



May 11, 2021

Via Electronic and Letter Mail

Georgia Governor Brian Kemp
206 Washington Street
Suite 203, State Capitol
Atlanta, GA 30334

RE: Ensuring Equitable Distribution of COVID-19 Vaccine in Georgia

Dear Governor Kemp:

On behalf of the NAACP Legal Defense and Educational Fund, Inc. (“LDF”), the Georgia NAACP, State Representative Rhonda Burnough (D-77), State Representative Viola Davis (D-87), and State Representative Sandra Scott (D-76) and, we call on you to take immediate steps to eliminate the stark racial disparities in Georgia’s distribution of COVID-19 vaccinations. COVID-19 is a public health crisis that affects the entire Georgia community but has disproportionately impacted communities of color. Ensuring vaccine equity through prioritization of those most vulnerable to COVID-19 protects and benefits everyone.

Since the onset of the coronavirus pandemic, communities of color have borne a disproportionate burden of COVID-19 infections, hospitalizations, and deaths.¹ Black communities, in particular, have been ravaged by COVID-19, dying at nearly twice the rate of white people nationwide,² and at disproportionately higher rates than white people in Georgia.³ Black and Latinx individuals often hold frontline essential and service industry jobs, which prevent them from working from home, and disproportionately experience social and healthcare inequities, all of which contribute to increased risk of COVID-19 exposure.⁴ Nevertheless, Black and Latinx individuals nationwide are receiving the COVID-19 vaccine (“the vaccine”) at significantly lower rates than white individuals. As of May 6, 2021, more than 149 million people nationally have received at least one vaccine dose, however, racial and ethnic data is available for only approximately 55% of recipients.⁵ Of those, only 8.8% doses thus far have been administered to Black people and 12.6% to Latinx people.⁶ In contrast, 63.2% of those vaccine doses have been administered to white people nationally.⁷ Black residents in Georgia are likewise underrepresented in vaccine distribution even though they should be especially targeted due to their disproportionate higher rates of serious illness and death from COVID-19: they have received only 24% of vaccine doses despite being 32% of the population, and compared to white residents who have received 59% of vaccine doses whilst being 58% of the Georgia population.⁸ These figures cannot be explained by so-called “vaccine hesitancy” among Black residents. In fact, polls indicate that Black people have no greater vaccine hesitancy than white people.⁹ Rather, the under-vaccination of Black residents is due primarily to lack of access, not lack of willingness.¹⁰

As Georgia’s leadership, it is your responsibility to ensure equitable vaccine distribution and protect your most vulnerable residents from increased risk of COVID-19 infection, hospitalization, and death. Barriers to vaccine access, such as vaccine deserts, lack of digital access, and inattention to unhoused and incarcerated communities, unduly burden communities of color and limit their ability to obtain the COVID-19 vaccine.¹¹ This disparate treatment directly threatens the rights of Black and Latinx Georgia residents in possible violation of Title VI of the Civil Rights Act of 1964, as well as the safeguards afforded under the Equal Protection Clause of the Fourteenth Amendment and Article I, § 1 ¶ II of the Georgia Constitution, guaranteeing equal protection of the laws. On April 2, 2021, the United States Department of Justice (the “DOJ”) issued a statement making clear that “[t]he Civil Rights Division, together with other agencies throughout the Federal government, will continue to monitor civil rights issues related to COVID-19 and vigorously enforce civil rights laws.”¹² Quite simply, “[c]ivil rights protections and responsibilities still apply, even during emergencies. They cannot be waived.”¹³ As a result, we urge you to review the following factors, among others, that contribute to vaccine inequity and immediately implement our recommendations, specified below, to remedy the racial inequities in your vaccination distribution methods.

A. Vaccine Deserts and Vaccine Tourism

Due to racial segregation, redlining, and other effects of structural racism, predominantly Black communities are often housed in areas with little to no healthcare infrastructure and few, if any, healthcare resources.¹⁴ This means Black residents are significantly more likely than white residents to live at least a mile away from the nearest quality pharmacy, clinic, hospital, or healthcare center.¹⁵ Thus, when local governments primarily rely on preexisting health care infrastructure and providers for vaccine administration, many Black individuals have few, if any, options for receiving the vaccine in their own communities—creating “vaccine deserts.”¹⁶ Further, vaccine deserts are largely concentrated in low-income communities of color, which commonly lack transportation or rely on public transport.¹⁷ Thus, the populations with high vulnerability to COVID-19 infection and death are the same populations excluded from vaccine access and distribution.¹⁸

The consequence is that Black residents live much farther, on average, from the closest vaccination site than white residents—a national trend that is “especially prevalent” in Georgia.¹⁹ In Georgia, therefore, Black residents in vaccine deserts must shoulder the additional costs and burdens of finding transportation to vaccine centers outside of their neighborhoods while juggling employment obligations, childcare responsibilities, declining health, and other consequences of living in racially segregated neighborhoods that are deprived of healthcare resources. This trend cannot continue. We strongly urge you to implement the following recommendations to eliminate these inexcusable barriers and racial disparities in Georgia’s vaccine access and distribution methods.

