LIGHTLY EDITED FILE

What Victim Service Providers Need to Know about

COVID-19 Vaccine Rollout for Survivors

National Alliance for Safe Housing

Remote CART

January 27, 2021

12:00 p.m. - 1:00 p.m. CST

* * * * *

during the event. * * * * *

CART Provided by Jayne Carriker, RPR, CRR, CRC

Paradigm Reporting & Captioning, a Veritext Company

612.339.0545

captioning-paradigm@veritext.com

CART captioning file

NOT A CERTIFIED TRANSCRIPT

>> Hello, everybody.

Thank you all for joining us.

I'm Debbie Fox with the National Network to End Domestic Violence.

And we're going to go ahead and get started.

It's 1:00 here and we have a lot to cover in the short hour.

So just so everybody knows we are going to record this webinar so the webinar is being recorded.

We want to welcome you all and encourage you to say hello as many of you are in the chat box and please if you have any questions throughout the webinar, put them

in the chat box and if we are not able to answer them in realtime, we will do a follow-up e-mail.

The webinar is being recorded so we'll do a follow-up e-mail with the information from the webinar along with any questions that we maybe did not get to or weren't able to answer during this webinar.

So everybody knows, we're doing a webinar today on what you all as service providers and survivors need to know about the COVID-19 vaccine rollout.

We've been through a lot.

It's almost the year mark of hearing about the first case of COVID in Seattle last year and we're coming around to the year mark of March where many of us went

into shutdown mode and where things slowed down and we shifted how our services were being provided so now we're at the point of the pandemic and COVID-19 where

we're looking at the vaccine rollout, and as many of you know people are getting vaccinated and maybe some of you here on this call have been vaccinated, so we're at a hopeful place where we're trying to get the vaccine out to folks as quickly as possible and hopefully getting it out to our advocates working on the front lines and victim service providers and also the survivors accessing our services.

We're going to hopefully answer any questions you have about the rollout for survivors receiving services.

We also specifically have presenters today who will discuss how to address vaccine skepticism as a result of historical and much -- and of course, much realistic skepticism about medical racism and neglect specifically in the African American community and the native communities, so we're going to just talk about how we can build trust with communities, increase access to the vaccine and how we can get these resources to survivors so we can return to life where we are more in community and connected to each other in spaces that are in person.

So at this point I think we will go ahead and go through some of our slides, and I also wanted to do an overview of who our presenters are.

We have Ashley Hesse who is a senior consultant from Indigenous Pact and then we also have Michele Williams who is a HUD technical assistance provider and also works at a homelessness and DV agency, the community crisis services incorporated in Maryland, and then we also have Ashley Reynolds Marshall, J.D., who's the chief executive officer at the YWCA in central Virginia.

So we'll go to the next slide please.

So just a little bit about our work and who we are with the DV housing and TA consortium.

We're doing this work in partnership with a bunch of federal agencies that fund our work and support our work so we're getting these resources from our federal

partners and then disseminating information around best practices for DV housing programs and survivors who are in need of assistance as it relates to housing and homelessness services, so we are funded and supported by the family violence prevention and services program and HHS, the Office on Violence Against Women, the office of victims of crime at the DOJ and also the Office of Special Needs Assistance Programs at the HUD office.

We also work work in collaboration with a bunch of technical assistance providers so I'm specifically with

the National Network to End Domestic Violence and we work with the state domestic violence coalitions across the country.

I'm on this call with Jill Robertson who is a part of Collaborative Solutions, they are HUD technical

assistance provider.

We also work closely with the National Alliance for Safe

Housing, the National Resource Center on Domestic Violence and the National Sexual Violence Resource Center and also the Corporation for Supportive Housing that is also another HUD TA provider.

So lots of support for this work.

Lots of acronyms so that's a quick overview of who we are, and then I think we're going to go to a -- our info

graphic next, how we frame our work.

We specifically are thinking about our work and the work

of domestic violence and sexual violence, racism and homelessness and now when we're thinking about health inequities layered on top of that, we center our work around those issues and the systemic barriers that communities of color and LGBTQI communities have faced since the inception of our country and nation state.

So I will without further ado have Jenny play that video.

>> And I apologize.

It looks this video didn't embed correctly into our webinar, so I'm going to put the link for the video into the chat and maybe we can look at the next slide and then return to it.

>> Great.

Thanks, Jenny.

So a little bit more about our work and how we're thinking about COVID-19 housing and racial equity.

So what we know and what we're seeing in terms of the disparities and health disparities that there's systemic racism playing out with this health pandemic.

I think about where I live in Washington, D.C., wards 7 and 8.

