

REGIONAL COMMUNITY HEALTH RESOURCES
AND NEEDS ASSESSMENT (CHRNA)

Salt Lake City, Utah, Community Report on COVID-19 Impacts

5/11/21 TO 11/6/21



Executive Summary

The Regional Community Health Resources and Needs Assessment (CHRNA) – Salt Lake City, Utah (n=395) was implemented to understand the health priorities, concerns, beliefs and behaviors, and access to healthcare and resources of the Native Hawaiian/Pacific Islander (NH/PI) communities in the Salt Lake City metropolitan area. This report covers the impact of the COVID-19 pandemic on NH/PI communities in the Salt Lake City metropolitan area, highlighting three key areas of importance: food hardships and access to food, COVID-19 vaccination, and language access.

The Regional CHRNA – Salt Lake City, UT survey and administration processes were collaboratively planned and developed with partnering community-based organizations and was administered from May 11, 2021 to November 6, 2021. The Regional CHRNA – Salt Lake City, UT is unique as compared to other regional population-based surveys and needs assessments, because it leveraged community-partnered data collection and engagement methods to reach historically unrepresented NH/PI ethnic groups. This cross-sectional survey mainly conducted online and in-person with trained community staff, and was offered in English, Tongan, and Samoan. This community-based sample includes 395 NH/PI individuals. Disaggregated data are presented for ethnic subgroups that had a statistically large enough sample size ($n \geq 35$ individuals); this included three NH/PI ethnic subgroups: Tongan (n=253), Samoan (n=92) and Other NH/PI (n=50). Other NH/PI includes individuals who self-identified as Fijian, Hawaiian, Maori, Marshallese, Polynesian, Tahitian, unspecified NH/PI, multiethnic NH/PI, and Multiracial NH/PI. More information about the Regional CHRNA – Salt Lake City, UT sample demographics and methods are on pages 13-15.

The unintended consequences of current data collection and reporting practices are that the social needs of NH/PI communities stay invisible. Many population-based surveys prior to and during the COVID-19 pandemic have not disaggregated NH/PI and Asian American data and are often administered solely in English and Spanish, limiting the reach into communities proficient in other languages. The data from these population-based surveys may therefore misrepresent NH/PI ethnic groups in a geographic region and may only include NH/PI individuals able to respond in these languages, who may often be individuals with higher education and income levels, and who tend to have better social and health outcomes.

Key Findings

Below are the key findings for responses from NH/PI communities in the Salt Lake City metropolitan area, with more detailed findings for each topic beginning on page 6.

Food Hardships and Access to Food

- Food insecurity affected 31.5% of NH/PI participants, with the highest prevalence among Other NH/PIs (42.9%) (**Figure 1**).
- Food insufficiency affected 34.9% of NH/PI participants, with the highest prevalence among Other NH/PI participants (37.5%) (**Figure 2**).
- Perceived reasons for insufficient food among NH/PI participants included: the stores did not have the food they wanted (29.7%) and couldn't afford to buy more food (25.1%) (**Figure 3**).

COVID-19 Vaccination and Vaccine Hesitancy

- There was low COVID-19 vaccination uptake and high vaccine hesitancy among NH/PI participants during this time.
- Among NH/PI participants, only 40.1% had received at least one dose of the COVID-19 vaccine during this time, with the lowest prevalence among Tongan participants (37.3%) (**Figure 4**).
- Among unvaccinated NH/PI participants (n=236), 67.4% were hesitant to get the COVID-19 vaccine, with the highest prevalence among Tongan participants (69.0%) (**Figure 5**).
- The top three information sources for the COVID-19 pandemic among NH/PI participants included family/friends (68%), social media (53%), and television, news, and radio (33%) (**Figure 6**).

Language Access

- In the sample, 41.6% of NH/PI participants spoke a language other than English at home. Among NH/PI individuals speaking a language other than English at home (n=163), 19.0% were limited English proficient (**Figure 7**).
- When accessing health care, 8.1% of NH/PI participants or their family members experienced language barriers during the COVID-19 pandemic (**Figure 8**).
- Among participants experiencing language barriers, the top barriers included: unable to access an interpreter (51.6%), unable to get materials or information in their preferred language (38.7%), long wait-times for an interpreter (22.6%), and difficulty with telehealth tools (22.6%).

Overall Recommendations

Our community-based partner organizations based nationally and in UT quickly pivoted to support community members' basic needs, including timely COVID-19 prevention and vaccination information in preferred languages, in-language community linkages to available and appropriate social services and public benefits, and provision of food support to increase food security. These issues were largely unaddressed by local, state, and national leaders in the COVID-19 emergency response efforts. This report highlights the needs of the NH/PI communities in the Salt Lake City metropolitan area during the COVID-19 pandemic that required equitable and sustained support and resources to bolster current and post COVID-19 pandemic response and relief efforts.

