

January 16, 2021

To: The State Disaster Medical Advisory Committee (SDMAC) Vaccine Subcommittee (via email)

CC: Tony Evers, Governor of the State of Wisconsin

CC: Andrea Palm, Secretary-Designee, Wisconsin Department of Health Services

RE: SDMAC VDS Phase 1b Recommendations for Public Comment, release date 1/12/2020.

Dear Members of the Subcommittee,

We write today in our role as scholars and collaborators at UW-Madison in the fields of criminal justice and infectious disease epidemiology. Our goal is to express our wholehearted support for your recommendation to include both facility staff and residents of congregate settings, including people who are incarcerated, in your draft recommendations for priority groups in COVID-19 vaccine phase 1b.

We support your decision, in part, because the incarcerated population—and communities that are more broadly affected by incarceration—have been devastated by widespread COVID-19 infection.

The Marshall Project in partnership with the Associated Press estimates that over 10,000 prisoners have been infected already in the state of Wisconsin, ranking 8th highest in the nation. The cumulative population incidence of COVID-19 in incarcerated people is 4.7 times that of the state as a whole.¹

The high levels of COVID-19 infection in prisons, jails, and other carceral facilities likely stem from three sources, each of which is relevant to the Ethical Framework to Guide the Allocation of COVID-19 Therapeutics and Vaccines:

1. As you have noted in the proposed Phase 1b recommendation, people who are incarcerated have, by definition, little control over their physical environment. They cannot effectively protect themselves from COVID-19 infection; they are required to live in high-risk, high-density conditions. Our prisons, jails, and other carceral facilities remain seriously overcrowded, and were not designed to permit effective social distancing even under normal conditions of crowding.²
2. People who are incarcerated, in Wisconsin as elsewhere in the United States, are very disproportionately Black and brown.³ Due in part to segregation in the housing and labor markets, people who are Black and brown are more likely to be exposed to COVID-19 in community settings, before they enter carceral facilities, and therefore more likely to bring COVID-19 into all settings where they spend time. This of course includes prisons and jails. The ethical framework laid out by the committee sets health equity as a central goal of vaccine prioritization decisions.

¹ <https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons>

² <https://www.prisonpolicy.org/blog/2020/12/21/overcrowding/>

³ United States Decennial Census 2010, Table PCT20

3. There are 470,000 corrections officers in the United States, 34% of whom are Black and 12% who are Latinx.⁴ Thus, protecting the prison staff who are in close and unavoidable contact with COVID-19 positive prisoners also aligns well with the goal of achieving racial health equity in Wisconsin.

In addition to the high risk of outbreaks *within* congregate settings such as jails and prisons, it is important to acknowledge that prisons, jails, and other carceral facilities are not the closed spaces we may imagine them to be. People come and go into carceral settings every day, including members of staff, lawyers, and social workers. Prisoners also leave their facilities to attend court dates, which involves contact with guards, drivers, judges, clerks, etc. These employees then go home to their own communities and families. Prisons themselves are located in communities that are both rural and minority race.⁵

In some facilities--for example jails--the people who are incarcerated themselves undergo substantial churn. For example, the average length of stay in the Dane County Jail is 24 days, and the median is just 4 days.

COVID-19 cases acquired while in a short jail stay are readily taken back to a community setting before symptoms even emerge. There, COVID-19 is likely to spread within the community, rather than the jail. Due to racial disparities in who is incarcerated, COVID-19 cases acquired while incarcerated and then transmitted forward at home will disproportionately spread within the Black and brown communities in our state. This is one source of the tremendous racial COVID-19 disparities we have observed so far.

Therefore, we believe that vaccinating the incarcerated population in our state as soon as possible is among the highest-impact actions we could take to reduce the pandemic's deleterious and unequal effects on Black and brown *individuals* and *communities* statewide.

It is also likely to have a substantial suppressing effect on the spread of COVID-19 writ broadly, benefitting all people in the state. Reducing or eliminating super-spreader events such as those we have seen inside prisons would reduce the effective reproductive number of COVID-19, providing benefits that extend to all Wisconsin residents.

The only sensible way to implement a non-pharmaceutical intervention to prevent the spread of COVID-19 within prisons, jails, and other carceral facility settings is to depopulate those settings through decarceration.

Controlling the spread of COVID-19 among those who remain incarcerated requires vaccination. An uncontrolled outbreak in our carceral facilities puts the lives of the incarcerated people at risk. It puts the lives of facility staff and justice system workers who support incarcerated people at risk. Finally, we believe outbreaks centered in carceral facilities to be a central source of COVID-19 disparities *in community settings* in our state.

⁴ <https://www.bls.gov/cps/cpsaat11.htm>

⁵ Eason, J. *Big House on the Prairie: Rise of the Rural Ghetto and Prison Proliferation*. University of Chicago Press, 2017.

In sum, we agree with your recommendation that people who live in congregate settings such as prisons, jails, and other carceral facilities should be included in Phase 1b of vaccine priority in Wisconsin.

Thank you for your consideration.



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