- **Prioritize the establishment and expansion of vaccination sites, such as mobile healthcare centers, clinics, and other healthcare facilities, in underserved communities hardest hit by COVID-19 and those located in vaccine deserts.** Ensure vaccination sites consider the targeted community’s specific challenges, such as access to healthcare facilities, limited

internet access, lack of transportation or limited mobility, limited English language proficiency, limited hours of availability due to work or childcare, and limited income, and provide solutions that circumvent these challenges.

- Review and analyze geographic data, such as ZIP Codes and census tracts, to ensure that investments in public health infrastructure prioritize healthcare and vaccination of populations that are underserved or most vulnerable to COVID-19 infection, including frontline essential and service industry workers.²⁰ Place new vaccination sites in accessible public spaces within underserved communities, *e.g.*, near or within churches, community centers, public housing residences, public schools, and parking lots.
- **Collaborate with and rely on trusted community-based organizations, religious institutions, stakeholders, leaders, and activists within communities most impacted by COVID-19, before, during, and after implementing all efforts to combat vaccine inequity.** Because vaccine inequity overwhelmingly impacts vulnerable communities of color, all efforts to ensure equitable vaccine access should center around meaningful engagement with Black and Latinx communities, particularly elders and those residing in vaccine deserts. These engagement efforts should be conducted in partnership with, or led by, grassroots organizations, local activists, clergy, and other key community stakeholders to achieve increased vaccine distribution and reduce vaccine hesitancy in vulnerable communities of color.²¹
- **Take action to guard against vaccine tourism.** Frequently, when vaccination centers are brought to underserved communities to increase vaccine access for vulnerable residents, the targeted vulnerable residents are still unable to access the vaccines because more affluent people from outside areas, who have the resources and connections to learn of and travel to the new vaccination site, “skip” ahead of underserved residents to receive a vaccination—commonly labeled “vaccine tourism.”²² To avoid vaccine tourism, elected officials should work with the targeted community’s stakeholders and leaders to ensure members of the targeted community are prioritized for vaccine resources.²³ There should also be a public campaign to condemn vaccine tourism and discourage more privileged constituents and people outside your constituency from depriving vaccine access to those more vulnerable to COVID-19 infection, serious illness, or death, which creates greater burdens and harms for everyone.
- **In coordination with trusted community-based organizations, stakeholders, leaders, and activists representing Black, Latinx, and other communities of color, create easily accessible public education campaigns** that target, reach, and inform vulnerable and underserved populations, including unhoused and incarcerated populations, about vaccine eligibility, safety, efficacy, and distribution sites, and emphasize the absence of any cost associated with vaccination.
 - All public education campaigns should directly address vaccine hesitancy in communities of color, in a manner that validates and takes seriously the concerns, acknowledges the healthcare industry’s history of racial discrimination and experimentation on Black communities, clarifies that the COVID-19 vaccine will not

replicate those practices, and provides accessible resources and data showing the safety of the vaccine.

- **Eliminate additional barriers to vaccine access.**
 - Increase community-based vaccination sites in vulnerable zip codes and—to prevent vaccine tourism and limited vaccine access for those targeted and vulnerable communities—encourage proof of residency within the targeted area prior to vaccination. However, because proof of residency requirements typically place additional burdens on low-income residents and communities of color,²⁴ all proof of residency requirements should be broad and include acceptance of identifying documents beyond government-issued identification, such as current mail (not limited to utility bills), statements from others residing in the community, school records, individual attestation of residency in targeted district, and more.
 - Eliminate all fees and co-pays associated with an individual’s COVID-19 vaccination, including hospital and clinic administrative fees, even if reimbursable.
 - Create free, COVID-19 sanitized,²⁵ wheelchair-accessible methods of public transportation to and from vaccination centers and underserved areas, racially segregated neighborhoods, and vaccine deserts for residents needing transportation assistance.²⁶