People are dying at higher rates, much higher rates than wards where people are more economically advantaged and also with the rollout of the vaccine that communities of color like in D.C. as well are ward 8 are getting less access to the vaccine.

So these are all things we need to be looking at when

we

are -- oops, we lost the slides.

As we are addressing the COVID-19 and the disparities that exist as it relates to housing and historical inequities in terms of access to health care and resources.

And I've lost the slides, so I apologize for the

7

technical difficulties we have.

I don't know if other folks can see the slides.

>> I was just getting the video cued up on our YouTube channel, so we can go back to the video now, and I apologize for disrupting.

>> We're good.

So I think we're going to play the video now, and then we'll have our speakers start after that, and thanks,

so

many people are on this call.

We have over 300 people attending this call, and it looks our video is starting now.

So thanks, Jenny.

>> Homelessness is an issue that far too many people face.

People of color, specifically black people, other persons of color, and indigenous people experience homelessness in a dramatically different way than their white counterparts.

People who hold multiple identities such as those who live at the intersections of disability, immigration status, sexual orientation, gender identify and more experience compounded barriers that further homelessness and housing instability.

A recent study found that 66% of people experiencing homelessness were black while 28% were white.

Black individuals are only 13% of the U.S. general population compared to 74% of those who are white.

Rates of homelessness within native communities are three to eight times higher than that of the general

population.
In total 78% of people experiencing homelessness identified as people of color.
This overrepresentation of indigenous, black and other people of color experiencing homelessness cannot be explained by poverty or identity alone.
Structural racism, historical policies, institutional practices, and cultural narratives that perpetuate racial inequity put people of color at a disadvantage in obtaining safe and affordable housing.
Statistically women of color are much more likely to experience domestic and sexual violence, and survivors often face network impoverishment which occurs when the additional of a financially distressed household member places an extra strain on family resources.
Oftentimes we tell a survivor experiencing homelessness to go to a relative or friend's house.
However that can cause immense burden on the existing limited finances and available support from that network.
Racial disparities arise at every juncture from the

legal system to housing to health care to child welfare to public benefits.

Understanding the intersections between domestic and sexual violence, racism and homelessness and applying an equity survivor-centered lens in our work is the only pathway to stability, safe housing and healing for all survivors.

If we want to address racial inequity, we have to acknowledge it, learn about it and talk about it so we can do more about it together.

To learn more visit safehousingpartnerships.org.

>> Thank you so much for sharing that video.

I know there were a couple of questions about the video and where to find that.

You can definitely share this video out far and wide as much as possible because it's quick information.

It's on the Safe Housing Partnerships website and our partners at the national resource center on domestic

violence were part of creating this info graphic, so please share and use it far and wide.

At this point we framed the issue and where we're coming from in terms of increasing access and addressing systemic racism and racial inequities as it relates to housing and responding to COVID-19, and I think at this point I'm going to turn it over to Ashley Hesse and so

we can get it started and you can all hear from our amazing presenters who are doing really great work in terms of addressing these issues with communities and out in the field.

So Ashley, it's all yours.

>> Thank you, Debbie.

I really want to say I appreciate this opportunity.

To all of you who are here, thank you for your time and attention.

My name is Ashley Hesse.

I am of Comanche and Apache descent.

I currently live in Wisconsin in the traditional areas of the Menomonee people.

I currently serve as VP of policy for Indigenous Pact which is a public benefit corporation and we're on a mission to create health equity for Native Americans and Alaska natives.

We really work to achieve those goals by trying to increase health care funding and access to quality care on and off the reservation.

So that really in and of itself allows us and provides us opportunity to work with tribal nations throughout the country to address these health inequities and disparities that you were just touching on and housing and all things that affect health.

So my role with the policy, I get to look at a lot of big issues and big topics and try to find some creative

solutions, and I'm very fortunate in that.

I want to thank you all for your time and attention and

let you know I'm coming to you with a good heart and good intentions.

I wish to convey my respects to all of us.

It's difficult work, difficult times, and we've all been

deeply impacted by this current public health emergency

and I appreciate you all for being here and for your work.

I just -- I want to kind of ground us in a little understanding and a brief background of Indian health services and Indian health systems because I believe it

might help inform your practices and possibly approaches

to working with your clients and families that you're supporting.

And maybe give you some thoughts and ideas about bringing additional resources and information to the conversations and challenges that you may be facing.

For those of you who are not really familiar, Indian health service is an agency within U.S. department of health and human services, and it is responsible for providing the comprehensive health care for 2.6 million

American Indians and Alaska natives who belong to 574

12

federally recognized tribes that are found in 37 states.

Now, there are well over 100 and some odd state recognized, maybe I'm off on my numbers.

