Who Needs a Flu Vaccine

Everyone 6 months and older should get a flu vaccine every season with rare exceptions. Vaccination is particularly important for people who are at higher risk of serious complications from influenza. A full listing of people at Higher Risk of Developing Flu-Related Complications is available.

Flu vaccination has important benefits. It can reduce flu illnesses, visits to doctor’s offices, and missed work and school due to flu, as well as make symptoms less severe and reduce flu-related hospitalizations and deaths.

Different flu vaccines are approved for use in different age groups.

- There are several flu shots approved for use in people as young as 6 months old and older, and two are approved only for adults 65 years and older.
- Flu shots also are recommended for pregnant people and people with certain chronic health conditions.
- The nasal spray flu vaccine is approved for use in people 2 years through 49 years of age. People who are pregnant and people with certain medical conditions should not receive the nasal spray flu vaccine.

There are many vaccine options to choose from.

- For people younger than 65 years, CDC does not recommend any one flu vaccine over another.
- For adults 65 years and older, there are three flu vaccines that are preferentially recommended for people 65 years and older. These are Fluzone High-Dose Quadrivalent vaccine, Flublok Quadrivalent recombinant flu vaccine and Fluad Quadrivalent adjuvanted flu vaccine. If none of the three flu vaccines preferentially recommended for people 65 and older is available at the time of administration, people in this age group can get any other age-appropriate flu vaccine instead.
The most important thing is for all people 6 months and older to get a flu vaccine every year.

If you have questions about which flu vaccine to get, talk to your doctor or other health care professional. More information is available at Who Should and Who Should NOT Get a Flu Vaccine.

Who Should Not Receive a Flu Shot:

Different influenza (flu) vaccines are approved for use in people in different age groups. In addition, some vaccines are not recommended for certain groups of people. Factors that can determine a person’s suitability for vaccination, or vaccination with a particular vaccine, include a person’s age, health (current and past) and any allergies to flu vaccine or its components. More information is available at Who Should and Who Should NOT Get a Flu Vaccine.

Are any of the available flu vaccines recommended over others?

Yes, for some people. For the 2022-2023 flu season, there are three flu vaccines that are preferentially recommended for people 65 years and older. These are Fluzone High-Dose Quadrivalent vaccine, Flublok Quadrivalent recombinant flu vaccine and Flucelvax Quadrivalent cell-based flu vaccine. This recommendation was based on a review of available studies which suggests that, in this age group, these vaccines are potentially more effective than standard dose unadjuvanted flu vaccines. There is no preferential recommendation for people younger than 65 years.

What if a preferentially recommended flu vaccine is not available?

If none of the three flu vaccines preferentially recommended for people 65 years and older is available at the time of administration, people in this age group should get any other age-appropriate flu vaccine instead.

Special Consideration Regarding Egg Allergy

People with egg allergies can receive any licensed, recommended age-appropriate influenza (flu) vaccine (IIV4, RIV4, ccIIV4, or LAIV4) that is otherwise appropriate. People who have a history of severe egg allergy (those who have had any symptom other than hives after exposure to egg) should be vaccinated in a medical setting, supervised by a health care provider who is able to recognize and manage severe allergic reactions.

Two completely egg-free flu vaccine options are available: Flublok Quadrivalent recombinant flu vaccine and Flucelvax Quadrivalent cell-based flu shot.

When Should I Get Vaccinated Against Flu?

For most people who need only one dose of flu vaccine for the season, September and October are generally good times to be vaccinated against flu. Ideally, everyone should be vaccinated by the end of October. Additional considerations concerning the timing of vaccination for certain groups of people include:

- Most adults, especially those 65 years and older, and pregnant people in the first or second trimester should generally not get vaccinated early (in July or August) because protection may decrease over time. However, early vaccination can be considered for any person who is unable to return at a later time to be vaccinated.

- Some children need two doses of flu vaccine. For those children it is recommended to get the first dose as soon as vaccine is available, because the second dose needs to be given at least four weeks after the first. Vaccination during July and August also can be considered for children who need only one dose.

- Vaccination during July and August also can be considered for people who are in the third trimester of pregnancy during those months, because this can help protect their infants for the first few months after birth (when they are too young to be vaccinated).

For more information, visit: https://www.cdc.gov/flu/prevent/vaccinations.htm

Stay Up to Date with COVID-19 Vaccines Including Boosters

What You Need to Know

- Updated (bivalent) boosters became available on:
  - September 2, 2022, for people aged 12 years and older
  - October 12, 2022, for people aged 5–11 years
  - December 9, 2022, for children aged 6 months–4 years who completed the Moderna COVID-19 vaccine primary series

- Updated (bivalent) Pfizer-BioNTech COVID-19 vaccine also became available on December 9, 2022, for children aged 6 months–4 years to complete the primary series.
• CDC recommends everyone stay up to date with COVID-19 vaccines for their age group:
  o Children and teens aged 6 months–17 years
  o Adults aged 18 years and older
• Getting a COVID-19 vaccine after you have recovered from COVID-19 infection provides added protection against COVID-19.
• People who are moderately or severely immunocompromised have different recommendations for COVID-19 vaccines.
• COVID-19 vaccine and booster recommendations may be updated as CDC continues to monitor the latest COVID-19 data.

Updated Boosters Are Recommended

CDC recommends one updated (bivalent) booster dose:

• For everyone aged 5 years and older if it has been at least 2 months since your last dose.
• For children aged 6 months–4 years who completed the Moderna primary series and if it has been at least 2 months since their last dose.

There is no booster recommendation for children aged 6 months–4 years who got the Pfizer-BioNTech COVID-19 vaccine primary series.

Boosters are an important part of protecting yourself or your child from getting seriously ill or dying from COVID-19. People ages 6 months and older should receive one updated (bivalent) booster, if they are eligible, including those who are moderately or severely immunocompromised.

People who did not receive Pfizer-BioNTech, Moderna, Novavax, or Johnson & Johnson’s Janssen, like people who were vaccinated abroad, have specific recommendations.

About COVID-19 Vaccines

COVID-19 vaccines available in the United States are effective at protecting people from getting seriously ill, being hospitalized, and dying. As with other vaccine-preventable diseases, you are protected best from COVID-19 when you stay up to date with the recommended vaccinations, including recommended boosters.

Four COVID-19 vaccines are approved or authorized in the United States:

• Pfizer-BioNTech
• Moderna
• Novavax
• Johnson & Johnson’s Janssen (J&J/Janssen) (CDC recommends that the J&J/Janssen COVID-19 vaccine only be considered in certain situations, due to safety concerns.)