B. Lack of Digital Access & Difficulties with Online Platforms

State and local governments nationwide, including those in Georgia, rely primarily on online platforms to disseminate crucial public health information about the safety and efficacy of the vaccine; vaccine appointment eligibility and registration; and location of vaccination sites. However, for more than 1 million Georgia residents, reliable internet access is a luxury beyond reach.²⁷ This digital divide disproportionately impacts the elderly, low-income residents, and those in rural communities.²⁸ Lack of digital access is also more prevalent in communities of color with over 80% of white Americans owning a computer as compared to just 58% of Black Americans and 57% of Latinx Americans.²⁹ Even residents who have technology devices and dependable internet access must contend with complex registration processes, multi-step verifications, and numerous platforms as they search for available vaccine appointments.³⁰ This complicated registration process further limits vaccine accessibility for those who lack digital proficiency or the time or capacity to review various websites. The digital divide and complicated registration systems should not prevent your constituents from receiving the vaccine.³¹ As such, we recommend you take the following steps:

- **Permit all vaccine sign-up and registration, waiting in line, and distribution processes to be completed in-person and by telephone, as well as online and via SMS messaging.**
- **Streamline the registration process by placing details about vaccine appointment availability on a single website.** Centralizing this information will increase user confidence and avoid confusion arising from users navigating multiple websites. Also ensure that vaccination telephone hotlines and in-person registration systems are consolidated so that all necessary information can be obtained from a central source. Make

all information about the vaccine and vaccination sites available in the most common languages used by your constituents.

- **Implement outreach methods from prior successful public education campaigns, such as the use of mobile sign-up units that travel to residences and frequent high-traffic locations in underserved communities, to ensure vulnerable communities can easily receive vaccine and appointment information.** Coordinate with local community-based organizations, religious institutions, elected officials, activists, and other leaders to identify additional reliable methods of broad transmission of vaccine and appointment information with considerations of language proficiency.

C. Inattention to the Unhoused and Incarcerated Populations

COVID-19 vaccination plans must prioritize those experiencing housing instability and homelessness.³² Black people, particularly those who are older or have poor health, are disproportionately represented in unhoused communities,³³ making them even more susceptible to severe COVID-19 infection and death.³⁴ Communities of color are also facing increased housing insecurity due to the economic toll of the pandemic.³⁵ Black and Latinx households are more than twice as likely to report being behind on housing payments than white households.³⁶ In fact, Black people represent just 21% of all renters, but 35% of all defendants on eviction cases during the pandemic.³⁷ In Georgia, 2018 findings revealed that, statewide, 9,499 people were homeless on a given night, constituting 9 per 10,000 people in the general population.³⁸ The pandemic has only made this problem worse—with 62% of renters facing eviction at some point during the past year, the number of unhoused Georgia residents is likely much higher today.³⁹ Unhoused communities often rely on congregate settings, such as homeless shelters or outdoor communities, where they are in poorly ventilated spaces and are unable to engage in the practices necessary to slow the transmission of the virus, such as social distancing, regular cleaning,⁴⁰ and frequent handwashing.

Similarly, vaccination plans must prioritize incarcerated people. COVID-19 outbreaks in carceral facilities have been rampant, with one in five state and federal prisoners testing positive for coronavirus, a rate more than four times greater than the general population.⁴¹ Like those in other congregate settings, individuals in jails, prisons, and detention centers are housed in poorly ventilated facilities and are unable to socially distance, have limited access to personal protective equipment and cleaning supplies, and lack adequate health care resources to prevent and treat COVID-19 infections.⁴² Additionally, the constant movement between carceral facilities and outside communities by both carceral staff and residents increases the likelihood of community spread of the virus from carceral facilities to outside communities.⁴³ Georgia is no exception; in fact, Georgia has the nation's seventh-highest number of deaths among the state's incarcerated population.⁴⁴ Nevertheless, Georgia's vaccine distribution efforts have, until recently, largely excluded incarcerated populations, prioritizing the vaccination of carceral staff.⁴⁵ This approach illogically ignores the *shared* increased risk of infection between staff and incarcerated persons, and creates an additional vector for spreading COVID-19 among communities and burdening the healthcare infrastructure.⁴⁶ Furthermore, it remains unclear whether vaccination of carceral staff prevents their transmission of COVID-19 to others; therefore, simultaneous vaccination of those living and working in carceral facilities is necessary to meaningfully reduce transmission rates

both within carceral settings and the surrounding outside communities.⁴⁷ Even when, in recent days, some vaccinations have been made available to incarcerated people, it has been reported that agreement to vaccination has been incentivized by offers of “cookies, chips and candy” rather than by sincerely sharing information and building trust. Incarcerated individuals have also reported lack of information about the vaccine prior to being asked to sign a consent form, noting that their requests for additional information were refused.⁴⁸ Incarcerated people must have the genuine opportunity to provide informed consent.⁴⁹