Our recommendations for NH/PI communities in the Salt Lake City metropolitan area are to:

Immediate

1. Prioritize COVID-19 outreach, vaccine and booster shot access among Pacific Islander and Asian American subpopulations – particularly those with low vaccination uptake at the time of this survey (i.e., Tongan, Samoan, and Other NH/PI adults).
2. Couple COVID-19 relief and recovery dollars with other support services, to address food, housing, and unemployment needs.
3. Prioritize group specific language justice strategies, by:
 - Developing COVID-19 messaging culturally and linguistically appropriate for Pacific Islander communities, which can be disseminated through social media and family/friends.
 - Prioritizing translation of websites with COVID-19 information in NH/PI languages.

Longer-term

1. Earmark funds to sustain infrastructure within community-based organizations for provision of in-language support related to COVID-19 testing and vaccination; expand enrollment navigation for public benefits support;

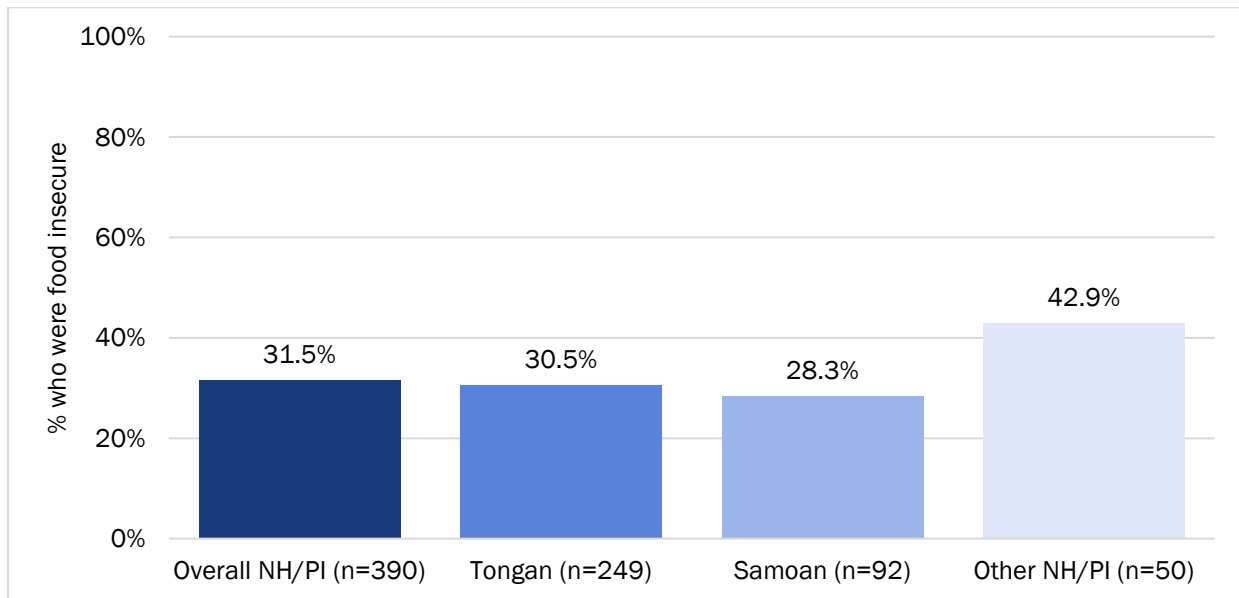
- provide culturally appropriate legal and mental health resources for victims of hate incidents; and to support in-language survey data collection.
2. Improve primary data collection efforts of city and state entities to better reach NH/PI communities such that data on NH/PI communities need not rely largely on academic and grassroots efforts to be able to gather, access, or use data.
 3. Support efforts that provide disaggregated data on NH/PI ethnic subgroups.

Food Hardships and Access to Food

Food Insecurity

Food insecure was defined as answering ‘often true’ or ‘sometimes true’ to either of the following statements: 1) “I/We worried whether my/our food would run out before I/we got money to buy more” and 2) “The food I/we bought just didn’t last, and I/we didn’t have money to get more.” Was that often, sometimes, or never true for you in the last 12 months? Among NH/PI participants, 30.5% of Tongan, 28.3% of Samoan, and 42.9% of Other NH/PI were food insecure in the last 12 months (**Figure 1**).

