

September 4, 2020

Committee on Equitable Allocation of Vaccine for the Novel Coronavirus;
National Academy of Medicine; National Academies of Sciences, Engineering,
and Medicine

William H. Foege, M.D., M.P.H. Committee Co-Chair
Emeritus Distinguished Professor of International Health, Rollins School of Public
Health, Emory University

Helene Gayle, M.D., M.P.H. Committee Co-Chair
President and Chief Executive Officer, The Chicago Community Trust

Re: Discussion Draft of the Preliminary Framework for Equitable
Allocation of COVID-19 Vaccine (2020)

Submitted electronically to <https://www.nap.edu/vaccine/>

Dear Dr. Foege and Dr. Gayle,

The Fenway Institute at Fenway Health submits the following comment regarding the Discussion Draft of the Preliminary Framework for Equitable Allocation of COVID-19 Vaccine (2020). The Fenway Institute is the research, education and training, and policy arm of Fenway Health, a federally qualified health center in Boston, MA. We provide care to about 32,000 patients every year. Half of our patients are lesbian, gay, bisexual and transgender (LGBTQIA+). About 2,300 of our patients are people living with HIV. We are a Ryan White Part C clinic. Currently we have 3,200 patients receiving pre-exposure prophylaxis for HIV prevention, and have prescribed PrEP to 4,700 patients since it became available earlier this decade.

In general, we think that the draft plan is well thought out and reasonable. We wish to make three points.

First, we agree that “the vaccine allocation criteria should mitigate the negative effects of existing health inequities on the transmission of and harms from the novel coronavirus.” In addition to the racial/ethnic and socioeconomic health inequities that you identify, we also point you toward health inequities and enhanced risk affecting LGBTQ people, which intersect with racial/ethnic and socioeconomic inequities.

LGBTQ people are nearly twice as likely to work in front line jobs such as food services and restaurants, retail, health care, and education that can make it harder to socially distance and work remotely.¹ (Citations are included in uploaded supporting file).

Additionally, LGBTQ people suffer economic disparities that place many in living environments that may make it harder to maintain social distancing: 22% of LGBTQ people in the U.S. are poor, compared to 16% of straight, cisgender people.² LGBTQ people are more likely to live in urban areas, where physical distancing measures are harder to maintain.

LGBTQ people are more likely to have some of the underlying health conditions that correlate with increased vulnerability to COVID-19-related health complications and fatalities, including cardiovascular disease, cancer, obesity, diabetes, HIV/AIDS,³ and asthma.^{4,5}

LGBTQ people across the age spectrum are more likely to smoke⁶ and vape,⁷ and to use substances.⁸ Higher rates of tobacco and substance use are related to experiences of stigma, minority stress, and social anxiety. These disparities intersect with racial and ethnic health disparities. All of these conditions and risk behaviors could increase the vulnerability of LGBTQ people if they are exposed to SARS-CoV-2.

¹ Whittington C, Hadfield K, Calderón C (2020, March). *The lives and livelihoods of many in the LGBTQ community are at risk amidst COVID-19 crisis*. Washington, DC: Human Rights Campaign Foundation. <https://www.hrc.org/resources/the-lives-and-livelihoods-of-many-in-the-lgbtq-community-are-at-risk-amidst>.

² Badgett, Choi, Wilson (2019). *LGBT poverty in the United States: A study of differences between sexual orientation and gender identity groups*. UCLA School of Law, The Williams Institute. <https://williamsinstitute.law.ucla.edu/wp-content/uploads/National-LGBT-Poverty-Oct-2019.pdf>

³ Cahill S and Wang T (2019, June). Quality Innovation Network, Quality Improvement Organizations (QIN-QIO) Sharing Call: “Reducing chronic disease and health disparities in diverse LGBT populations.” National webinar.

⁴ Landers, S. J., Mimiaga, M. J., & Conron, K. J. (2011). Sexual orientation differences in asthma correlates in a population-based sample of adults. *American journal of public health, 101*(12), 2238–2241.

⁵ Fredriksen-Goldsen, K. I., Kim, H. J., Shui, C., & Bryan, A. (2017). Chronic Health Conditions and Key Health Indicators Among Lesbian, Gay, and Bisexual Older US Adults, 2013–2014. *American journal of public health, 107*(8), 1332–1338.

⁶ Lee JG, Griffin GK, Melvin CL. (2009). Tobacco use among sexual minorities in the USA, 1987 to May 2007: A systematic review. *Tob Control 18*:275–282.

⁷ Washington R, Cahill S. (2019, June). “Do e-cigarettes represent a harm reduction approach for the LGBT community? How do we reduce disparities in use?” National LGBTQ Health Conference, Emory University, Atlanta. Concurrent session—substance use.

⁸ Song YS, Sevelius JM, Guzman R, Colfax G. (2008). Substance use and abuse. *The Fenway Guide to Lesbian, Gay, Bisexual and Transgender Health*. Philadelphia: American College of Physicians. 2008. 209-247.