Housing insecurity and incarceration should not be death sentences. Accordingly, we ask that you take the following efforts:

- **Provide targeted information to unhoused and incarcerated populations about vaccine eligibility, safety, efficacy, distribution, and lack of cost** with special consideration of the unique concerns and hesitations of these populations.
- **Prioritize the unhoused and incarcerated populations in vaccination plans** given their greater susceptibility to infection within congregate settings and greater risk of serious illness or death given their higher rates of comorbidities.⁵⁰ At a minimum, these populations should be vaccinated simultaneous to staff working with them.
- **Employ mobile vaccination clinics to reach unhoused communities and individuals**, including those residing outside of shelters and simultaneously offer free and COVID-safe forms of transportation (*e.g.*, designated buses, free taxis, shuttle service) to vaccination sites.

D. Collection and Publication of Demographic Vaccine Data

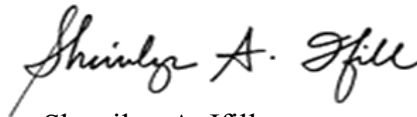
In addition to the above barriers to vaccine equity, there is a nationwide lack of public vaccine distribution data, disaggregated by key demographics, such as race, ethnicity, age, sex, disability, English proficiency, and geographic location.⁵¹ These gaps in data hinder the public from tracking and evaluating the racial equity of vaccine distribution nationally and within specific localities. Given the importance of accurate information in ensuring fair treatment of all Georgia residents, we therefore strongly recommend that you continue to require rigorous and frequent collection and publication of vaccine administration data at the county, city, and state level, disaggregated by race, ethnicity, age, sex, disability, English proficiency, geographic location, including residency of those vaccinated, and other relevant demographics.

To rectify the stark racial disparities in Georgia’s vaccine distribution and halt the spread of COVID-19, you must ensure that Georgia centers racial equity as a key principle in vaccine distribution plans and efforts. Without this critical intervention, your most vulnerable constituents will remain largely unvaccinated and will continue to disproportionately fall ill from the virus or die, creating greater risks of community spread within your entire constituency and further burdening your overstretched healthcare infrastructure. Communities of color have already

disproportionately borne the weight of this unprecedented public health crisis. You now have a critical opportunity to reverse this trend by ensuring racial equity in vaccine distribution.

During this unprecedented public health crisis, residents of Georgia, including residents of color, are looking to you for the bold leadership and swift action that is desperately needed at this time. We thus encourage you to meet this moment by implementing the above recommendations and making clear your firm commitment to racial equity for all. Thank you for your time and consideration, and please do not hesitate to contact Katurah Topps at ktopps@naacpldf.org or Kaydene Grinnell at kgrinnell@naacpldf.org if you have any questions or concerns.

Sincerely,



Sherrilyn A. Ifill
President and Director-Counsel
NAACP Legal Defense and Educational Fund, Inc.

Dexter Benning
Third Vice President
Bartow County Branch
Georgia NAACP

Representative Rhonda Burnough
Georgia House District 77

Representative Viola Davis
Georgia House District 87

Representative Sandra G. Scott
Georgia House District 76

CC:

Dr. Kathleen Toomey
Commissioner, Georgia Department of Public Health
2 Peachtree Street, NW
Atlanta, GA 30303-3186
Ket1@dhr.state.ga.us

Jeffrey E. Turner
Chairman, Board of Commissioners, Clayton County, GA
112 Smith Street, Annex 1

Jonesboro, GA 30236
katrina.holloway@claytoncountyga.gov

Hon. Van R. Johnson, II
Mayor, City of Savannah, GA
Savannah City Hall, 2nd Floor
2 East Bay Street
Savannah, GA 31401
MayorJohnson@savannahga.gov

Robyn A. Crittenden, Commissioner, Georgia Department of Human Services
2 Peachtree Street, NW,
Room 29-250
Atlanta, Georgia 30303-3142

Christopher Nunn., Commissioner, Georgia Department of Community Affairs
60 Executive Park South NE
Room 305
Atlanta, Georgia 30329-2231
Christopher.Nunn@dca.ga.gov
region3@dca.ga.gov