There are a significant number of tribes that are recognized by states and not the federal government, so there's other things to note there and the impacts of that.

Indian health services supposed to provide the direct care to Indian folks through tribal health facilities, contract facilities and urban Indian programs.

Now American Indians and Alaska natives are also free to take advantage of other resources such as Medicare and Medicaid.

And I mention this background because I believe it's important to point out that the federal responsibility to provide for the direct care and public health

services to American Indians and Alaska natives while it's on each of us to make our own decisions and be informed and responsible to the extent we're able to for our own well being, for Indian people so much has been taken, as we know, probably acknowledge, but the responsibility to provide for that health and well being fell squarely on the shoulders of federal government. Now, over time many Indian communities through legal means have been able to take over those federal

responsibilities to provide their own tribal health programs.

But before I get too -- I don't want to get too far off track here, I just really wanted to mention at the beginning we talked about the disproportional impact that COVID-19 is having on many of our communities and the American Indian and the Alaska native communities, the disproportionately impacts are deplorable.

It's just horrifying to see what is happening in so many of these areas.

And all I will say to that is from my perspective and from the perspective of many Indian people with the passing of every member or descendant of our Indian nations, whether we reside on or off the reservation, live in rural or urban environments, every one of those lives matters very deeply and greatly because the reality is we all are embodiments of the living memory of the earth, the sky, the life blood and the everlasting spirit of the people.

It's carrying our genetic code, it's the seed of our future, the language, the songs, the ceremonies, the dances, the food.

So to me this is deeply personal work, and this is just really important to recognize that for many American Indians and Alaska native people, not all, but there may

exist some deeply inherent distrust and mistrust, many aspects of the social and civic life that are dominant in our current culture in America for many, many reasons.

But again I just want to kind of bring this to your attention and help us recognize these sort of realities because again it's in my opinion and my belief that it's up to all of us to really work to inform ourselves of the history of indigenous people in America because I think collectively, I'll say this, I came through the same school system.

We were collectively robbed of much of our nation's history.

So I just encourage us all to work in tandem and further educate ourselves through dialogue and experiences like this to learn from one another because that's where we will find the solutions.

Really to speak more to the point of COVID vaccines and tribal nations and how tribal nations and Indian people are obtaining some of these, and it's not a uniform answer, but in general the Indian health service if you

really want to see the play book, the Indian health service released their vaccine plan in November 2020 and it was really developed and based on the CDC's COVID-19 their vaccination, the interim playbook for jurisdiction

operations.
So based off of that, Indian health services created their own plan.
Tribal health programs and Indian organizations were presented an option and issued a rather short notice to decide if they wanted to work through existing state and local health jurisdictions to obtain their share of the COVID vaccines as they became available, or they could choose to obtain the vaccines directly from the Indian health service, and that matters in certain ways, but once the vaccines are available they're allocated to jurisdiction who then distributed them to Indian

health

programs and urban Indian organizations.

Tribal nations play a key roll in the planning of the vaccine rollout across Indian country, and so this is a

continuing process.

Just a few highlights and some touch points and I'll get

into some other details here.

There was -- let's see here.

On January 14 I believe it was, 15, right around there,

about 340 Indian health service or tribal health

programs or urban Indian organizations chose to receive

the vaccines from the Indian health officers.

The remaining urban Indian organizations chose to

receive vaccines through their state and local

jurisdictions.

Where I work I'm finding that that's really an important

thing to be aware of because as we're finding the plans that jurisdictions and the jurisdictional rollout and oversight is how these vaccines are distributed, it's kind of messy, you know, and it seemed to really depend a lot upon those strengths of those relationships that had existed prior to this.

As we all are realizing, this pandemic has pointed out many weaknesses in our ability to respond to this pandemic or any other pandemic.

So I just wanted to let you know that there are -- tribes were given different options to receive their vaccines.

So depending on which option was chosen, that somewhat dictates how the vaccines are rolled out, who is in the priority category, how quickly can you move from one priority group to the next.

So state and local jurisdiction have their playbook and that script is there.

Within tribal communities and the urban programs or tribal health programs that have chosen to get their vaccines through IHS, being sovereign nations they have a bit more flexibility if you will to move and determine

for those to be vaccinated.

They can also make some changes as to who they chose to

prioritize, so it might not mirror necessarily the local

or state jurisdictional rollout of these vaccines.

They may choose to prioritize all their elders age 55

and up versus the 65 and older or 70 and over or

whatever the states have decided.

There's some flexibility that tribes had that others did

not.

I don't want to get lost too far into that, but to the

point of things to know about Indian people and ways to

possibly approach them, I mean there's so much I could

talk about I'm kind of like -- I'm being stuck here for

a bit.