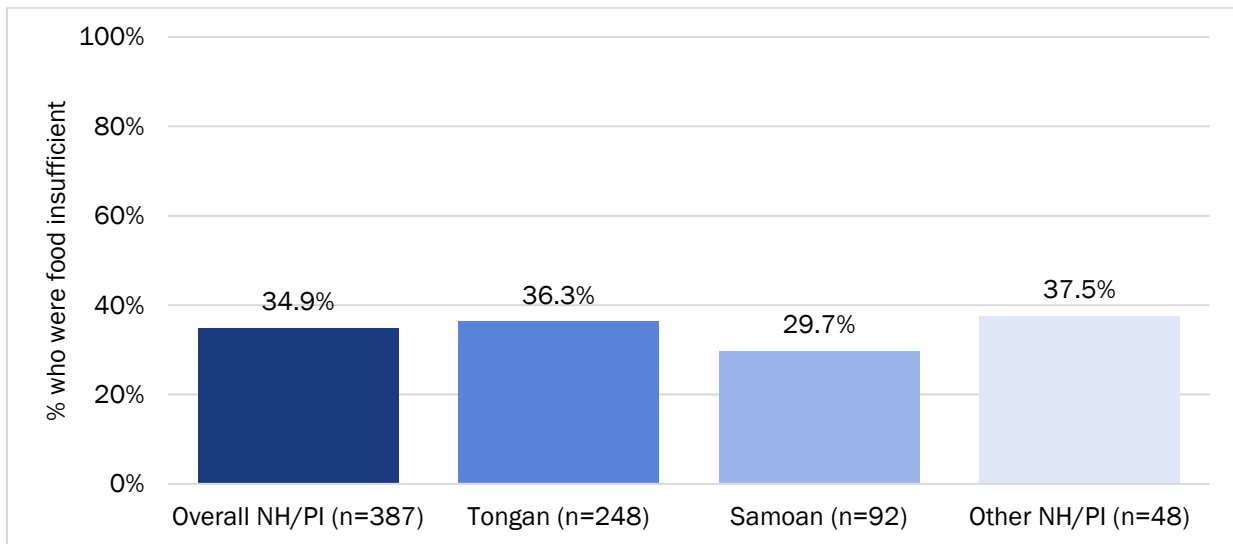
Figure 1. Food insecure in the last 12 months among NH/PI participants (n=390)



Food Insufficiency

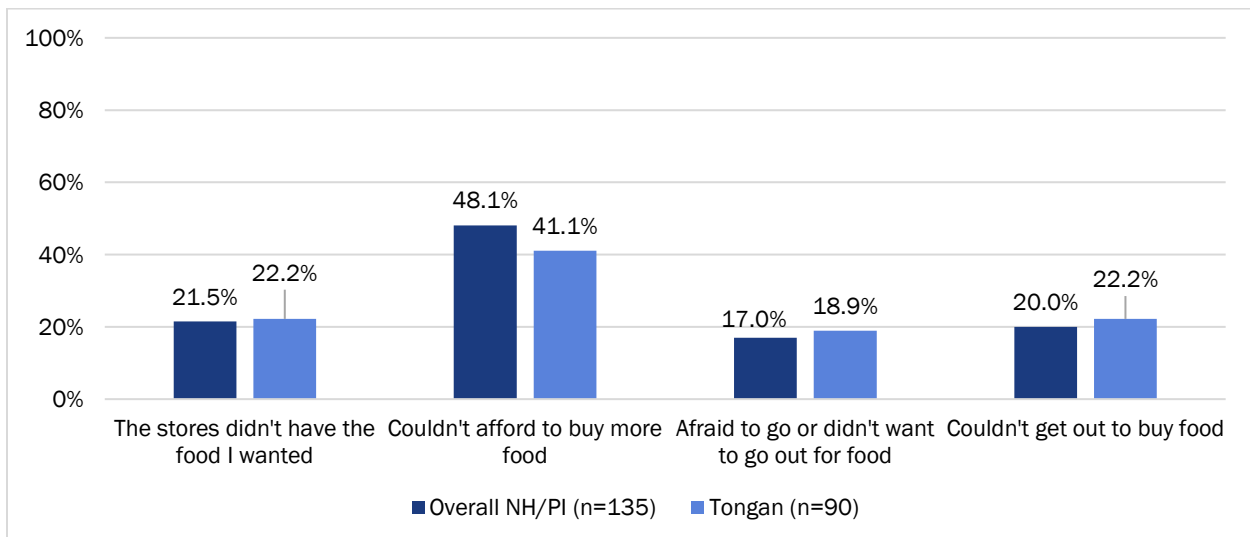
There were significant food affordability and access challenges because of the COVID-19 pandemic. Food insufficiency was defined as “sometimes not enough to eat,” “often not enough to eat” or “enough but not always the kinds of foods I/we wanted to eat” to the question: In the last 7 days, which of these statements best describes the food eaten in your household? Food insufficiency affected 34.9% of NH/PI participants in the sample. By ethnic subgroup, 37.5% of Other Pacific Islanders experienced food insufficiency in the past week, followed by 36.3% of Tongans and 29.7% of Samoan participants (**Figure 2**).