Updated (Bivalent) Boosters

The updated (bivalent) boosters are called “bivalent” because they protect against both the original virus that causes COVID-19 and the Omicron variant BA.4 and BA.5.

Previous boosters are called “monovalent” because they were designed to protect against the original virus that causes COVID-19. They also provide some protection against Omicron, but not as much as the updated (bivalent) boosters. The virus that causes COVID-19 has changed over time. The different versions of the virus that have developed over time are called variants. Learn more about variants of the COVID-19 virus.

Two COVID-19 vaccine manufacturers, Pfizer and Moderna, have developed updated (bivalent) COVID-19 boosters.
When Are You Up to Date?

You are up to date with your COVID-19 vaccines when you have completed a COVID-19 vaccine primary series and got the most recent booster dose recommended for you by CDC.

- If you have completed your primary series—but are not yet eligible for a booster—you are also considered up to date.
- If you become ill with COVID-19 after you received all COVID-19 vaccine doses recommended for you, you are also considered up to date. You do not need to be revaccinated or receive an additional booster.

COVID-19 vaccine recommendations are based on three things:

1. Your age
2. The vaccine you first received, and
3. The length of time since your last dose

People who are moderately or severely immunocompromised have different recommendations for COVID-19 vaccines.

Getting Vaccines If You Had or Currently Have COVID-19

If you recently had COVID-19, you may consider delaying your next vaccine dose (whether a primary dose or booster) by 3 months from when your symptoms started or, if you had no symptoms, when you first received a positive test.

Reinfection is less likely in the weeks to months after infection. However, certain factors, such as personal risk of severe disease, or risk of disease in a loved one or close contact, local COVID-19 Community Level, and the most common COVID-19 variant currently causing illness, could be reasons to get a vaccine sooner rather than later.

For more information, visit:

CDC and FDA Identify Preliminary COVID-19 Vaccine Safety Signal for Persons Aged 65 Years and Older

January 13, 2023

Transparency and vaccine safety are top priorities for the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA). U.S. government agencies use multiple, complementary safety monitoring systems to help detect possible safety signals for vaccines and other medical countermeasures as early as possible and to facilitate further investigation, as appropriate. Often these safety systems detect signals that could be due to factors other than the vaccine itself.

All signals require further investigation and confirmation from formal epidemiologic studies. When one system detects a signal, the other safety monitoring systems are checked to validate whether the signal represents an actual concern with the vaccine or if it can be determined to be of no clinical relevance.

Following the availability and use of the updated (bivalent) COVID-19 vaccines, CDC’s Vaccine Safety Datalink (VSD), a near real-time surveillance system, met the statistical criteria to prompt additional investigation into whether there was a safety concern for ischemic stroke in people ages 65 and older who received the Pfizer-BioNTech COVID-19 Vaccine, Bivalent. Rapid-response investigation of the signal in the VSD raised a question of whether people 65 and older who have received the Pfizer-BioNTech COVID-19 Vaccine, Bivalent were more likely to have an ischemic stroke in the 21 days following vaccination compared with days 22-44 following vaccination.

This preliminary signal has not been identified with the Moderna COVID-19 Vaccine, Bivalent. There also may be other confounding factors contributing to the signal identified in the VSD that merit further investigation. Furthermore, it is important to note that, to date, no other safety systems have shown a similar signal and multiple subsequent analyses have not validated this signal:

- A large study of updated (bivalent) vaccines (from Pfizer-BioNTech and Moderna) using the Centers for Medicare and Medicaid Services database revealed no increased risk of ischemic stroke
- A preliminary study using the Veterans Affairs database did not indicate an increased risk of ischemic stroke following an updated (bivalent) vaccine
- The Vaccine Adverse Event Reporting System (VAERS) managed by CDC and FDA has not seen an increase in reporting of ischemic strokes following the updated (bivalent) vaccine
- Pfizer-BioNTech’s global safety database has not indicated a signal for ischemic stroke with the updated (bivalent) vaccine
- Other countries have not observed an increased risk for ischemic stroke with updated (bivalent) vaccines
Although the totality of the data currently suggests that it is very unlikely that the signal in VSD represents a true clinical risk, we believe it is important to share this information with the public, as we have in the past, when one of our safety monitoring systems detects a signal. CDC and FDA will continue to evaluate additional data from these and other vaccine safety systems.

These data and additional analyses will be discussed at the upcoming January 26 meeting of the FDA’s Vaccines and Related Biological Products Advisory Committee.

No change in vaccination practice is recommended.

CDC continues to recommend that everyone ages 6 months of age and older stay up-to-date with COVID-19 vaccination; this includes individuals who are currently eligible to receive an updated (bivalent) vaccine. Staying up-to-date with vaccines is the most effective tool we have for reducing death, hospitalization, and severe disease from COVID-19, as has now been demonstrated in multiple studies conducted in the United States and other countries:

- **Data** have shown an updated COVID-19 vaccine reduces the risk of hospitalization from COVID-19 by nearly 3-fold compared to those who were previously vaccinated but have not yet received the updated vaccine.
- **Data** have shown that the updated COVID-19 vaccine also reduces the risk of death from COVID-19 by nearly 19-fold compared to those who are unvaccinated.
- Other preliminary data from outside the U.S. have demonstrated more than 80% protection against severe disease and death from the bivalent vaccine compared to those who have not received the bivalent vaccine.

Once again, no change is recommended in COVID-19 vaccination practice.

**TOUGH QUESTIONS AND ANSWERS**

How often do you see these sorts of preliminary signals for the COVID-19 vaccine?

- Not often. Preliminary signals often emerge as we have more experience with a product and accumulate data. All signals are assessed for further evaluation.
- To date, this particular system, VSD, has identified 1 “true” signal associated with the COVID-19 vaccine (for myocarditis) - meaning a signal that is an actual health risk, albeit a relatively rare one.

- Preliminary signals from VSD are run through an assessment, including comparing findings to other vaccine safety monitoring systems.
- VSD uses a type of analysis that allows us to conduct near real-time safety monitoring. VSD rates are then assessed weekly. If the rate of adverse events among vaccinated people in the risk period is higher than among during the comparison window, it results in a signal and prompts further investigation into whether the vaccine may be associated with an adverse event. All potential signals are further analyzed to verify the signal and quantify if a true health risk exists.