But there's a lot of ways that we can really kind of

support that, and I guess there are a few things that come to my mind when I was thinking about this is so much of it came down to just we have to recognize that reality is people make decisions based on values often far more than they do on science for better or for worse.

I was looking at one survey indicated the majority of people that responded chose to get their vaccines to protect others in their family or others around them that they knew were vulnerable.

And I found that this was very not a value that seemed apparent or universally in alignment with many different cultures, and I look at our dominant culture in some ways and I see some of the resistance to vaccines and to getting vaccinated, and to me that's a very big cultural divide there.

Do I do this on behalf of the others and other people in

my community or is this just about me.

We also have to make those decisions, but there are those kind of nuanced cultural approaches that we face in making our individual decision.

Since, you know, a lot of our decisions around getting vaccinated or not or other health care choices are really grounded in our cultural and community and personal values, communication can get really difficult

and there are so many subpopulations, American Indians I think might be one since we're maybe 2% of the population of the nation as a whole would we would often be considered subpopulations especially within urban environments.

So we're often unseen and unheard and not a lot is known, and we're so varied and widespread in our beliefs and practices and knowledge of history and traditions, and cities, you know, more Indians live in cities than they do on reservations due to all kinds of reasons.

But communication was the first thing.

Not really creative but communication was a huge piece.

Trusted sources of communication are important using official information to amplify those messages.

Being that central source of information for folks and being consistent, concise and accurate and repeating the messages that whatever message we're trying to get out,

that is so critical in influencing people's behavior.

And I don't think this is necessarily new, but I want to emphasize that when I'm talking to so many folks where I live we have lots of immigrants and refugees and folks and there are so many gaps in knowledge and communication about just the basics, the vaccine, who is eligible, is it safe, is there a cost to it, where do I get it, is COVID even real.

I mean there's so many of these messages that are being communicated and perpetuated that are coming from sources that are not necessarily the best, but they have great influences over people.

So Indian folks are not necessarily any different than that, but I point it out to say that we all have our own communication channels that we primarily rely upon.

So try and understand the coordination of the communication channel is a big one.

I would say coordination with what's already happening

in your community.

I can't emphasize enough the need to explore and understand is there an urban Indian organization in your community that if you have individuals or families that are native or identify as being American Indian or Alaska native in your community, these urban Indian organizations could be a great resource to help connect you as an agency and/or your clients to resources that might not otherwise be available through the traditional jurisdictional rollout.

A lot of folks that are Indian might not have any idea that there is a satellite office or a tribe that they're connected to in their region.

Also those urban Indian programs could serve anyone that's native if they identify.

If there are certain criteria they can let you know if they can provide help or support.

As well as tribes that might be in the area and the region.

They are also great resources to reach out to if you're able to connect with them.

Frankly a lot of them are shut down with the pandemic and all.

There are a lot of partnerships that can be formed with tribes.

They have very robust health systems and they're very advanced in so many ways and they're grounded in that

whole person wellness and care and well being and likely have some means to support your work within your individual agency.

Just real quickly, unique solutions.

I've had a chance to see some really great things happening in tribal communities that I think are replicable elsewhere.

Setting up quarantine facilities, tiny houses or just units that are already kind of off the shelf by other companies that are creating these things, mobile medical units to get vaccines out.

Supporting people in their transportation needs to get to the clinics or to get to a vaccination site, making sure that those people if you are eligible to get vaccinated have the accurate information, doing the work to coordinate that information to provide the information and getting the details together and providing that information is critical.

I'm going to have to cut myself short here a little bit for the sake of other presenters, but there's so much I wish I could get into now, but just I wanted to last acknowledge we all have our knowledge gaps and sometimes

want our knowledge gaps around American Indian people and Alaska natives to prevent us from feeling like we're unable to help or we're doing something wrong or like just to let our own internal biases or stereotypes that we're all fed continually around Indian people to negatively impact our ability to work and support the folks that you're supporting, but I will just say that this -- you are fully aware generational and historic traumas are real and manifest themselves in so many ways.

Many Indian people are carrying a lot of wounds with them that are unseen, that they're struggling and working through addressing.

You know, this is a collective challenge that we're all trying to get through.

I just -- I'm going to have to stop myself here and

hand

it off to Michele but I really wanted to say I'm hopeful

through our collective and individual efforts in our intentions to support each other that we're going to continue to create healing and helpful communities and safe spaces to figure out how to approach these difficult challenges and maximize our unique individual

potentials and persevere and survive and live through these trying days.

Again, I just thank you for your attention.

CART captioning file

NOT A CERTIFIED TRANSCRIPT

There's so much more I'd love to share.