Figure 2. Food insufficiency in the last 7 days among NH/PI participants (n=387)



Among overall NH/PI participants who experienced food insecurity (n=135), perceived reasons included: couldn't afford to buy more food (48.1%), stores didn't have the food they wanted (21.5%), couldn't get out to buy food (20.0%), and afraid to go or did not want to go out to buy food (17.0%). Among Tongan participants who experienced food insecurity (n=90), perceived reasons included: couldn't afford to buy more food (41.1%), stores didn't have the food they wanted (22.2%), couldn't get out to buy food (22.2%), and afraid to go or did not want to go out to buy food (18.9%) (**Figure 3**).

Figure 3. Perceived reasons for food insufficiency among NH/PI participants (n=135)



Note: Perceived reasons for insufficient food are not presented for Samoan or other Pacific Islander subgroups because of the small sample who were food insufficient (n<35).

Food Access Recommendations

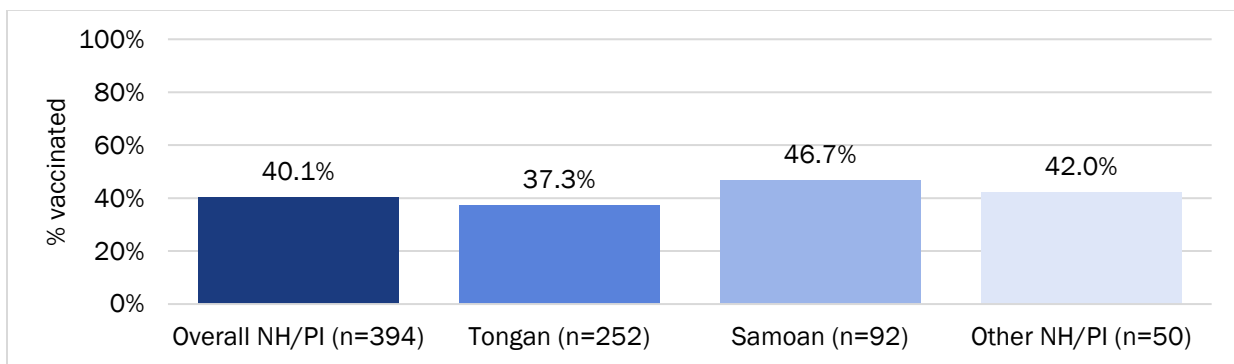
- Couple COVID-19 relief and recovery dollars with other support services, to address food, housing, and unemployment needs.
- Connect food insecure individuals to food pantries and food banks, particularly those with in-language support and/or culturally appropriate foods, to ensure communities have adequate food to meet dietary needs.
- Expand funding to hire and support bilingual staff at community-based organizations who are already providing culturally and linguistically relevant community outreach and food assistance.
- Prioritize infrastructure supporting food access community programs, including those that provide mobile markets, local distribution options and/or to introduce home delivery, to connect residents to nutritious food.

COVID-19 Vaccination and Vaccine Hesitancy

COVID-19 Vaccination Uptake

Vaccination is defined as receiving at least one dose of the COVID-19 vaccine. At the time of our survey in 2021, 37.3% of Tongan, 46.7% of Samoan, and 42.0% of Other NH/PI adults were vaccinated (low COVID-19 vaccination uptake) (**Figure 4**).

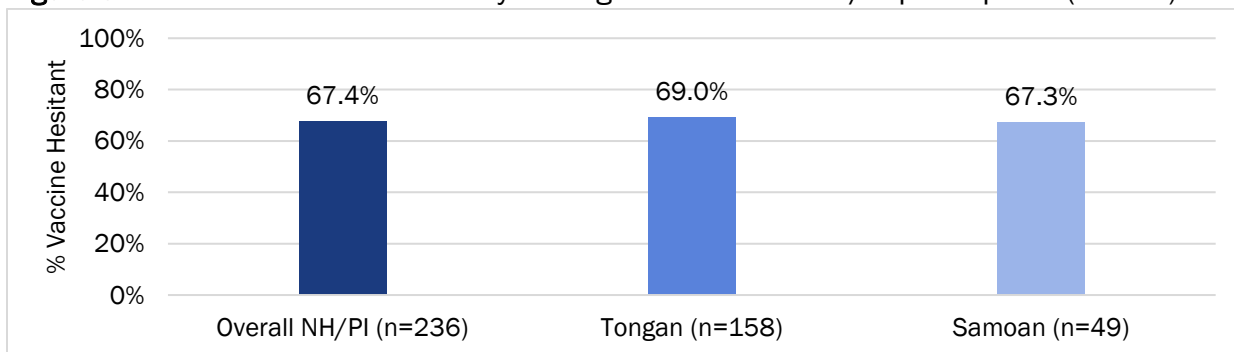
Figure 4. COVID-19 vaccination uptake among NH/PI participants (n=394)



COVID-19 Vaccine Hesitancy

Vaccine hesitant is defined as individuals who were ‘very unlikely,’ ‘somewhat unlikely,’ or ‘unsure’ about getting the COVID-19 vaccine among unvaccinated participants. There was high COVID-19 vaccine hesitancy. Among unvaccinated NH/PI participants (n=236), 67.4% of NH/PI overall, 69.0% of Tongan, and 67.3% of Samoan adults were vaccine hesitant (**Figure 5**).