Do you typically notify the public when a signal hasn’t been confirmed?

If not, why are you doing so now?

- We routinely communicate early about preliminary vaccine safety data.
- We strive to be timely and transparent in our communications.
- CDC and FDA are currently working together to assess if there is a causal association between stroke and vaccination. At this point there is insufficient information to conclude if a true health risk exists.
- Given the importance of transparency in the confidence people feel about the safety of COVID-19 vaccines, we are sharing this signal with the public now as we continue to evaluate additional data to determine if this is a true association.
The statistical signal has been described as “preliminary.”
Would you characterize it as a strong preliminary signal or a weak one?

- We need to distinguish the signal observed here from the determination of any associated safety risk. Though a preliminary signal has been identified, multiple other lines of evidence suggest that this signal may not be confirmed on further evaluation, and thus, the totality of the evidence does not suggest a true safety risk exists at this time that should change clinical practice.

- Currently, the signal is slightly elevated but stable/persistent. The rate ratios seen so far are significantly lower than statistical signals seen for issues like myocarditis.

- This statistical signal has a slightly elevated rate ratio (a measure of relative risk) that has just exceeded our pre-specified threshold for statistical significance. Similar findings have not been observed in other vaccine safety monitoring systems in the United States and have not been observed in other global monitoring programs. Additional analyses are underway to evaluate if this finding represents a true clinical risk. At this point there is insufficient information to conclude a true health risk exists.

How long will it take you to confirm whether this signal is more than preliminary? When will you communicate an update about this again?

- Scientists are working to determine if this is a true association.

- Our analyses become more stable with more data. We’re hopeful to have a clearer picture from the assessment and more data in the coming weeks.

- In January, CDC and FDA will share updates to the assessment in planned upcoming vaccine safety meetings, including with ACIP’s COVID-19 Vaccine Working Group and FDA’s Vaccines and Related Biological Products Advisory Committee (VRBPAC). CDC and FDA have already briefed the ACIP COVID-19 Vaccine Safety Technical Sub-Group (VaST). When did CDC first notice this signal?

- In mid-December, CDC had sufficient information to conclude that the statistical signal was persisting and began a series of supplementary analyses to further evaluate the potential reasons for the persistent statistical finding. This assessment is still underway.

What percentage of signals do not turn out to be clinically significant?

- Many signals that are detected in our monitoring systems do not end up indicating true increased risk.

What data points need to be met to confirm the certainty of this signal?

- CDC is continuing to monitor VSD data weekly and explore potential data-related explanations for the statistical signal.

- When CDC identified a potential signal in mid-December, CDC: o assessed data quality, including diagnostic codes and comparison groups o began comparing data to other monitoring systems, including FDA (CMS data) and VA o conducted a temporal scan analysis to assess clustering of cases following vaccination o examined if the rates between the two groups were caused by decreased risk in the comparison window or increased risk in risk window, or combination of both.

- By mid-February, CDC will:
  o review cases to confirm diagnoses and better characterize the cases (i.e., if ischemic strokes reported were actually transient ischemic attacks, also known as TIAs),
  o continue to conduct weekly temporal scan analysis,
  o conduct sub-analyses of different segments (strata) of the population,
  o develop statistical models that stratify by confounding factors (e.g., comorbidities or other conditions, risk factors, vaccine uptake patterns, coadministration of other vaccines),
  o review more data as it continues to accumulate weekly and exploring potential data-related explanations for the signal,
  o evaluate the signal further in other data systems (i.e., in CMS, VA), and
  o communicate findings on CDC’s website and other communication channels.
In the next several months, there is consideration for expanding chart reviews and conducting additional medical record reviews confirming the case diagnosis, onset date, and if the cases had any documented history of COVID-19 disease.

FDA may conduct a definitive study using appropriate epidemiologic study designs such as self-controlled or other designs.

What is the timing estimate on the confirmation of this preliminary data?

Please see the above answer.

CDC hopes to assess all factors listed above by mid-February 2023.

Signal assessment analyses and supplementary analyses in the data system where the signal was detected are underway. The timeline for these assessments will take weeks. The timeline for formal epidemiologic studies in other data systems will take months.

Additional expected data will make the assessment stronger. CDC will continue to update on its assessment of whether a causal association between bivalent booster vaccine and ischemic stroke exists.

Has stroke and COVID-19 vaccinations been studied previously?

Yes. CDC performs safety monitoring of vaccines to assess and identify serious outcomes. Clinical trials for the bivalent booster did not show serious safety concerns. An interim analysis of 6.2 million people (all ages) who received the primary series of the vaccine found no significant associations between vaccination with mRNA COVID-19 vaccines and selected serious health outcomes, including stroke, 1 to 21 days after vaccination. CDC typically conducts retrospective analyses for specific adverse outcomes if signals are detected through surveillance systems.

FDA has routinely evaluated ‘Hemorrhagic’ and ‘Non-hemorrhagic’ stroke 1-28 days following vaccination as part of its COVID-19 Vaccine Safety Surveillance efforts. This monitoring evaluates 16 or more outcomes for adult patients who received the primary series, monovalent boosters, and bivalent boosters. FDA has found no signals for stroke in any of their analyses.

Should people with a family history of stroke be concerned?

As with any condition, people with increased risk of stroke can consult their healthcare providers. It is important to note that at this time it is unclear if a true risk of stroke exists. What is CDC doing about this?

CDC is currently conducting additional analyses. Signal assessments typically take weeks to months. CDC hopes to have a clearer picture of the signal by mid-February.

For the issue of stroke, relative risk is particularly difficult to parse out as ischemic stroke was already common in the U.S population prior to the introduction of COVID-19 vaccines.

CDC has notified the ACIP COVID-19 Vaccine Safety Technical Sub-Group (VaST) and will brief the COVID-19 Vaccines Work Group and Vaccines and Related Biological Products Advisory Committee (VRBPAC) later in January, as scheduled. These groups advise on the safety, development, and administration of vaccines and are critical to the risk assessment process.

Is this finding going to result in any revisions in the vaccine schedule for adults 65 and older?

No, CDC is not changing the current routine vaccination recommendations based on this signal, which to date, has not shown up in other safety monitoring systems. There continues to be overwhelming evidence of the benefits of COVID-19 vaccination. CDC will continue to share information in a timely and transparent manner as it becomes available.
What is FDA doing about this?

- FDA continues to evaluate and monitor Hemorrhagic and Non-hemorrhagic stroke outcomes in the CMS dataset for persons 65 years of age and older.