I hope some of what I said was useful.

But I will end my time and turn it over to Michele.

Thank you.

>> Thanks, Ashley.

That was all very helpful and I appreciate you providing

us with that information that we may not have gotten

before about how to work with tribal nations and how to support each other in the work that we do.

I'm Michele Williams.

I'm a HUD technical assistance provider working on the vaccine distribution team as well as I work with crisis services in Maryland and we operate both homeless shelter and we're the lead victim services agency for the county.

So all of this work is really -- very close to my heart and a large part of my activities.

I wanted to share with you all today just the steps that we're rolling out from a HUD perspective as to what communities and individual providers can do to ensure that the people that you serve and staff have access to vaccination.

So we have framed up our work really in a set of steps, and I want to go through what we've identified kind of as the first five steps for communities to take.

So the first is if you have not read your state vaccination plan, I really encourage you to do so so that you can understand the framework under which your community within your state is going to receive the vaccine and who is prioritized into what groups. Congregate shelter providers, you know, are classified differently in every community.

In my community here in Maryland they were in 1B, so effective today the staff of our programs and residents started receiving their first vaccinations.

I received mine this morning.

So things are happening and understanding where you are in that process is really important.

The second step is to work with your public health partner and so while the state plan is, you know, for the entire state, how things actually roll out in your community is determined primarily by your public health system.

And so as Ashley said, if you have a relationship, that's wonderful.

If you don't have a relationship, start one now.

And, you know, plan to continue and nurture it.

One of the things that we found very helpful in reaching out to our public health partners to plan for how we were going to get a program participants and staff

25

vaccinated was being able to negotiate a bit, right?

We had different settings and different concerns, so for our domestic violence safe house, it was very important to us that we protect the people who are staying there, and so we were very concerned about them going to -- my connection is unstable.

Can you guys still hear me?

Okay.

Great.

We were very concerned about then going to a mass vaccination site so we were able to work with public health for them to bring the mobile unit to our safe

house, and so the very first test of that is actually happening today as well and it was the first youth of that mobile unit for public health so they were anxious to figure out how to make this work and we were very anxious to have them come so we didn't have to put people in a situation where their safety or confidentiality may be a concern.

So definitely that relationship is important for our homeless shelter where we have more than 200 residents.

We weren't really able to set up a unit it and that has a lot to do with the vaccines themselves, the temperatures they need to be kept at and the length of time a vehicle can be out.

So we agreed to provide transportation for our residents so we can run shuttles basically from shelters to vaccination -- to the vaccination site for everyone.

The other thing that you want to work with public

health

about is really assuring that there is priority access for your staff who are coming into direct contact with folks.

It's really important as you try to decrease the level of safety in your program that people are getting vaccinated at the same time or in the same time period because that's going to help ensure better coverage.

One of the things that we know as we move out into this

process is that not everyone is comfortable with the idea of a vaccine, with getting a vaccine for themselves

at this point, and that's okay.

It's really important that we continue to provide good information, right?

And opportunities for people to ask questions, you know,

to understand more about the vaccine, to have access to

all the things in the media and there's tons of resources out now, social media, good resources, not the -- not every source because social media says a lot

of stuff but there are certainly very reputable sources

coming from the CDC, from other health organizations.

I want to direct you all to the resource section to the

27

page on the HUD exchange that is a vaccine kind of landing page and we put out a weekly message with information and links for providers and fliers that you can download and post, and so all of those things we want to make available.

We also link to a lot of other very valuable resources that we're finding that we want to make sure gets shared out in communities.

One of the major strategies that we suggest is if you're able to identify vaccine ambassadors, and vaccine ambassadors are people who are either participants of a program or trusted staff, trusted community leaders who can -- who are supportive of getting the vaccine, who are willing to talk to people about their experiences, who are willing to answer questions or direct people to

places where they can get really good information. It's all really wonderful when someone stands up and says, I'm getting the vaccine, but if I don't feel a connection to them it doesn't sway me one way or another.

In some cases it sways me in the opposite direction so pay attention to who is a trusted source in your community and how can we talk with those folks and even people who maybe have talking about why they're hesitant.

Conversation is the thing that's going to move all of this forward so it really is important that we support each other and engage in conversations and I would say the thing that I think we're kind of losing a little bit, one of the things when the pandemic started as we moved through it, we all began to extend to each other a level of grace, and I don't want us to lose that, so even though there are folks who were really excited

myself included that there's a vaccine and I want everybody to be vaccinated, I have to extend grace to people who are not ready and so I really want to encourage us to continue to do that.

It's really important that we build vaccine confidence.