Figure 5. COVID-19 vaccine hesitancy among unvaccinated NH/PI participants (n=236)

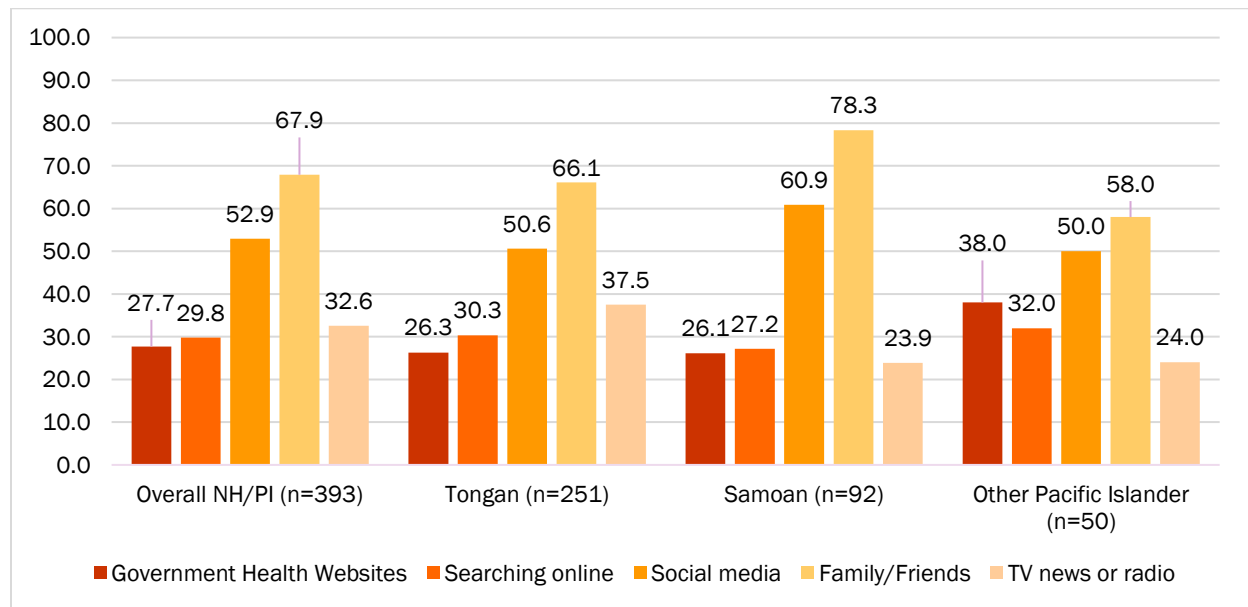


Note: Data for Other NH/PI participants are not included because the number of unvaccinated individuals was too small (n<35) to examine vaccine hesitancy.

Main Information Sources

The top COVID-19 information sources varied by NH/PI subgroup (**Figure 6**). Social media and family/friends ranked in the top three for all NH/PI subgroups. Tailored, targeted communication efforts might improve outreach and dissemination of COVID-19 public health guidance and information to these communities.

Figure 6. Top information sources for the COVID-19 pandemic among NH/PI participants (n=393)