- FDA continues to evaluate and monitor Hemorrhagic and Non-hemorrhagic stroke outcomes in three large commercial health plan databases for persons 65 years of age and older.

- FDA may conduct a definitive study using appropriate epidemiologic study designs such as self-controlled or other designs.

Could the difference actually represent the opposite, that is a protective effect for stroke? How can we know?

- Additional analysis would be needed to better characterize the background rate of stroke in this population.

Tell me more about the single monitoring system that identified this signal and how this was evaluated? What is the Vaccine Safety Datalink (VSD)?

- The Vaccine Safety Datalink (VSD) is a collaborative project between CDC’s Immunization Safety Office, integrated health care organizations, and networks across the U.S. The VSD started in 1990 and continues today to monitor safety of vaccines and conduct studies about rare and serious adverse events following immunization. As of September 28, 2022, there are 13 VSD sites that provide clinical, methodological, and data expertise; 11 are data providing sites.

- The VSD uses electronic health data from participating sites to monitor and assess the safety of vaccines. This includes information on vaccines: the kind of vaccine given to each patient, date of vaccination, and other vaccinations given on the same day. The VSD also uses information on medical illnesses that have been diagnosed at doctors’ offices, urgent care visits, emergency department visits, and hospital stays.

- The VSD conducts vaccine safety studies based on questions or concerns raised from the medical literature and reports to the Vaccine Adverse Event Reporting System (VAERS). When there are new vaccines that have been recommended for use in the United States or if there are changes in how a vaccine is recommended, the VSD will monitor the safety of these vaccines.

How does CDC determine the risk vs. benefit for COVID-19 vaccines?

- CDC evaluates the benefits of COVID-19 vaccines through multiple methodologies, employing various methods and using information collected through different surveillance platforms or electronic health records, among other avenues. In addition, COVID-19 vaccines continue to undergo the most comprehensive and intense safety monitoring in U.S. history. These data are presented and discussed through ongoing benefit-risk analyses to both the ACIP COVID-19 vaccines Work Group and the public ACIP meetings. These analyses have continued to demonstrate that COVID-19 vaccination is the single best way to protect people from serious COVID-19 illness and the benefits continue to outweigh the risks. As with all emerging data for the vaccines, CDC and ACIP will continue to evaluate the balance of benefits and risks for COVID-19 vaccines.

The following steps are taken to assess a signal identified in RCA:

- Check data quality, especially of diagnostic codes

- Review charts to confirm or exclude cases as true incident cases; ‘quick’ chart reviews (i.e., incident physician diagnosed case with symptom onset in risk window) can generally be performed within several days

- Check inputs, ‘background incidences’ (i.e., temporal trends)

- Check whether comparison groups are defined appropriately

- Check other analyses that use a different control group (e.g., concurrent vs. historical) or compare with a different vaccine

- Conduct a temporal scan to see if outcomes cluster during a post-vaccination time window

- Evaluate the signal further in other data systems (i.e., in CMS, VA). Other signal detection and assessment systems exist, such as CDC’s v-safe (signal detection only), the FDA’s CMS collaboration and BEST, VA near real-time sequential monitoring, and DoD’s DMSS.

- Conduct a definitive study using appropriate epidemiologic study designs such as self-controlled or other designs.

How does CDC determine the risk vs. benefit for COVID-19 vaccines?
What is an ischemic stroke?

- Most strokes are ischemic strokes. An ischemic stroke occurs when blood clots or other particles block the blood vessels to the brain. Fatty deposits called plaque can also cause blockages by building up in the blood vessels. During a stroke, parts of the brain become damaged or die. A stroke can cause lasting brain damage, long-term disability, or even death. Some health conditions and lifestyle habits can increase your risk for stroke.

For more information, visit:
file:///C:/Users/abodie/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/X6DJ0XDE/Tough%20QA%20Preliminary%20COVID-19%20Vaccine%20Safety%20Signal%20for%2065+.pdf

Under the EEO complaint process, petty slights, annoyances, and isolated incidents (unless extremely serious) will not rise to the level of harassment or hostile work environment. **To be unlawful, the conduct must create a work environment that would be intimidating, hostile, or offensive to a reasonable person.**

However, the intent of the Department of Labor’s Harassing Conduct Policy is to provide a process for addressing incidents of unwelcome conduct long before they become severe and pervasive enough to create a hostile work environment under the law. The Harassing Conduct Policy seeks to discover and remedy, in particular, “minor” violations so that harassment does not spread or escalate and rise to the level of a legal violation. The Department will not wait for a pattern of harassing behavior to emerge. Rather, the Department will endeavor to act before the harassing conduct is so severe and pervasive as to constitute an unlawful hostile work environment. The Harassing Conduct Policy is referenced at the end of this fact sheet.

Overall, DOL policies and procedures promote prompt recognition, reporting, and remedying of harassing workplace conduct with the goal of eliminating such conduct quickly and effectively, even in cases in which the reported conduct may not be severe and pervasive so as to constitute a violation of federal law.

This fact sheet provides a brief explanation of workplace harassment, how to recognize it, and both the responsibilities of an employee who has witnessed or been subjected to workplace harassment and the agency that has been put on notice of allegations of workplace harassment.

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What Do I Need to Know About Workplace Harassment?

Under federal law and Department of Labor (DOL) policy, harassment based on race (including dress and grooming), color, ancestry, national origin (including ethnicity, accent, and use of a language other than English), religion or religious creed (including reasonable accommodation of religious beliefs or practices), physical or mental disability (including reasonable accommodation of physical or mental disability), genetic information, sex (including pregnancy, childbirth, lactation, abortion, and related medical conditions and procedures), sexual orientation, gender identity, gender expression, intersex conditions, age, parental status, marital status, political affiliation or any other prohibited factor, and/or retaliation for engaging in protected Equal Employment Opportunity (EEO) activity (e.g., filing or participating in a complaint or otherwise opposing discrimination, including harassment; requesting a reasonable accommodation) is prohibited. The Department of Labor does not permit harassing conduct by anyone in the workplace, including co-workers, contractors, and customers.

This fact sheet primarily discusses prohibited conduct under federal law — that it, “actionable” harassment, or hostile work environment for which people may file Equal Employment Opportunity (EEO) complaints and seek “make-whole” relief.
Hostile Work Environment Harassment

A hostile environment can result from the unwelcome conduct of supervisors, co-workers, customers, contractors, or anyone else with whom the victim interacts on the job, and the unwelcome conduct renders the workplace atmosphere intimidating, hostile, or offensive.