Thomas Moore, Deputy Director, Emergency Management, Georgia Emergency Management
and Homeland Security
Post Office Box 18055, Atlanta, GA, 30316-0555
Thomas.moore@gema.ga.gov

Frank W. Berry, Commissioner, Georgia Department of Community Health
2 Peachtree Street NW
6th Floor
Atlanta, Georgia 30303-3142

Jeff Zients, White House Coronavirus Response Coordinator
1000 Independence Ave. SW
Washington, DC 20585

White House Covid-19 Health Equity Task Force
Dr. Marcella Nunez-Smith, Chair
The White House
1600 Pennsylvania Ave NW
Washington, DC 20500

¹ Samantha Artiga, Bradley Corallo & Olivia Pham, *Racial Disparities in COVID-19*, KAISER FAM. FOUND. (Aug. 17, 2020), <https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-covid-19-key-findings-available-data-analysis/>.

² Ctrs. for Disease Control & Prevention, COVID-19 Hospitalization and Death by Race/Ethnicity (Apr. 23, 2021) <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html#footnote02>.

³ Nambi Ndugga, Olivia Pham, Latoya Hill, Samantha Artiga & Salem Mengistu, *Latest Data on COVID-19 Vaccinations Race/Ethnicity*, KAISER FAM. FOUND., <https://www.kff.org/coronavirus-covid-19/issue-brief/latest-data-covid-19-vaccinations-cases-deaths-race-ethnicity> (last visited May 7, 2021).

⁴ See David Waldstein, *As Georgia Reopens, Virus Study Shows Black Residents May Bear Brunt*, N.Y. TIMES (Apr. 30, 2020), <https://www.nytimes.com/2020/04/30/health/coronavirus-georgia-african-americans.html> (“African-Americans are essential employees in our system . . . [e]verything from bus drivers to health care workers and cleaning services, they are on the front line, and therefore are far more likely to be exposed.”).

⁵ Ctrs. for Disease Control & Prevention, *Demographic Characteristics of People Receiving COVID-19 Vaccinations in the United States*, <https://covid.cdc.gov/covid-data-tracker/#vaccination-demographic> (last visited May 6, 2021) (reporting that Hispanic/Latinx, Black non-Hispanic, and Asian non-Hispanic populations are all being vaccinated at disproportionately lower rates, while the white non-Hispanic population is being vaccinated at higher rates).

⁶ *Id.*

⁷ *Id.*

⁸ Ndugga et al., *supra* note 3.

⁹ Juana Summers, *Little Difference In Vaccine Hesitancy Among White And Black Americans, Poll Finds*, NPR, <https://www.npr.org/sections/coronavirus-live-updates/2021/03/12/976172586/little-difference-in-vaccine-hesitancy-among-white-and-black-americans-poll-find> (Mar. 12, 2021) (“There is little difference in reluctance to take the coronavirus vaccine among Black and white people in the U.S.”)

¹⁰ *Id.*; see also Akilah Johnson, *Lack of Health Services and Transportation Impede Access to Vaccine in Communities of Color*, WASH. POST (Feb. 13, 2021), <https://www.washingtonpost.com/health/2021/02/13/covid-racial-ethnic-disparities> (highlighting structural barriers limiting access to care for communities of color as key drivers of racial disparities in vaccination).

¹¹ In addition to the factors listed here, a failure to prioritize vaccination of frontline essential workers and individuals 65 years old and older, as the Center for Disease Control (CDC) recommends, contributes to the racial inequalities in COVID-19 infection and vaccine access. See Ctrs. For Disease Control and Prevention, *How CDC is Making Vaccine Recommendations* (Apr. 28, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations.html>; Kathleen Dooling, *Phased Allocation of COVID-19 Vaccines* (Dec. 20, 2020) <https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2020-12/slides-12-20/02-COVID-Dooling-508.pdf>.

¹² Press Release, Pamela S. Karlan, U.S. Dep’t of Just., Statement by the Principal Deputy Assistant Attorney General for Civil Rights Leading a Coordinated Civil Rights Response to Coronavirus (COVID-19) (Apr. 2, 2021), <https://www.justice.gov/opa/pr/statement-principal-deputy-assistant-attorney-general-civil-rights-leading-coordinated-civil>.