Vaccination-Related Recommendations

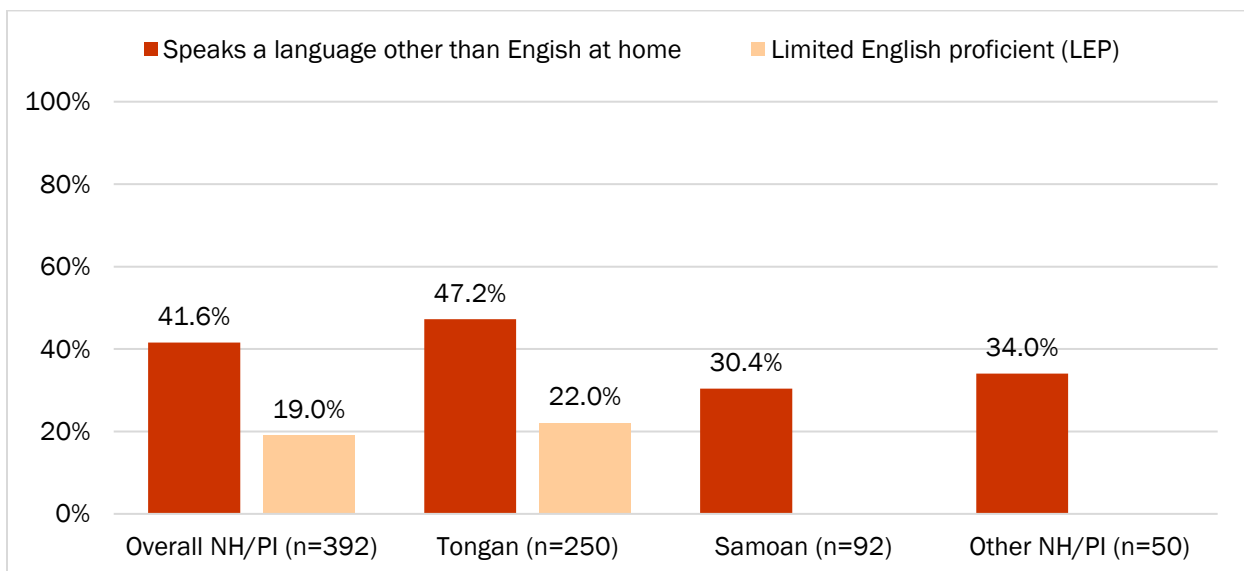
- Continue efforts to increase outreach and increase access to vaccinations and related booster shots for all NH/PI groups, particularly among high-risk populations, like older adults and children.
- Partner with trusted NH/PI community leaders and community-based organizations to prepare more effective outreach approaches and to disseminate critical vaccination information and resources more efficiently.
- Continue to provide funding and resources to support community-based and culturally-targeted efforts to facilitate vaccination across diverse NH/PI populations.
- Set up vaccination sites or mobile vaccination sites in close collaboration with trusted community leaders and community-based organizations at frequented locations (e.g., community centers) of NH/PI communities to increase accessibility and uptake.
- Provide translated materials and on-site interpreters, bilingual staff, or community health workers to make vaccinations more accessible across the community.

Language Access

Insufficient language access creates significant barriers to accessing health and mental health care resources and COVID-19 relief and recovery benefits in the short-term and has negative, long-term implications for health and well-being. COVID-19 relief and recovery efforts cannot be equitable without timely access to public health guidance and information in peoples’ preferred languages (including written text and audio).

NH/PI communities face persistent language barriers. Among NH/PI participants, 41.6% of overall NH/PIs, 47.2% of Tongan, 30.4% of Samoans, and 34.0% of Other NH/PIs spoke a language other than English at home. Among those speaking a language other than English at home, 22.0% of Tongan adults spoke English less than very well (in other words, they were limited English proficient) (**Figure 7**).

Figure 7. Language spoken at home and Limited English proficiency among NH/PI participants (n=392)

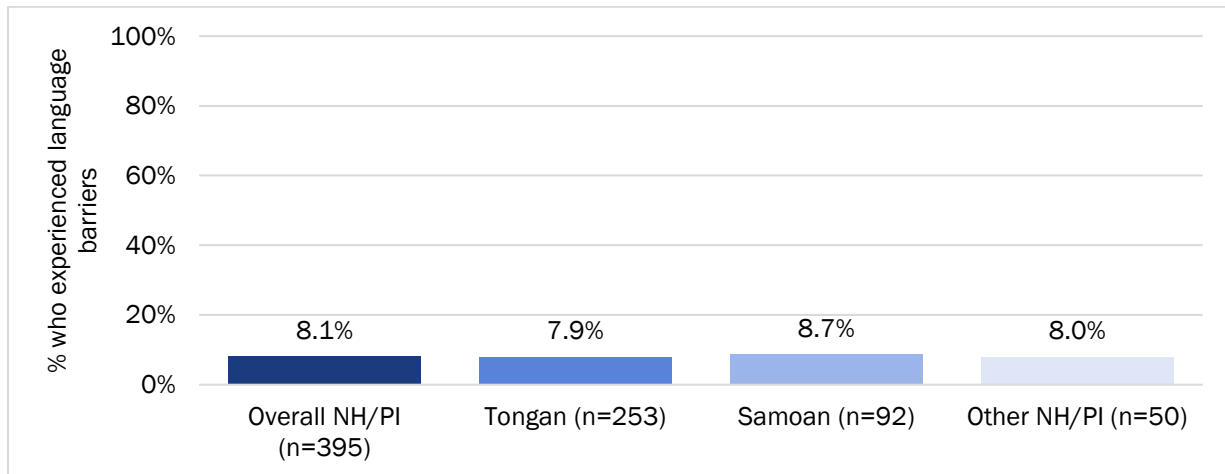


Note: LEP is defined as speaking English less than very well among individuals who speak a language other than English at home. Samoan and Other NH/PI subgroups were too small to examine individually for LEP (n<35).

