

# **COVID-19 Vaccine Hesitancy or Access Barriers**

Understanding Utah's  
Racial and Ethnic  
Minority Communities'  
Attitudes to Inform an  
Effective Approach

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UTAH DEPARTMENT OF  
**HEALTH**  
Office of Health Disparities



*A snapshot of the perception of Utah's community health workers in considering the state's racial and ethnic minority communities' attitudes and hesitancy toward the COVID-19 vaccine. Analysis of local data compared with national narratives around vaccine hesitancy may inform strategic approaches to respond to barriers and improve timely vaccine uptake.*



## INTRODUCTION

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It has been widely assumed throughout the pandemic that racial and ethnic minority groups in the U.S. are vaccine hesitant and unwilling to access the COVID-19 vaccine. This assumption is

based on past behavior concerning lack of vaccination access among underserved and underrepresented populations. Applying national narratives of COVID-19 vaccine hesitancy to Utah's unique vulnerable communities has potential repercussions, including ignoring access barriers, which can further perpetuate health disparities.

To better understand Utah's racial and ethnic minority communities' COVID-19 vaccine attitudes, the Utah Department of Health (UDOH) Office of Health Disparities (OHD) gathered snapshot data about communities reached through the [COVID Community Partnership \(CCP\) project](#). Data was collected from community health workers (CHWs) in both community-based organizations (CBO) and local health department (LHD) settings representing their communities. This snapshot data may help inform a strategic approach for targeted vaccine distribution, rather than presuming national narratives of vaccine hesitancy as the biggest influence in Utah's underserved and underrepresented communities' failure to access the COVID-19 vaccine.

# BACKGROUND

Once the COVID-19 vaccine was available, racial and ethnic minority communities nationwide were categorized and grouped together as vaccine hesitant.

National narratives of ongoing vaccine hesitancy among racial and ethnic minority groups is partly related to historical trauma within medical research and treatment of minority groups, particularly with the Tuskegee Study with Black/African Americans,<sup>1</sup> the Diabetes Project with Havasupai Tribe American Indians,<sup>2</sup> Project 4.1 with Marshallese Pacific Islanders,<sup>3</sup> and the San Antonio Contraceptive Study with Hispanic/Latinos.<sup>4</sup> Additional research showcased ongoing vaccine hesitancy and mistrust of doctors, with lower rates of vaccinations with the MMR, Hepatitis B, Influenza, HPV, and Pneumonia vaccines among some racial and ethnic minority groups.<sup>5,6,7</sup>

National research on COVID-19 vaccine hesitancy reported outcomes that follow national narratives, with sources reporting variation among different racial and ethnic minority groups.<sup>8,9</sup> However, the Kaiser Family Foundation<sup>9</sup> suggested differences in vaccine attitudes did not appear substantial enough to explain the emerging disparities in vaccination rates.

1. Researchers with the Tuskegee Study conducted research without informed consent on black male adults who had contracted syphilis and withheld proper treatment. (CDC. (2021). The Tuskegee Timeline. CDC.gov. <https://www.cdc.gov/tuskegee/timeline.htm>)
2. The Havasupai Tribe sued researchers using their collected DNA samples for agreed upon type 2 diabetes research in other genetic studies, resulting in a monetary compensation settlement, but no legal precedent for researchers to obtain proper informed consent. (Garrison N. A. (2013). Genomic Justice for Native Americans: Impact of the Havasupai Case on Genetic Research. Science, technology & human values, 38(2), 201-223. <https://doi.org/10.1177/0162243912470009>)
3. The U.S. tested nuclear weapons and the side effects of consuming radioactive food on Marshallese islanders, resulting in development of cancers, stillborn births, and babies with serious birth defects. (Horowitz, A. J. (Producer & Director). (2011). Nuclear Savage: The Islands of Secret Project 4.1 [Motion picture]. United States: Pacific Islanders in Communications, Primordial Soup Company/Equatorial Films.)
4. A study on oral contraceptive side effects was conducted with Mexican-American women who were not informed about the chance of receiving randomized placebo/inactive medication, resulting in a high number of unplanned pregnancies in the placebo group. (Kim W. O. (2012). Institutional review board (IRB) and ethical issues in clinical research. Korean journal of anesthesiology, 62(1), 3-12. <https://doi.org/10.4097/kjae.2012.62.1.3>)
5. CDC. (2018). Vaccination Coverage among Adults in the United States, National Health Interview Survey, 2017. Box 2, Table 2. CDC.gov. <https://www.cdc.gov/vaccines/imz-managers/coverage/adultvaxview/pubs-resources/NHIS-2017.html>.
6. CDC. (2020). Flu Vaccination Coverage, United States, 2019-20 Influenza Season. CDC.gov. <https://www.cdc.gov/vaccines/imz-managers/coverage/adultvaxview/pubs-resources/NHIS-2017.html>.
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When the COVID-19 vaccine was rolled out in Utah, decision makers prioritized high-risk groups for vaccine eligibility, which might partly explain disparities in vaccination rates among racial and ethnic minority communities. The first groups to become eligible for vaccination were healthcare workers and older populations; groups not representative of racial and ethnic minority communities. However, as of June 2021, these health disparities continue. Utah's COVID-19 vaccination rates among racial and ethnic minority groups range from one percent to 19% lower than Utah's overall vaccination rate (see Table 1).