Examples of behaviors that may contribute to an unlawful hostile environment include:

- **The use of microaggressions, or verbal and nonverbal insults, comments, or other unwelcome behavior, that may be intentionally or unintentionally offensive, demanding or degrading.**
- Using the term "tranny" to refer to transgender persons, or asking personal and private questions about a perceived or known transgender person's genitalia;
- **Telling racist, sexist, homophobic, transphobic, or xenophobic jokes or stories;**
- Teasing, name calling, insulting, mocking, mimicking or repeatedly commenting on or making gestures about an individual's disability, accent, hair, or other protected characteristic.
- Using "pet" names or sex-based nicknames or other forms of stereotypes.
- Making demeaning, obscene, or lewd comments, slurs, epithets, or suggestions.
- Displaying or discussing inappropriate or sexually suggestive or insensitive objects, pictures, images, or cartoons.
- **Exhibiting bullying, intimidating, or threatening behavior.**
- Continuing unwelcome behavior (as defined by the Policy and procedures) after an individual has objected.
- Displaying belittling caricatures or objects depicting persons of a particular race, national origin, religion, or other protected basis, or other objects with a sordid history based in racism or discrimination, such as the display of Swastikas, nooses, or the Confederate flag;
- Leering at or ogling another person.
- Stalking or following a colleague, including through the use of social media or off-site.
- **Improperly disclosing confidential information about another person related to their actual or perceived status in a protected class.**
- Unwelcome sexual advances or requests for sexual favors; and,
- Unwelcome touching.

Two basic types of unlawful harassment

Prohibited workplace harassment may take either of two forms. It may entail *quid pro quo* harassment, which occurs in cases in which employment decisions or treatment are based on submission to or rejection of unwelcome conduct, typically conduct of a sexual nature. Workplace harassment may also consist of offensive conduct based on one or more of the protected groups above that is so severe or pervasive that it creates a hostile or offensive work environment or when it results in an adverse employment decision (such as being fired or demoted).

**Quid Pro Quo Harassment — "This for That"**

*Quid pro quo* harassment generally results in a tangible employment decision based upon an individual's acceptance or rejection of unwelcome sexual advances or requests for sexual favors, but it can also result from unwelcome conduct that is of a religious nature. This kind of harassment is generally committed by someone who can effectively make or recommend formal employment decisions (such as termination, demotion, or denial of promotion) that will affect the victim.

Examples:

- Supervisor who fires or denies promotion to a subordinate for refusing to be sexually cooperative.
- Supervisor requires a subordinate to participate in religious activities as a condition of employment.
- Supervisor offers preferential treatment/promotion if subordinate sexually cooperates or joins supervisor's religion.

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**NO HARASSMENT ZONE**
Resources and Responsibilities — What to do if you witness or are subjected to harassment?

Under the Harassing Conduct Policy — The Department has determined that the most effective way to limit harassing conduct is to treat it as misconduct, even if it does not rise to the level of harassment actionable under the law. The goal of the Policy is to eliminate harassment before it becomes severe and pervasive enough to violate the law.

Therefore, for the purposes of the Harassing Conduct Policy, harassing conduct is defined more broadly as "any unwelcome verbal or physical conduct based on any characteristic protected by law when: (1) the behavior can reasonably be considered to adversely affect the work environment; or (2) an employment decision affecting the employee is based upon the employee's acceptance or rejection of such conduct." Conduct that "adversely affects the work environment," even though it may not be "severe or pervasive" as required under federal law, is prohibited by the Harasssing Conduct Policy.

It is the responsibility of every DOL employee to promptly report harassing conduct to anyone in your supervisory chain; or to your Agency Workplace Equality Compliance Office (WECO) in the National Office; or for regional employees, to the Regional Administrator, OASAM. Management must take prompt, remedial action to investigate and eliminate any harassing conduct. All information will be maintained on a confidential basis to the greatest extent possible.

When harassing conduct violates the law

First, unlawful harassing conduct must be unwelcomed and based on the victim's protected status.

Second, the conduct must be:

- Subjectively abusive to the person affected; and
- Objectively severe and pervasive enough to create a work environment that a reasonable person would find hostile or abusive.

Whether an instance or a pattern of harassing conduct is severe or pervasive is determined on a case-by-case basis, with consideration paid to the following factors:

- The frequency of the unwelcome discriminatory conduct.
- The severity of the conduct.
- Whether the conduct was physically threatening or humiliating, or a mere offensive utterance.
- Whether the conduct unreasonably interfered with work performance.
- The effect on the employee’s psychological well-being; and
- Whether the harasser was a superior within the organization.

Each factor is considered, but none are required or dispositive. Hostile work environment cases are often difficult to recognize, because the particular facts of each situation determine whether offensive conduct has crossed the line from "ordinary tribulations of the workplace, such as the sporadic use of abusive language... and occasional teasing," to unlawful harassment.
The Department cannot correct harassing conduct if a supervisor, manager, or other Department official does not become aware of it. When an employee unreasonably fails to report harassing conduct, the Department has the right to raise this as a defense against a suit for harassment.

Under the EEO Process — The Department’s Harassing Conduct Policy is not intended to replace an employee’s EEO rights. An employee may pursue claims of harassing conduct through both avenues simultaneously.

To learn more about your EEO rights, please contact an EEO Counselor or visit CRC's web page at https://www.dol.gov/agencies/oasam/centers-offices/civil-rights-center.

Contact the Civil Rights Center at 202-693-6500; TTY 7-1-1 within 45 days of the alleged discriminatory event in order to preserve your right to file an EEO complaint. Any questions on this guidance should also be addressed to the Department of Labor’s Civil Rights Center.

Not a DOL employee?

Please visit http://www.dol.gov/agencies/oasam/programs/crc/external-enforc-complaints to learn more about filing a complaint with the Civil Rights Center or contact the Civil Rights Center at 202-693-6500; TTY 7-1-1.

To file a complaint against a private employer, please visit the U.S. Equal Employment Opportunity Commission’s (EEOC) website at: https://www.eeoc.gov/filing-charge-discrimination.

For more information, visit: https://www.dol.gov/agencies/oasam/centers-offices/civil-rights-center/internal/policies/workplace-harassment/2012#:~:text=Hostile%20Work%20Environment%20Harassment,intimidating%2C%20hostile%2C%20or%20offensive.