¹³ *Id.*

¹⁴ See Lucas A. Berenbrok et al., *Access to Potential COVID-19 Vaccine Administration Facilities: A Geographic Information Systems Analysis*, UNIV. OF PITT. SCH. OF PHARMACY & W. HEALTH POL’Y CTR., 3-4 (Feb. 2, 2021), <https://s8637.pcdn.co/wp-content/uploads/2021/02/Access-to-Potential-COVID-19-Vaccine-Administration-Facilities-2-2-2021.pdf> (finding that, across 69 U.S. counties housing 26 million people, and nearly 70,000 potential COVID-19 vaccine administration sites nationwide, “Black residents had a significantly higher risk than White residents of having a driving distance greater than 1 mile to the closest potential COVID-19 vaccine administration facility”).

¹⁵ *Id.*

¹⁶ See *Where Black Americans Will Travel Farther than Whites for COVID-19 Vaccination*, UNIV. PITT. MED. CTR. (Feb. 4, 2021), <https://www.upmc.com/media/news/020421-vaxmap-2>.

¹⁷ *Id.*

¹⁸ See Berenbrok et al., *supra* note 14, at 4; see also Mackenzie Bean, *Black Americans More Likely to Live in Vaccine Deserts, Pitt Study Finds*, BECKER’S HOSP. REV. (Feb. 4, 2021), <https://www.beckershospitalreview.com/public-health/black-americans-more-likely-to-live-in-vaccine-deserts-pitt-study-finds.html> (“About three-fourths of the counties with disparities in vaccine access also had high COVID-19 infection rates, averaging more than 50 new cases per 100,000 residents between November 2020 and January [2021].”).

¹⁹ Bean, *supra* note 18.

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- ²⁰ See *supra* note 4; see also Elise Gould & Valerie Wilson, *Black Workers Face Two of the Most Lethal Preexisting Conditions for Coronavirus—Racism and Economic Inequality*, ECON. POL’Y INST. (June 1, 2020), <https://www.epi.org/publication/black-workers-covid/> (noting that Black workers are more likely to be in frontline essential jobs, forcing them to risk their own and their families’ health to earn a living).
- ²¹ See, e.g., Ellie Rushing, Oona Goodin-Smith & Anna Orso, *Philly Black Doctors Clinic Outpaced the City in Vaccinating Black Residents, but Group Says There’s ‘Room for Improvement’*, INQUIRER (Feb. 25, 2021), <https://www.inquirer.com/health/coronavirus/philadelphia-coronavirus-vaccine-black-doctors-covid-consortium-20210225.html>.
- ²² Jen Kirby, *Don’t Hate the Vaccine Tourists, Hate the Vaccine Game*, VOX (Feb. 12, 2021) <https://www.vox.com/22262653/vaccine-tourism-covid-19>; Kiran Misra, *‘Vaccine Tourism’: Tens of Thousands of Americans Cross State Lines for Injections*, GUARDIAN (Jan. 31, 2021), <https://www.theguardian.com/us-news/2021/jan/31/us-vaccine-tourism-state-borders-covid-19-shots> (noting that vaccine tourism has “contributed to racial and socioeconomic disparities in vaccine distribution so far: from New York to New Jersey to Chicago, vaccine recipients have been overwhelmingly white, residing in wealthier zip codes”).
- ²³ For example, setting up mobile vaccination centers at various times and locations most accessible to low-income communities of color, such as within a public housing community, in the evening, to account for working families.
- ²⁴ See e.g., Sari Horwitz, *Getting a Photo ID So You Can Vote Is Easy. Unless You’re Poor, Black, Latino or Elderly*, WASH. POST (May 23, 2016), https://www.washingtonpost.com/politics/courts_law/getting-a-photo-id-so-you-can-vote-is-easy-unless-youre-poor-black-latino-or-elderly/2016/05/23/8d5474ec-20f0-11e6-8690-f14ca9de2972_story.html; see also NAACP LDF, *Frequently Asked Questions: Alabama’s Discriminatory Photo ID Law*, <https://naacpldf.org/wp-content/uploads/Greater-Birmingham-Ministries-v.-Alabama-FAQ-1.pdf> (noting that “[n]ationally, 25% of Black and 16% of Latino voting-age citizens have no form of government issued photo ID, compared to just 8% of whites.”).
- ²⁵ Any public transportation method must follow rigorous COVID-19 safety and cleaning protocols. See Ctrs. for Disease Control & Prevention, *Using Transportation*, [HTTPS://WWW.CDC.GOV/CORONAVIRUS/2019-NCOV/DAILY-LIFE-COPING/USING-TRANSPORTATION.HTML#PARATRANSIT](https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/using-transportation.html#paratransit) (last updated Feb. 17, 2021) (describing robust COVID-19 safety measures recommended for use with various forms of transportation, including mask requirements, social distancing guidelines, and cleaning protocols).
- ²⁶ For example, some cities provide free curb-to-curb service for individuals with vaccine appointments. See Taylor Moore, *If You Can’t Get to Your Vaccine Appointment, These Cities Will Drive You*, NEXT CITY (Feb. 17, 2021), <https://nextcity.org/daily/entry/if-you-cant-get-to-your-vaccine-appointment-these-cities-will-drive-you>.
- ²⁷ *New Broadband Availability Map Shows 1 Million+ Georgians Without Reliable Internet Access*, ALLONGEORGIA (July 2, 2020), <https://allongeorgia.com/georgia-state-news/new-broadband-availability-map-shows-1-million-georgians-without-reliable-access>.
- ²⁸ Andrew Perrin & Erica Turner, *Smartphones Help Blacks, Hispanics Bridge Some – But Not All – Digital Gaps with Whites*, PEW RES. CTR. (Aug. 20, 2019), <https://www.pewresearch.org/fact-tank/2019/08/20/smartphones-help-blacks-hispanics-bridge-some-but-not-all-digital-gaps-with-whites/>.
- ²⁹ *Id.*
- ³⁰ Cristina Silva, *‘It’s Life and Death’: Non-English Speakers Struggle to Get COVID-19 Vaccine Across US*, USA TODAY (Feb. 22, 2021), <https://www.usatoday.com/story/news/nation/2021/02/22/covid-19-vaccine-registration-non-english-speakers-left-behind/4503655001>; see also Sydney Pereira, *New Yorkers Eligible for COVID Vaccine Report Frustrations with City Registration Websites*, GOTHAMIST (Jan. 11, 2021), <https://gothamist.com/news/new-yorkers-eligible-vaccine-report-frustrations-city-registration-websites>.
- ³¹ Sara Ashley O’Brien, *COVID-19 Vaccine Rollout Puts a Spotlight on Unequal Internet Access*, CNN BUS. (Feb. 4, 2021), <https://www.cnn.com/2021/02/04/tech/vaccine-internet-digital-divide/index.html>.
- ³² See Ctrs. for Disease Control & Prevention, *Interim Guidance on COVID-19 Vaccination Implementation*, <https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/vaccination-guidance.html>. (last updated Apr. 30, 2021) (“Homeless services are often provided in congregate settings, which could facilitate the spread of infection, including infection caused by the virus that causes COVID-19. Because many people who are homeless are older adults or have underlying medical conditions, they may also be at increased risk for severe illness.”).
- ³³ Harmeet Kaur, *African Americans Are Disproportionately More Likely to Experience Homelessness, a Government Report Finds*, CNN, (Jan. 24, 2020), <https://www.cnn.com/2020/01/24/us/african-americans-hud-homelessness-report-trnd/index.html>.