We know that there are striking racial/ethnic disparities in the COVID-19 pandemic because racial/ethnic data are collected, however imperfectly, in COVID-19 testing and care. Unfortunately, only a handful of states are collecting sexual orientation and gender identity (SOGI) data in the COVID-19 pandemic, and the federal government has taken no steps to encourage the collection of SOGI data. Still, it is likely that LGBTQ people are more likely to contract the novel coronavirus and experience complications if they develop COVID-19. We encourage you to identify LGBTQ people as an intersecting, vulnerable population that experiences health inequities and may be “hard to reach” as a result. This could be done in the discussion on pages 38-39 of the draft plan.

Secondly, LGBTQ people experience discrimination and stigma, which negatively affects physical and mental health⁹ and constitutes a barrier to accessing care.¹⁰ Lesbian and bisexual women¹¹ and transgender people¹² are less likely to access routine, preventive health care compared to their heterosexual and cisgender peers. LGBTQ people of color experience intersectional stigma based on race as well as SOGI.¹³ In recent years, the federal government has enacted discriminatory religious refusal policies¹⁴ and removed SOGI nondiscrimination language from federal health care regulations.¹⁵

Partly as a result of stigma and discrimination in health care, LGBTQ people, and especially LGBTQ people of color¹⁶ and transgender people,¹⁷ experience medical mistrust, which could affect the likelihood that they will know when a vaccine

⁹ Reisner SL, White Hughto JM, Dunham E, Heflin K, Begenyi JB, Coffey-Esquivel J, Cahill S (2015). Legal protections in public accommodations settings: A critical public health issue for transgender and gender nonconforming people. *Milbank Quarterly*. 93(3):484-515.

¹⁰ Ahmed Mirza, Shabab and Rooney, Caitlin (2018). *Discrimination Prevents LGBTQ People from Accessing Health Care*. Washington, DC: Center for American Progress.

¹¹ Kerker BD, Mostashari F, Thorpe L. Health care access and utilization among women who have sex with women: Sexual behavior and identity. *J Urban Health*. 2006;83(5):970-979.

¹² Gonzales, G., & Henning-Smith, C. (2017). Barriers to Care Among Transgender and Gender Nonconforming Adults. *The Milbank quarterly*, 95(4), 726–748.

¹³ Conron K, Wilson J, Cahill S, Flaherty J, Tamanaha M, Bradford J (2015, November 30). *Our health matters: Mental health, risk, and resilience among LGBTQ youth of color who live, work, or play in Boston*. Fenway Institute. <https://fenwayhealth.org/wp-content/uploads/our-health-matters.pdf>

¹⁴ Cha, A., Eilperin, J. (2018, January 17). New HHS civil rights division to shield health workers with moral or religious objections. *Washington Post*.

¹⁵ Keith K (2020 June 15). HHS Strips Gender Identity, Sex Stereotyping, Language Access Protections From ACA Anti-Discrimination Rule. *Health Affairs*. <https://www.healthaffairs.org/doi/10.1377/hblog20200613.671888/full/>

¹⁶ Cahill S, Taylor SW, Elsesser SA, Mena L, Hickson D, Mayer KH (2017). Stigma, medical mistrust, and perceived racism may affect PrEP awareness and uptake in Black compared to White gay and bisexual men in Jackson, Mississippi and Boston, Massachusetts. *AIDS Care*. 29(11): 1351–1358.

¹⁷ D'Avanzo, P. A., Bass, S. B., Brajuha, J., Gutierrez-Mock, L., Ventriglia, N., Wellington, C., & Sevelius, J. (2019). Medical Mistrust and PrEP Perceptions Among Transgender Women: A Cluster Analysis. *Behavioral medicine (Washington, D.C.)*, 45(2), 143–152.

becomes available, know how to access it, and be willing to trust those offering the vaccine. Public health authorities and health care providers should conduct affirmative outreach and enlist trusted community leaders to promote vaccination in Black and Native American communities, immigrant communities, LGBTQ communities, and other communities in which medical mistrust is high.

Finally, the draft plan states on page 48:

The committee appreciates that decisions about the public's health are made in the context of existing political realities and those are not static. However, the committee believes that regardless of the political context, officials at all levels will administer these principles faithfully, considering the wellbeing of all members of the communities that they are elected or appointed to serve.

In a normal time, this might be a reasonable assumption. However, throughout the COVID-19 pandemic the current administration and many governors have politicized and undermined faith in science, and undermined public health by rushing to reopen the economy and prohibiting local governments from enacting mask ordinances and other common sense public health measures. We believe the administration grossly mishandled coronavirus testing, and told states that they were on their own in terms of providing personal protective equipment to health care workers. The administration has threatened to withhold federal funding to municipalities and states for fighting wildfires, for policing, and to punish so-called "sanctuary cities." We believe that strong civil society oversight is necessary in order to ensure implementation of the draft plan's principles of equity and fairness, and to address issues of vulnerability and health inequity in the allocation of the vaccine.

Thank you for the opportunity to comment on the draft vaccine allocation plan. Should you have any questions, please contact Sean Cahill, PhD, Director of Health Policy Research, at scahill@fenwayhealth.org or 617-927-6016.

Sincerely,

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