Different groups and communities can have markedly different levels of health. Some populations can have higher rates of cancer, for example, while others might be more likely to be obese or use tobacco. These differences in health or medical conditions are called health disparities, and they can have a profound impact on the public health of a community.

Definition

The U.S. government defines health disparity as "a particular type of health difference that is closely linked with social or economic disadvantage." These disparities negatively impact whole groups of people that already face significantly more obstacles to maintaining good health, often because of specific social or economic factors, such as:

- Socioeconomic status or income
- Race or ethnicity
- Age
- Sex or gender
- Geography, ex. rural vs. urban
- Disability
- Sexual orientation
- Immigrant status
- Religion
- Mental health status
Historically, these characteristics have been linked to discrimination or exclusion. When a particular group of people doesn’t have the same kind of access to health care, education, or healthy behaviors, it can cause them to fall behind their peers on all kinds of health measures. These disparities can often persist for generations.

**Impact**

The negative repercussions of health disparities go beyond just the individual and extend to their children, whole communities, and society at large. Health disparities are often self-perpetuating. Parents too sick to work, for example, can become low-income. Unemployed, low-income individuals are less likely to have access to health insurance. If they’re unable to afford health care, they could get sicker, making them even less able to find a new job, and so on. Getting healthy and out of poverty becomes increasingly difficult.

**Examples**

Health disparities exist all over the world, including in the United States, and affect every age, race/ethnicity, and sex. Here are just a few examples:

- **Infant mortality**: Babies born to Black women in the United States die at more than double the rate of babies born to white women.
- **Dementia**: Black people also have the highest risk for dementia, and are twice as likely to develop Alzheimer’s disease than whites in the United States.
- **Cancer**: People with lower incomes and education levels are more likely to get cancer and to die from it compared to their more affluent peers, and that gap appears to be widening.
- **Obesity**: Even after controlling for family income, rates of obesity in Black women and Mexican-American men are substantially higher than in other races or ethnic groups.
- **Smoking**: Native American/Alaska Native men and women have disproportionately higher rates of smoking, as do individuals living below the federal poverty level and those who are unemployed.
- **Binge drinking**: Young white men are more likely than other groups to binge drink (5+ drinks in a two-hour period).

**Causes**

Like many aspects of public health, the root causes of health disparities are complex. Health is influenced by so many factors that it can be difficult to pinpoint just why a gap between two groups is so wide. That said, disparities are often the result of health inequities—that is, differences in how resources are distributed among different groups. These resources could be tangible, like in the case of physical parks where kids can exercise safely, or intangible opportunities, such as being able to see a doctor when ill. Disparities often have multiple root causes, but there are a few major inequities in the United States that are known to contribute to health gaps between groups.

**Income Inequality**

The U.S. healthcare system is one of the most expensive in the world, spending roughly twice as much on health care as other high-income nations. On average, the country as a whole spent an estimated $10,348 per person in 2016, and healthcare spending accounts for nearly 18% of the U.S. gross domestic product (GDP), a rate that’s increased year after year. Americans pay more for health services like clinic visits, hospital stays, and prescription drugs. A growing income gap between the rich and the poor in the United States has made it harder for poor Americans to keep up. While top incomes skyrocketed between 1980 and 2015, real wages for low-income individuals fell, making it increasingly difficult for poor people in the United States to afford basic medical care or engage in healthy behaviors. This, in turn, makes it harder to stay healthy or treat and manage health conditions.

**Systemic Discrimination or Exclusion**

Social drivers—like racism, sexism, ableism, classism, or homophobia—can perpetuate inequities by prioritizing one group over another. These forces are so deeply ingrained in cultural practices and norms that many people might not realize they’re happening. Oftentimes, these forces are the result of past inequities that still affect communities today.

Take, for example, mid-20th-century discriminatory housing practices. These policies forced many minority families into neighborhoods without nearby access to community resources, like public transportation, quality education, or job opportunities—all of which affect a family’s financial stability and, therefore, long-term health.
Researcher Camara Phyllis Jones used a gardening analogy in the *American Journal of Public Health* to illustrate just how this happens. Imagine, for generations to come.

**Environmental Factors**

Many health outcomes are the result of personal choices, like eating healthy foods or getting enough exercise. But many of those choices are shaped, influenced, or made for us by the environment we’re in. Environmental health is the physical, chemical, and biological forces that can impact our health, and they can be a driving force behind health disparities. It’s hard for people to eat healthy food, for example, when they don’t have access to it in their neighborhood (areas known as food deserts).

Neglected tropical diseases (NTDs) are an example of environmentally driven health disparities. This collection of 20+ conditions primarily impact the poorest of the poor, both in the United States and worldwide, often due to a lack of clean water or bathrooms. These conditions make it harder for kids to learn and adults to work, exacerbating the effects of poverty on people’s health and well-being.

**Addressing Health Disparities**

Closing the gap in health outcomes is no easy task. Causes are often multi-layered. Solutions would need to address not only the root cause of a given disparity but also the context that made it possible in the first place.

For its part, the Healthy People 2020 objectives—a set of goals laid out by the U.S. government to improve the health of Americans by the year 2020—aims to reduce health disparities by addressing key factors known as social determinants of health.

Social determinants of health are the environmental conditions and circumstances that affect and shape how healthy we are. Many things in our social circles and environment can impact our behaviors and limit our ability to make healthy choices. These include things like cultural norms (ex. distrust of authority figures) or community design (ex. bike lanes). There are dozens of social factors exacerbating health disparities, but the Healthy People 2020 objectives have put just five front and center: economic stability, education, social and community context, health and health care, and neighborhood and built environment.
**Expand Access to Health Care and Improve Health Literacy**

Helping ensure people are able to see a medical professional when they're sick is important for curbing health disparities. But perhaps equally important is their ability to see a doctor when they're healthy. Many medical issues in the United States could be prevented with routine, preventive care like health screenings, vaccinations, and lifestyle changes.

The Affordable Care Act attempted to expand access to primary care by making it easier to get health insurance and requiring insurance companies to cover the whole cost of preventive services, like blood pressure screenings and obesity counseling. The law also called on medical and public health professionals to address health literacy by ensuring everyone can obtain, understand, and communicate information essential to health decisions. More than 28 million people, however, still lack health insurance, and more can be done to ensure increased access to health care in the United States.