³⁴ Nat'l Health Care for the Homeless Council, COVID-19 & the HCH Community: Needed Policy Responses for a High-Risk Group 1 (Mar. 2020), <https://nhchc.org/wp-content/uploads/2020/03/Issue-brief-COVID-19-HCH-Community.pdf>.

³⁵ Consumer Fin. Protection Bureau, Housing Insecurity and the COVID-19 Pandemic (Mar. 2021), https://files.consumerfinance.gov/f/documents/cfpb_Housing_insecurity_and_the_COVID-19_pandemic.pdf.

³⁶ *Id.*

³⁷ Emily Lemmerman, Renee Louis, Joe Fish & Peter Hepburn, *Preliminary Analysis: Who is being filed against during the pandemic?*, EVICTION LAB (Dec. 21, 2020), <https://evictionlab.org/pandemic-filing-demographics/>.

³⁸ NAT'L ALLIANCE TO END HOMELESSNESS, <https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness-report/georgia> (last visited Mar. 15, 2021).

³⁹ See Hannah May Jones, *Pandemic Has Adverse Effects on Georgia State's Homeless Population*, SIGNAL (Oct. 27, 2020), <https://georgiastatesignal.com/covid-19-pandemic-has-adverse-effects-on-georgia-states-homeless-population>.

⁴⁰ See Samantha Batko, *Winter Is Here. With COVID-19 Limiting Shelter Capacity, What Will It Mean for People Experiencing Homelessness?*, URBAN INST. (Dec. 18, 2020), <https://www.urban.org/urban-wire/winter-here-covid-19-limiting-shelter-capacity-what-will-it-mean-people-experiencing-homelessness> (noting that because of COVID-19, many “homeless shelters are closed or operating at limited capacity.”).