We don't want people to jump into something they're not comfortable with and so providing that education, that person to talk to, that access to information is going to be really important so as you're working in your program that you're having meetings, having opportunities for people to come in and provide expert information, to share their experience in getting vaccinated, all those things are really important in building vaccine confidence for staff and for program participants.

I wanted to highlight on that when you go to the web page and I think we can actually send some materials

that have come out so far, I think we have four messages out, a fifth coming this week, we encourage you to review those materials to check out all the links to go back to that page because there's going to be a lot more information added to it, and it's -- we want it to be a resource for you, so you don't have to, you know, struggle to find the answers to questions or to find tools.

We even have -- go as far as to give you a guide for how to have a staff meeting around vaccination.

So please check out those tools whenever you have time.

There's a lot there for you and really familiarize yourself so that we approach this conversation with the people that we serve and with our staff in a really informed and appropriate manner.

So thank you and I'll turn it over to Ashley Marshall.

>> Thank you so much, Michele and Ashley, for the amazing information that you have provided so far.

So my name again is Ashley Reynolds Marshall, and I'm extremely thankful to join you all and for the work that you do.

As a person who gets to support both domestic violence and sexual assault services at YWCA of central Virginia, always so grateful for all of the associations and organizations across our nation that work to provide

direct and technical support to those advocates who are working to turn victims into survivors.

I also happen to be an academic who focuses on the intersection of public administration, public policy and non-profit management on issues of diversity, equity, inclusion and justice.

I was provided with a very interesting opportunity this summer, summer of 2020, to work with a group of talented professors in the areas of history, folk lore and public health to produce a textbook that looks at a very unique sub section of COVID-19 which is COVID conspiracies.

My work first focused on the clear conspiracies that specifically black Americans may have believed, and second I looked to provide context to some of the rumors and legends that black Americans were having surrounding the pandemic.

I always like to let people know that I use the term black American versus African American because some individuals are not descendants of slaves but they're still as deeply impacted as anyone else.

When we think about the work so you heard me say conspiracy theories and rumors and legends.

What is the difference.

When we think about conspiracy theories, I'm sure everyone here had one come to mind, and we typically

look at those as a way to explain an event or a set of circumstances as a result of a secret usually by a powerful conspirator.

Whereas academics think a black conspiracy thought as

a

way to make sense to a logical conclusion based on centuries of evidence regarding American's relationship

to black citizens.

Professor David Dennis created an interesting way to differentiate.

He says that traditional conspiracy theories offer a way

to escape from an inconvenient reality versus black-focused conspiracy theories really look towards the historical touch points that communities of color may hold.

Don't get me wrong.

Of course individuals of color can believe in what we think of as more traditional conspiracy theories.

There are some black Americans who think that 2 pock.

Is alive and living in Cuba.

And that an NFL player named Sammy Watkins and an NBA player have all publicly stated that they believe the earth could be flat with BOB going the farthest as he joined the flat earth society as a member and in 2016 created a pretty interesting distract against Neal Tyson

who certainly believes that the earth is round.

For black Americans however and this includes both your colleagues, your staff and your clients that you may serve, some beliefs, rumors and legends really come from that residual trauma of actual historical prejudices and racist experiments since 1619.

Typically we see these rumors based on the historical devaluation of black bodies, and I saw that someone in the chat mentioned Henrietta lacks, that is an amazing one but the one that most people think of is the Tuskegee experiment.

For individuals who do not know in 1932 600 black men 399 of them who had syphilis and 201 did not have the disease joined the study that was entitled the study of untreated syphilis in the Negro man.

The study was run by the U.S. public health service and what actually happened is that these individuals did not receive the informed consent that we see now.

They were told that they were being treated for the disease, but that was incorrect.

As a matter of fact, if they had some additional medical issues, anything like that, in their communities the public health service told the doctors not to treat them because what the study really wanted to see was what happens to syphilis patients when they go untreated.

The study ended in 1972, but keep in mind it was only

supposed to originally last six months.

So remember earlier Debbie touched on the issue of the percentage of black Americans who have been vaccinated.

So as of January 20 it was reported that about 30% of all Americans had received at least one dose of the coronavirus vaccine, but in the 16 states that actually released data by race we see the clear inequalities.

I know that Debbie mentioned in D.C. one of the sort of

largest barrier and space we see is in Pennsylvania, so in Pennsylvania as of that date as of January 14, I'm sorry, 1.2% of white people in Pennsylvania had been vaccinated at least receiving one dose while only 0.3% of black Pennsylvania residents had received the vaccine.

And then if we think even earlier in April of 2020 as opposed to restricting the vaccine there was discussion of maybe we should test on people of color.

