aligned interventions are
20 implemented, there was a significant increase in favorable health behaviors.⁴⁷ Contact tracing
21 should also be conducted in a manner that aligns with the needs and culture of a population.
22 Indigenous and rural populations benefit through face-to-face contact tracing which can help
23 uncover other sick persons, identify other health needs, and help families follow quarantine
24 procedures.⁴⁸ The research and allocation process for COVID-19 treatment and vaccinations
25 must involve community members from development to implementation. One way is to
26 implement new standards of practice for meaningful patient and community engagement from
27 the Patient Centered Outcomes Research Institute and the National Institutes of Health.

28 **XI. Opposing Argument/Evidence**

29 The collection of sociodemographic data, while critical for scientifically informed decisions,
30 may pose risks to confidentiality and privacy. If these data are not kept private, their release may

1 lead to negative social and professional consequences.⁴⁹ In tandem with building up systems to
2 support sociodemographic data collection for COVID-19 reporting, public health and federal
3 entities must also build systems and processes to limit the use of protected health information
4 and educate and train staff.⁴⁰ Presenting sociodemographic-specific data are subject to
5 misinterpretation by the public if taken out of context. Special care must be taken to ensure these
6 data are properly translated and accurately reported by public health practitioners and the media
7 to empower, not mislead, communities and avoid stigmatizing or blaming them.

8 Others have suggested that the U.S. should focus on gaining natural herd immunity while a
9 vaccine is being developed rather than building up non-pharmacologic strategies to prevent
10 COVID-19. However, epidemiologic models show that large proportions of the population
11 would need to be infected and many of those infections could result in death.⁵⁰ Considering that
12 underserved populations are already experiencing disproportionate impacts of COVID-19 related
13 morbidity and mortality, the natural herd immunity strategy would widen these disparities and be
14 unethical.

15 Eliminating health disparities requires providing concentrated resources in areas of need.¹⁴ This
16 raises some financial concerns as robust financial support is needed to prioritize resources by
17 levels of risk and others may want to equally allocate financial resources across all communities.
18 This argument of equality versus equity is examined often and the primary finding suggest that
19 addressing health disparities of all forms is best done through health equity.¹⁴ Ample evidence
20 suggests that ignoring health disparities perpetuates a greater long-term economic burden on
21 society.¹⁴

22 **XII. Alternative Strategies**

23 COVID-19 is a novel condition and data supporting strategies to address this disease and
24 resulting disparities are fairly limited. One alternative proposed strategy is to develop local, state,
25 and national task forces and response teams on health equity to address COVID-19 health
26 disparities. At present, over ten states have enacted this strategy but most lack sufficient funding
27 to address the root causes of health disparities and incomplete COVID-19 sociodemographic data
28 collection.⁴⁴ The formulation of task forces requires substantial funding and proper infrastructure
29 and without such support, it is unlikely to affect sustainable progress.

1 **XIII. Action Steps**

2 APHA calls on the US Congress and federal government and state, local, and tribal governments
3 and their supportive agencies and organizations to take the following steps:

- 4 1. Declare disparities in the COVID-19 pandemic and current delayed public health
5 responses as unacceptable threats to the health and wellbeing of all U.S. communities.
6
- 7 2. Prioritize funding and mobilize stakeholders to enable timely and sustainable
8 scientifically informed actions in addressing the direct and indirect COVID-19
9 impacts to a) prevent further transmission; b) treat COVID-19 illnesses and related
10 health risks; and c) provide economic and psychosocial support to at-risk
11 communities. All testing should include availability of mobile and walk-up options to
12 improve accessibility.
13
- 14 3. Support timely, community-level interventions and policies by funding and staffing
15 near-to-real time, flexible, integrated, secure and transparent public health
16 surveillance, evaluation, and research through epidemiological standards of practice.
17
- 18 4. Enact and fund legislation and enable adequate personnel levels to comply with
19 federal and state initiatives to address missing sociodemographic data in COVID-19
20 case reporting. Surveillance systems should implement expanded data analyses
21 examining sociodemographic data to provide communities with timely and actionable
22 information.
23
- 24 5. Fund and recruit the active engagement of persons from underserved communities in
25 all stages of clinical trial research, compassionate use implementation, guideline
26 development, and allocations of novel therapeutics and vaccines to assure their
27 distribution is equitable and scientifically informed.
28
- 29 6. Fund and implement evidence-based interventions that address health disparities.
30 Ensure timely and sustainable access to healthcare including mental health, healthy
31 foods, clean water, reliable internet, health insurance, affordable medications,
32 housing, and transportation.
33
- 34 7. Empower community leaders and members to plan and implement COVID-19
35 prevention and mitigation strategies and evaluate the effectiveness. All community-
36 level messaging should adhere to the National Standards for Culturally and
37 Linguistically Appropriate Services in Health and Health Care.
38
- 39 8. Enact specific legislation and rules that protects workers at-risk for COVID-19 such
40 as healthcare and essential workers and their families by ensuring the equitable
41 distribution of personal protective equipment and financial and health assistance.
42 Federal Occupational Safety and Health Administration (OSHA) and state equivalent
43 agencies specifically must enact and enforce strong infectious disease control
44 workplace standards to protect against workplace transmission and provide rules

1 covering employee sick leave that include COVID-19 as a workplace hazard.

- 2
3 9. Collect, fund, disseminate, and translate rigorous, scientifically peer-reviewed and
4 community-engaged research on the effectiveness of COVID-19 interventions paying
5 particular attention to social determinants of health in preparation for future public
6 health emergencies.
7

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