⁴¹ Beth Schwartzapfel, Katie Park & Andrew Demillo, *1 in 5 Prisoners in the U.S. Has Had COVID-19*, MARSHALL PROJECT (Dec. 18, 2020), <https://www.themarshallproject.org/2020/12/18/1-in-5-prisoners-in-the-u-s-has-had-covid-19>.

⁴² *Id.*; see also Joshua Manson, *Who's Getting the Vaccine Behind Bars?*, UCLA L. COVID-19 BEHIND BARS DATA PROJECT (Feb. 18, 2021), <https://uclacovidbehindbars.org/blog/vaccine-rollout>.

⁴³ See Kesha S. Moore, *When an Arrest Becomes a Death Sentence: Overpopulation of U.S. Jails Increases the COVID-19 Threat to Every Community*, LDF THURGOOD MARSHALL INST. 3-5, 8 (July 2020), https://tminstituteldf.org/wp-content/uploads/2020/07/LDF_07082020_JailsCOVIDTMIBrief-6-2.pdf (“While the risks of exposure to COVID-19 may be higher within jails, the risks do not remain contained within the jails . . . successfully managing the COVID-19 pandemic [] requires successfully managing it in our prisons and jails”).

⁴⁴ *A State-by-State Look at Coronavirus in Prisons*, MARSHALL PROJECT, <https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons> (last visited Apr. 15, 2021).

⁴⁵ See generally GA. DEP'T OF PUB. HEALTH, COVID-19 VACCINATION PLAN (Mar. 4, 2021), <https://dph.georgia.gov/covid-vaccine> (embedding a link to download PDF version of Georgia's Vaccination plan).

⁴⁶ *Id.*; see also MOORE, *supra* note 43.

⁴⁷ Ctrs. for Disease Control & Prevention, *Vaccine FAQs in Correctional and Detention Centers*, <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/vaccine-faqs.html> (last updated Feb. 16, 2021); see also UCLA L. COVID-19 Vaccine Recommendations Letter (Dec. 17, 2020), <https://docs.google.com/document/d/1Rlz51CDHLCJ4Pnhl0mdNI3VeRSuBu8QWbIRtjXu6zN0/edit>.

⁴⁸ Katie Park, Ariel Goodman, Kimberlee Kreusi, *As States Expand Vaccine Eligibility, Many People in Prison Still Wait for Shots*, MARSHALL PROJECT, (Apr. 6, 2021) <https://www.themarshallproject.org/2021/04/06/as-states-expand-vaccine-eligibility-many-people-in-prison-still-wait-for-shots>.

⁴⁹ Matthew Impelli, *Georgia, Mississippi Prisons Offer Inmates Cookies, Commissary Credit as COVID Vaccine Incentive*, NEWSWEEK (Apr. 7, 2021), <https://www.newsweek.com/georgia-mississippi-prisons-offer-inmates-cookies-commissary-credit-covid-vaccine-incentive-1581822>.

⁵⁰ See Harper Sutherland, Mir M. Ali & Emily Rosenoff, OFF. OF THE ASSISTANT SEC'Y FOR PLAN. & EVALUATION, U.S. DEP'T OF HEALTH & HUM. SERVS., *Issue Brief: Individuals Experiencing Homelessness Are Likely To Have Medical Conditions Associated with Severe Illness from COVID-19* 2 (June 2020), <https://aspe.hhs.gov/system/files/pdf/263671/COVIDIB.pdf> (finding that “individuals experiencing homelessness had increased prevalence for most medical conditions associated with severe illness from COVID-19”); Kate Kelly, Nai Soto, Nadi Damond Wisseh & Shaina A. Clerget, *Approaches to Reducing Risk of COVID-19 Infections in Prisons and Immigration Detention Centers: A Commentary*, CRIM. JUST. REV., Sept. 18, 2020, at 2, <https://journals.sagepub.com/doi/pdf/10.1177/0734016820957707> (noting that “incarcerated people experience an increased comorbidity burden . . . which may increase the risk of severe illness or death if COVID-19 infection occurs”).

⁵¹ See Ndugga et al., *supra* note 3; Press Release, Pamela S. Karlan, *supra* note 12 (noting that “[c]omplete, consistent, and accurate data collection and reporting on race, ethnicity, disability, and limited English proficient status are essential to our ability to recognize and address disparities and inequality.”).