At that point two French doctors believed we should treat Africans because they were highly exposed and they didn't bother to protect themselves.

So this was a wonderful place to test any treatment.

So when we think about these things, we think about that history, we have to have a moment of understanding about maybe why our staff, our colleagues, our clients and our loved ones may have a bit of hesitancy.

So we know that African Americans right now here in it the U.S. are not receiving the vaccine at an equal rate and maybe we might want to say that's because the first round was health care workers.

But what we also know is that black workers are 50% more likely to work in health care and social assistance industry and 40% more likely to work in hospitals than their white counterparts.

So it's pretty easy to see the historical trauma of events like the Tuskegee experiment and now Henrietta lacks, the current issues where there's certainly valid and actual news about disparities we can see how that can create some vaccine hesitancy.

So Michele just provided you with some tools to have these conversations with your team.

The thing is to make sure we listen and give space for those thoughts.

Ashley provided some information about that historical generational trauma that could be just under the surface as to some of their hesitancy.

So we need to make sure we legitimize these ideas and as

we have all stated, give facts.

A lot of people are just nervous.

They think for example this vaccine is new technology.

Well, it's a new vaccine, but it's not a new technology.

They have been working on this for many years, so giving

that kind of information and also talking about individuals of color who have had the shot.

I always tell people that my mother who is of many different risks has had both of her vaccinations as a health care worker and she's fine.

She happened to have no symptoms and that's given some solace for members of our family to go ahead and get the

vaccine.

So I just want to make sure that I'm very thankful for having the opportunity to talk about some of that historical frame of mind of vaccine hesitancy for communities of color that you're going to see again

not

only in your staff and colleagues but also in your survivors who are moving from certainly the trauma of domestic violence now into this moment of can I trust western medicine.

So I appreciate the opportunity.

>> Thank you, everybody.

Ashley and Michele, and Ashley, thank you so much for being with us today and presenting some incredibly

value

information, gave us so much to think about and things that we should be doing in the field just to make sure that we minimize the trauma to individuals as they decide about vaccinations.

So we do have a few questions, and I wanted to toss those out and see if you all might be able to help us, so we did have one, I think maybe Ashley Marshall, you were discussing this briefly, but just wondering if

you

might be able to provide or any of you some guidance

around how to convince clients that might have been involved with that Tuskegee experiment whether they should or shouldn't take the vaccine.

I don't know if anyone wants to tackle that but I'll toss that question out.

>> So I think it's very interesting.

I think a lot of people have very much affected by the Tuskegee experiment.

It's certainly something we heard about our entire lives, so yes, it's a reason for us to be skeptical.

I think the things that Ashley Marshall mentioned about why this process is different are really important and I think there's quite a bit of information if you actually Google that that helps kind of explain even in an article I read from the family of a Tuskegee experiment survivor, you know, talking about why this process is so much different and why they are encouraging people to get the vaccine.

I think it's not a matter of convincing necessarily.

I think it's a matter of providing people information so

that they can begin to feel comfortable.

>> And I would just quickly agree with Michele.

It really is that provision of information.

What I often see is that of course individuals who bring up Tuskegee and then if I make the point that the issue in Tuskegee was that they were withheld from the opportunity to receive treatment versus now people are encouraged when it is available for them to go get treatment, it sometimes makes people pause because it is different.

It's a very different situation, but also just recognizing that generational trauma that comes from the knowledge that black bodies and indigenous bodies have been used as a testing space by modern medicine I think is just really important that we don't kind of pooh-pooh that side of it but we provide those facts about the fact that the vaccine isn't new and that even the

survivors of the families of the Tuskegee experiment are saying, no, please, if you're willing, if you're able, if you're not medically compromised go get the vaccine.

All of that helps people have this kernel of knowledge because we're all in a bit of an echo chamber so typically if you're a bit of a nervous person you're going to Google web MD yourself.

One of the ways we can be really supportive is say I

recognize that you're really nervous and I understand but, hey, I heard this and then you're just breaking into that echo chamber in such a loving way.

That doesn't mean they're going to take your advice but that does mean you've given them something different to think about.

>> I just want to -- real quickly again the information that it is critical and just wanted to point out

organizations like national Indian health board, John Hopkins, there's a number of resources specifically geared toward Indian folks as well and the point about finding the ambassadors is critical, and if you explore travel websites, go to their newsletters or newspapers, you will find so many great bits and gems to share as far as encouragement and around safety and helping making informed decisions.

>> Thank you all.

You're just such a wealth of information.

Really appreciate your being here with us today.

We have a few more questions.

I know that we had a question and I think this has come up a couple of times, just wondering about the question of making the vaccine mandatory or not especially when communities and public health are talking about the herd immunity and trying to get the collective community to

that level.