Language access is particularly critical for individuals during public health emergencies and who are not fluent in English. Language barriers related to health care access were a challenge for 7.9% of Tongan, 8.7% of Samoan, and 8.0% of other NH/PI participants or their families during the COVID-19 pandemic (**Figure 8**).

Among overall NH/PI participants experiencing language barriers when accessing health care (n=31), the top barriers included: unable to access an interpreter (51.6%), unable to get materials or information in their preferred language (38.7%), long wait-times for an interpreter (22.6%), and difficulty with telehealth tools (22.6%). Subgroups were too small to examine individually for language access barriers (n<35).

Figure 8. Experienced language barriers when accessing health care during the COVID-19 pandemic by NH/PI racial/ethnic groups (n=395)



Language Access Recommendations

- Prioritize tangible support to offer in-language community-facing services and resources.
- Provide funding to community-based organizations who are already providing services in community members’ preferred languages with staff fluent in those languages, to bolster organizational infrastructure and capacity.
- Broaden language and interpreter services and availability of translated written materials in health care and public service settings to ensure equal access to care.
- Expand COVID-19 language services and translate materials in a timely manner at federal (e.g., the NIH and CDC) and state (state Departments of Health) agencies and increase outreach and dissemination efforts for NH/PI communities.
- Tailor messages to respond to the distinct concerns of NH/PI ethnic groups, and ensure COVID-19 messaging and communication are targeting community members in their preferred language and communication platforms.

Survey Methods

The Regional CHRNA – Salt Lake City, UT survey instrument and administration processes were collaboratively planned and developed with partnering community-based organizations and was administered May 7 to December 31, 2021. This cross-sectional survey was conducted online and in-person with trained community staff and was offered in English, Tongan, and Samoan. The majority of participants completed the survey in English (99.2%).

The Regional CHRNA – Salt Lake City, UT is a community-based sample consisting of 395 participants who: were 18 years or older; self-identified as Native Hawaiian or Pacific Islander (NH/PI); and who lived in the Salt Lake City metropolitan area. Disaggregated data are presented for three NH/PI ethnic groups: 253 Tongan, 92 Samoan, and 50 Other NH/PI adults. Other NH/PI includes individuals who self-identified as Fijian, Hawaiian, Maori, Marshallese, Polynesian, Tahitian, unspecified NH/PI, multiethnic NH/PI, and Multiracial NH/PI.

Results from the Regional CHRNA – Salt Lake City, UT may not be representative of the NH/PI communities in the Salt Lake City metropolitan area or nationally. However, by leveraging the breadth and depth of trusted community partners, we were able to reach historically unrepresented NH/PI ethnic groups, collect information on the COVID-19 pandemic, and relay this information back to community partners and public health professionals to inform COVID-19 pandemic-related and broader health promotion efforts. The community-engaged research practices that arose from this partnership are elaborated on in further detail [here](#).

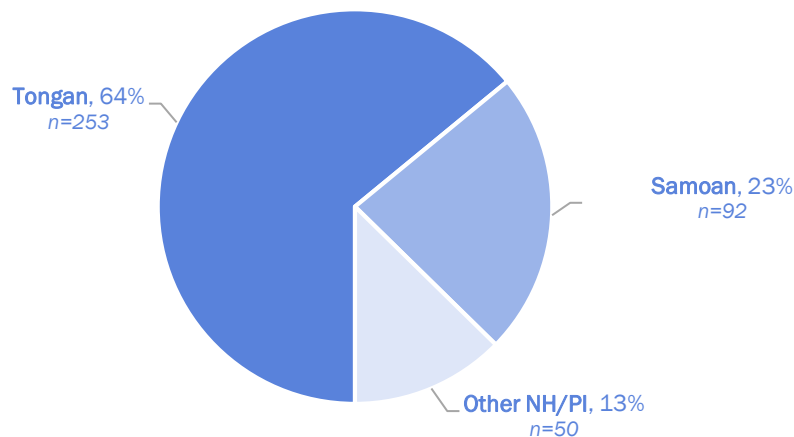
Participant Demographics

The majority of NH/PI participants (**Figure 9**) were younger (63.1% were 18 to 34 years) and middle-aged (30.4% were 35 to 54 years); 62.4% were female; 40.7% had a high school education, 42.2% had some college education, and 13.7% were college graduates; and 46.8% had an annual household income < \$50,000. Approximately 16.5% of NH/PI adults were born outside of the US, and of these, the majority (93.7%) had lived in the US for 10 years or more. A total of 41.6% spoke a language other than English at home; of these individuals, 19.0% were limited English proficient (LEP). NH/PI adults had a median household size of 4 people, with 66.7% reporting at least two generations living in their household and 29.4% reporting an adult essential worker in their household.