**Neighborhood and Built Environment**

Just like a person’s social environment can impact their health and well-being, so can their physical surroundings. Improving access to healthy foods, supporting healthy eating behaviors, improving the quality of housing, reducing crime and violence, and protecting the environment are all things that can be done to improve the environmental health of a community and reduce health disparities as a result.

One important example of ways the United States could reduce health disparities in obesity rates is addressing the issue of food deserts and food swamps. Building partnerships between local governments, food retailers (such as grocery stores), and communities could help bring more affordable and healthier food options to areas where such foods are scarce. This, combined with increased targeted education on why and how to incorporate healthy foods into a family’s favorite meals, could go a long way to cutting disparities in obesity rates.

For more information, visit: https://www.verywellhealth.com/health-disparities-4173220

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**How Does Homelessness Impact Seniors?**

Experiencing homelessness is a challenge, and often a traumatic experience, for individuals at any age. For elderly people, the experience of aging exacerbates health and social challenges.

Homeless elders face significant health challenges. Diagnosing and treating homeless seniors and older people can be difficult due to lack of money or insurance to pay for treatment. Some older people experience distrust of health care and social service providers. Getting to public assistance programs can also be daunting to homeless elders who have limited mobility. Once in the door, some get discouraged by lengthy application processes or ultimately refuse help.

Not only is homelessness a barrier to health care, but it can also increase the risk for health conditions. The aging homeless population experiences high rates of diabetes and hypertension. Age also puts people at further risk for complications from COVID-19.

This is likely for a number of reasons including:

- Emotional stress (e.g., being scared)
- Physical stress (e.g., walking long distances or sleeping uncomfortably on streets), and
- Inadequate nutrition

Many older homeless individuals have difficulty with self-care and keeping up with hygiene which can cause infection. Due to stress and social isolation, the experience of homelessness may also exacerbate mental health conditions. Sadly, homeless seniors in urban centers have disproportionately high rates of premature death.
Elderly people who are homeless will likely present increasing challenges for behavioral health and medical systems.

Social Relationships Are Vital for Elderly People

Health isn’t the only key to wellbeing. In addition to health, experiencing homelessness can make it hard for older individuals to maintain their social relationships. People may feel ashamed about being homeless and distance themselves from family and friends. Homeless seniors may not want to be a burden to their children, nieces, or nephews. Moreover, without a stable place to live, an address, or consistent access to a phone or the Internet, people can lose contact with their support system.

Safety Net Programs for Homeless Seniors

What exists to help homeless seniors survive and cope? In terms of health, older people have several safety net programs specifically designed for them, such as subsidized housing, Medicare, and Social Security. Subsidized housing is housing that is paid for partially by a government “subsidy”—a paid for portion of the cost. The number of safety net programs that are available to seniors is helpful. However, those who fall between the ages of 50 and 65 are a group of individuals who are not old enough to qualify for programs like Medicare. They often fall through the cracks despite having similar physical health to those much older due to daily stress, poor nutrition, and living conditions.

For more information, visit: https://invisiblepeople.tv/effect-of-homelessness-on-elderly-people/
Founded in 1970, The National Caucus and Center on Black Aging, Inc. (NCBA) is a national 501 (c) (3) nonprofit organization. Headquartered in Washington, DC, NCBA is the only national aging organization who meets and addresses the social and economic challenges of low-income African American and Black older adults, their families, and caregivers.

**NCBA Supportive Services include:**

**Job Training & Employment**

NCBA administers Senior Community Service Employment Program (SCSEP) with funding from the U.S. Department of Labor (DOL) to over 3,500 older adults, age 60+ in North Carolina, Arkansas, Washington, DC, Illinois, Missouri, Michigan, Ohio, Florida, and Mississippi.

SCSEP is a part-time community service and work-based job training program that offers older adults the opportunity to return or remain active in the workforce through on the job training in community-based organizations in identified growth industries.

Priority is given to Veterans and their qualified spouses, then to individuals who: are over age 65; have a disability; have low literacy skills or limited English proficiency; reside in a rural area; may be homeless or at risk for homelessness; have low employment prospects; failed to find employment after using services through the American Job Center system.

Annually, NCBA and CVS partner to host job fairs to orient SCSEP participants about the benefits of working at CVS as a mature worker.

To learn more about the Senior Community Service Employment Program (SCSEP), visit: https://ncba-aging.org/employment-program-resources

NCBA administers the Environmental Employment (SEE) Program with funding from the U.S. Environmental Protection Agency.

Agency (EPA) to older adults, age 55+ with professional backgrounds in engineering, public information, chemistry, writing and administration the opportunity to remain active in the workforce while sharing their talents with the U.S. Environmental Protection Agency (EPA) in Washington, DC, and at EPA Regional Offices and Environmental Laboratories in NC, OK, FL, and GA.

To learn more about the Senior Employment Environment Program (SEE), visit: https://www.ncba-aged.org/environmental-employment-program-resources

**Health**

The NCBA Health and Wellness Program offers continual education, resources, and technical assistance either in-person, online, or through self-paced learning opportunities. The program offers a wide variety of social and economic services and support including, the delivery and coordination of national health education and promotion activities, and the dissemination of and referral to resources.

To learn more visit https://ncba-aging.org/health-and-wellness
Established in 1977, the NCBA Housing Management Corporation (NCBA-HMC) is the organization’s largest program and service to seniors. NCBA-HMC provides senior housing for over 500 low-income seniors with operations in Washington, DC, Jackson, MS, Hernando, MS, Marks, MS, Mayersville, MS and Reidsville, NC.

To learn more about NCBA Housing Program, visit https://www.ncba-aged.org/affordable-housing/

Samuel J. Simmons NCBA Estates located in Washington, DC

NCBA Presents Free Tool Kit and Recorded Webinar for Dispelling Fears and Myths about COVID-19 Vaccines

Rather than a live webinar, we have linked a recorded webinar for you to view at your convenience to help in your outreach to older African Americans in your community who are still wary about the Covid-19 vaccines or have trouble accessing services. The webinar runs less than 20 minutes.

The webinar offers practical learned about organizations seeking to educate their members and facilitate vaccinations, but it also includes a Tool Kit with an infographic, tip sheet, a brief informational video that addresses myths and facts about the vaccines, and appointment cards to help recipients keep track.

Here is the link to the Recorded Webinar and the Tool Kit.

We strongly encourage you to download the informational video in the Tool Kit for public showings, to email it to members, or to share with other organizations and individuals who are engaged in Covid-19 education. There is no copyright on the video, so feel free to distribute it far and wide.