Could any of you address the aspects of mandatory vaccines whether that should be something that victim service providers specifically require or not.

>> So I can take this one.

Our organization, the YWCA, we have a volunteer vaccination policy that we strongly encourage our staff to consider being vaccinated.

We of course will recognize the ADA and civil rights opportunities to request for accommodations either for medical reasons or for religious reasons. Even though we have a voluntary policy, we have put paperwork in place just so we can have it in the team member's file should we ever need it, should something go wrong.

And in our voluntary policy it does say that if you're unable or choose not to get the vaccine, you may be asked to wear a mask maybe even a little bit longer because I know that the science is still moving as far as the area and other options.

What I normally have seen is if there is an organization that already has a mandatory vaccine policy, you could think about it.

I have also seen individuals who traditionally have a

mandatory vaccination policy such as hospital systems having this vaccine to be voluntary, and so while the

law is a little muddy, if I had an organization that had a mandatory vaccine policy and I was thinking about this particular vaccine, what would give me pause is if major medical and hospital systems are leaving it as voluntary and they traditionally have mandatory practices. They usually have more high-paid lawyers than I would, so I sort of take that into consideration.

If you or any member of your team is a member of SHERM, I think there's some really great HR resources there because I know running a non-profit we don't normally have lawyers on staff who do this work but they are not going to release anything that will get anyone HR wise to get into trouble.

Reach out to an employment law attorney to get their

take on it.

The law is continuously evolving on it.

EEOC regulations, OSHA regulations are just continuously

changing about this so I would definitely consult an attorney if either, A, you want to make it mandatory, you have a mandatory policy, definitely if you want to make it mandatory and you've never had a vaccination policy before.

>> Great.

Thank you, Michele.

I think that's wise especially if when you're in doubt

spending the money for an attorney might be incredibly valuable at this particular juncture.

I did want to tack off to a question that was asked because it's come up a couple of times related to the vaccine.

We do know and we're hearing in the media that COVID has

mutated maybe even a couple of times.

Since there's really not a lot of data at this point, would anyone be willing to talk a little bit whether the vaccine will help people with the various mutations and also just in terms of helping people make informed decisions around getting the vaccine and the long-term effects, if there's anything anybody would want to share on that, love to hear your input.

>> So I will share.

I'm not a medical provider, so I can say that very specifically.

So I'm only watching the news that continues to come out about those variants and I think Dr. Fauci actually made a statement today on that.

But I think one of the things that we do know about the current strand is that they can be very deadly, and so, you know, as we're trying to figure out all of the new strands, for me the risk of getting COVID is more scary to me than the potential.

So if I had a limited amount of protection, I think that's what I'm certainly seeking. Just in full closure

I had COVID, my husband and I both contracted COVID in December, and fortunately had very mild cases.

I know that's not the case for everyone, and so I worry

tremendously about a second round added in terms of contracting again.

It's not a risk that I feel comfortable taking, so I don't know.

I don't know how viruses mutate.

I don't pretend to understand the science but I do know

for myself I want to have protection.

>> Great.

Thank you, Michele.

Appreciate your sharing that.

Let's see.

We might have time for maybe one or two more questions.

I did want to mention we will make the slides and I believe the chat notes available to everyone.

We'll be sending those out in a few days, so I know we've talked fast and furiously, so we'll be sure to share this information with you because it's just been really amazing.

Let's see.

We did have a question on policies, if anyone had any

sample vaccination policies that they could share. Do any of you have those that you'd be willing to share?

>> I would be happy to share mine, and just like Michele my caveat is I went to law school and then I ran, so I have a law degree but I do not practice, but I shared our policies at the YWCA with our action alliance in the commonwealth of Virginia and I'm happy to share with anyone else who would like to see them and use them or send them to their lawyer, whichever you would like, and remember mine were all voluntary.

I do not have a mandatory one.

>> Great.

Thank you so much, Ashley.

I also wanted to just mention that somebody sent to us an answer around the mutation question, and if I can hold on to it long enough I'll just read it.

The vaccine does not contain a live virus.

It contains a protein.

That protein is how it attacks the human body.

As long as that protein is present in the strain meaning the mutations, the vaccine should be effective on those strains.

So that's all that any of us know at this point but just sharing that information.

And if you have any other questions, feel free to reach

out to us.

I think we are at the top of the hour, so this will

conclude our webinar for today and just again want to thank both Ashleys and Michele for being with us and presenting such incredibly helpful information.

Thank you all for joining us.

We look forward to joining you in the near future on future webinars.

Have a great day.

CART captioning file

NOT A CERTIFIED TRANSCRIPT