By NH/PI ethnic group, Tongan adults had the highest proportion not born in the US (19.0% vs. 10.9% for Samoan and 14.0% for Other NH/PI) and a greater percentage speaking a language other than English at home (47.2% vs. 30.4% for Samoan and 34.0% for Other NH/PI). Tongan adults were more likely to be age 55 or older (9.6% vs. 1.1% of Samoan and 0.0% of Other NH/PI); while Other NH/PI adults were more likely to have a college education (25.0% vs. 11.9% of Tongan and 13.0% of Samoan) and report the highest prevalence of adult essential workers in the household (44.7% vs. 29.8% for Tongan and 20.2% for Samoan). Tongan (47.0%) and Samoan (51.0%) adults were more likely to have an income <\$50,000 than Other NH/PI (38.0%) adults.

Table 1 provides Regional CHRNA – Salt Lake City, UT participant demographics by NH/PI racial/ethnic group (n=395).

Figure 9. NH/PI racial/ethnic group distribution among Regional CHRNA – Salt Lake City, UT participants (n=395).



Note: *Other NH/PI* includes individuals who self-identified as Fijian, Hawaiian, Maori, Marshallese, Polynesian, Tahitian, unspecified NH/PI, multiethnic NH/PI, and multiracial NH/PI.

Table 1. Participant Demographics by NH/PI racial/ethnic group (n=395), %

Characteristic, %	Overall NH/PI (n=395)	Tongan (n=253)	Samoan (n=92)	Other NH/PI (n=50)
Age group, %				
18 to 34 years	63.1	62.2	64.8	64.6
35 to 54 years	30.4	28.1	34.1	35.4
55+ years	6.4	9.6	1.1	0.0
Gender, %				
Male	36.8	35.6	40.7	36.0
Female	62.4	63.2	59.3	64.0
Other	0.8	1.2	0.0	0.0
Education, %				
Less than high school	3.3	4.3	0.0	4.1
High school graduate	40.7	38.7	46.7	39.6
Some college	42.2	45.1	40.2	31.3
College or more	13.7	11.9	13.1	25.0
Income, %				
<\$25,000	8.4	8.7	7.6	8.0
\$25,000 -<\$50,000	38.5	38.3	43.5	30.0
\$50,000 - <\$75,000	26.6	23.7	34.8	26.0
≥ \$75,000	11.4	12.3	5.4	18.0
Missing/Don't know	15.2	17.0	8.7	18.0
Born outside the US, %	16.5	19.0	10.9	14.0
Speaks a language other than English at home, %	41.6	47.2	30.4	34.0
Limited English proficient, %	19.0	22.0	-	-
Speaks English well	17.2	19.5	-	-
Speaks English not well	1.8	2.5	-	-
Speaks English not at all	0.0	0.0	-	-
Household Size, median	4.0	4.0	3.0	6.0
Generations in household				
1	33.3	34.7	36.6	20.0
2	53.2	48.7	56.1	71.1
3	13.5	16.5	7.3	8.9
Adult Essential Worker in Household, %	29.4	29.8	20.2	44.7

Report Information

Acknowledgments

The Regional CHRNA – Salt Lake City, UT was a collaborative community survey effort developed, implemented, and conducted by a dynamic partnership between:

- The National Tongan American Society (NTAS),
- NYU Center for the Study of Asian American Health (CSAAH),
- in partnership with five community-based organizations serving the NH/PI communities in SLC, including: Utah Pacific Islander Health Coalition, Free Wesleyan Church of Tonga in Utah, Utah Fijian Association, Hui Hawai'i 'O Hawaiian Civic Club, and the Utah Marshallese Association.

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About NYU CSAAH

The Center for the Study of Asian American Health (CSAAH) at NYU Langone Health is a National Institutes of Health (NIH) National Institute on Minority Health and Health Disparities (NIMHD)–funded Specialized Center of Excellence. The center is based in NYU Langone's Section for Health Equity. Established in 2003, CSAAH is focused on community-engaged research and investigator development programs to advance health equity among Asian American communities in the United States (US). CSAAH works closely with national and local organizations serving Asian American, as well as Native Hawaiian/Pacific Islander (NH/PI) communities to support coordinated research policy and dissemination activities, such as advancing disaggregated racial/ethnic data collection.

About National Tongan American Society

Founded in 1994, the National Tongan American Society (NTAS) is one of the longest running non-profit organizations to advocate for and empower all Tongan-Americans and other Pacific Islanders. Our organization's mission is Fakamālohia 'o e Kāinga mei Motú 'aki hono paotoloaki 'o e mo'ui leleí, akó, pukepuke fonuá, mo e fakama'unga 'o e fatongia ki he fonuá. "Strengthen the Pacific Islander family by promoting health, education, cultural preservation and civic engagement".

Icons

Icons used in this report are from MBCR, little_dipper_studio, NAPISAH, and Zunli Pebruansyah via The Noun Project.

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<https://aanhpihealth.org/resource/regional-chrna/>

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