We would very much appreciate your feedback about this webinar, the Tool Kit and your distribution numbers. Please let us hear from you at covid@ncba-aging.org.

NCBA social media

To learn more about NCBA programs, services, and upcoming events, follow us on Facebook, Twitter, and Instagram!

Facebook @NCBA1970
Twitter@NCBA1970
Instagram@NCBA_1970

You’re also welcome to learn more about NCBA by visiting our website at www.ncba-aging.org. We look forward to hearing from you!
Upcoming Events

Heart Valve Disease Awareness Day
February 22, 2023
1:00 pm- 3:00 pm EST (In-person only)
Samuel J. Simmons NCBA Estates
Washington, DC 20009

Event will include basic heart screenings provided by MedStar Heart & Vascular Institute, speakers who will share information on the basics of valve disease, heart healthy snacks, and more!
Virtual (Only)

Register here: https://us02web.zoom.us/webinar/register/WN_8HUJTCXmR8Ki-bZy88HjGQ
It is an idea America has never fully lived up to, but it is an idea we have never fully walked away from either. The struggles and challenges of the Black American story to make a way out of no way have been the crucible where our resolve to fulfill this vision has most often been tested. Black Americans’ struggles for freedom, equal treatment, and the right to vote; for equal opportunities in education, housing, and the workplace; for economic opportunity, equal justice, and political representation; and so much more have reformed our democracy far beyond its founding. Black Americans have made a way not only for themselves but also have helped build a highway for millions of women, immigrants, other historically marginalized communities, and all Americans to more fully experience the benefits of our society.

From the start, the Biden-Harris Administration has been committed to using the power of the Federal Government to address the long-standing disparities that have hampered the progress of Black communities. On day one of my Presidency, I issued an Executive Order to advance equity and racial justice in every policy we pursue. I began by appointing the most diverse Cabinet in American history. I have continued to nominate a historic number of Black judges to the Federal bench — including Justice Ketanji Brown Jackson, the first Black woman to serve on the Supreme Court.

During the height of the COVID-19 crisis, my Administration provided relief to hardworking families, which cut the rate of poverty in Black American communities by nearly a third and cut the rate of poverty among Black children by more than half.

My health care policies have dramatically increased health care access and reduced costs for Black American families and capped insulin bills for seniors at $35 per month per prescription. We are also working to address centuries of neglected infrastructure in Black American communities.

My Administration is leading the replacement of lead pipes embedded in cities across America so that every child can safely turn on the faucet and drink clean water. We are expanding public transit and providing high-speed Internet to every neighborhood in the country so parents can get to work and children can do their homework in the comfort of their own homes.

We are using every avenue to confront racial discrimination in housing and in mortgage lending and to help build generational wealth in Black communities. We are working to ensure that any housing agency that receives Federal funds will reach beyond the simple promise not to discriminate and will instead take meaningful, affirmative steps to overcome historic patterns of segregation, giving every person a fair chance to live where they choose. We are addressing the negative impacts of redlining and other forms of financial discrimination. And we are working to end a discriminatory system of appraisals that assigns lesser values to Black-owned family homes than to similar homes owned by white families.

Proclamation on National Black History Month, 2023

During National Black History Month, we celebrate the legacy of Black Americans whose power to lead, to overcome, and to expand the meaning and practice of American democracy has helped our Nation become a more fair and just society. This country was established upon the profound but simple idea that all people are created equal and should be treated equally throughout their lives.

The struggles and challenges of the Black American story to make a way out of no way have been the crucible where our resolve to fulfill this vision has most often been tested. Black Americans’ struggles for freedom, equal treatment, and the right to vote; for equal opportunities in education, housing, and the workplace; for economic opportunity, equal justice, and political representation; and so much more have reformed our democracy far beyond its founding. Black Americans have made a way not only for themselves but also have helped build a highway for millions of women, immigrants, other historically marginalized communities, and all Americans to more fully experience the benefits of our society.
Additionally, we have invested nearly $6 billion in Historically Black Colleges and Universities. We have also taken historic action to ease the burden of crippling student debt — action which benefits so many Black students and families. I am proud to have permanently authorized the Minority Business Development Agency and to have given it expanded authority to help grow Black-owned businesses. I have set a goal to increase the share of Federal contracting dollars going to small, disadvantaged businesses by 50 percent by 2025, which will bring up to an additional $100 billion in capital to these businesses.

In May 2022, I signed an Executive Order promoting effective, accountable, and transparent community policing — delivering the most significant police reform in decades. Among other important measures that increase transparency and accountability, it raises policing standards by banning choke holds, restricting no knock warrants, and requiring body-worn cameras on patrols and during searches and arrests. It creates a new national law enforcement database to track records of misconduct, and it aims to safely reduce incarceration, support rehabilitation and reentry, and address racial disparities in our criminal justice system. Additionally, I signed three new hate crime bills, including the Emmett Till Antilynching Act which finally made lynching a Federal crime.

Equal access to the ballot box is the beating heart of our democracy. Without it, nothing is possible; with it, anything is. I restored the Civil Rights Division of the Department of Justice, appointing top attorneys to oversee enforcement of civil rights laws, and the Department has doubled the voting rights enforcement staff. Every agency of my Administration has been ordered to expand access to voter registration and election information. These are all important steps, but I will continue to push the Congress to repair the damage to voting rights in this country by passing the John Lewis Voting Rights Advancement and Freedom to Vote Acts, to ensure every American has a voice in the democratic process.

This year, on what would have been Dr. King’s 94th birthday, I was honored to be the first sitting President to deliver a sermon at Sunday service at his cherished Ebenezer Baptist Church in Atlanta. The life of Dr. King demonstrates that democracy is an enduring covenant that must be persistently renewed; nothing about it is guaranteed. During National Black History Month, we honor and continue the work of Black Americans who have created a more fair and inclusive democracy, helping our Nation move closer to the realization of its full promise for everyone.

NOW, THEREFORE, I, JOSEPH R. BIDEN JR., President of the United States of America, by virtue of the authority vested in me by the Constitution and the laws of the United States, do hereby proclaim February 2023 as National Black History Month. I call upon public officials, educators, librarians, and all the people of the United States to observe this month with relevant programs, ceremonies, and activities.

IN WITNESS WHEREOF, I have hereunto set my hand this thirty-first day of January, in the year of our Lord two thousand twenty-three, and of the Independence of the United States of America the two hundred and forty-seventh.

JOSEPH R. BIDEN JR.