**Table 1. Crude Vaccination Rates by Race/Ethnicity in Utah as of June 24, 2021**

| Race/Ethnicity*                    | % of People Fully Vaccinated | Absolute Difference from Overall Rate |
|------------------------------------|------------------------------|---------------------------------------|
| Utah Overall                       | 42.2%                        | Not applicable                        |
| American Indian/Alaska Native      | 23.9%                        | -18.3%                                |
| Asian/Asian American               | 41.4%                        | -0.8%                                 |
| Black/African American             | 24.2%                        | -18%                                  |
| Hispanic/Latino                    | 35.2%                        | -7%                                   |
| Native Hawaiian/Pacific Islander   | 23.5%                        | -18.7%                                |
| White alone, (not Hispanic/Latino) | 48.4%                        | +6.2%                                 |

\*Race and ethnicity groups follow U.S. Census minimum standards are calculated as race alone or in combination unless otherwise noted.

Data source: <https://coronavirus.utah.gov/case-counts/>

The Utah Department of Health (UDOH) Office of Health Disparities (OHD) identified the importance of collecting local data to better determine the drivers of racial and ethnic health disparities in vaccination for Utah's unique communities. The COVID Community Partnership (CCP) project snapshot data highlighted attitudes of Utah's racial and ethnic minority groups' attitudes toward the COVID-19 vaccine. This data contributed to a more accurate depiction of barriers to vaccination faced by Utah's vulnerable populations and can help inform development of a strategic approach to reach target groups with ongoing vaccine distribution.

# METHODS

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Snapshot data was gathered from the COVID Community Partnership (CCP) project's community health workers (CHWs) to gather insight into the experiences of Utah's racial and ethnic minority communities. CHWs often serve as advocates and representatives of Utah's racial and ethnic minority communities, as many CHWs are members of the community they serve and work to reach.

Three separate surveys were conducted from February to April 2021 during CCP weekly check-in calls with CHWs. Electronic surveys of closed-ended questions with an "other" open-ended option were administered through SurveyMonkey.

CHWs were asked to report on communities' concerns with getting the COVID-19 vaccine, as well as whether community members were willing to get the COVID-19 vaccine. Questions were asked in different formats two separate times from February to April in an effort to measure development and trends of vaccine attitudes.

Data analyses consisted of quantitative grouping for closed-ended responses. Snapshot data findings were averaged together and reported overall; variations in findings by communities were also reported. Trends and development of responses were reported and compared.

## FINDINGS

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A range of 44 to 66 community health workers (CHWs) responded to the three surveys between February and April 2021. CHWs reported serving the following racial and ethnic minority community members who identify as: American Indian/Alaska Native, Asian/Asian American, Black/African American, Hispanic/Latino, and Native Hawaiian/Pacific Islander. It is important to acknowledge that there was more representation of certain communities by CHWs, particularly the Hispanic/Latino communities.

## February 16, 2021

In the initial survey, 66 CHWs selected all applicable concerns the communities' had with getting the COVID-19 vaccine. CHWs reported fear of side effects (84.6%) and misinformation about the vaccine (83.3%) as the most prevalent concerns. Other concerns reported by CHWs included: lack of information about the vaccine (62.1%); no appointment or lack of times available to get the vaccine (60.6%); fear of requirements or citizenship requests (40.9%); cost or fear of cost (31.8%); and location (22.7%). Additionally, 9.1% reported other options, including: signing up for appointments; lack of access to technology; difficulties with online registration; past vaccine concerns with experimentation on black communities; questions surrounding fertility; as well as not wanting to waste vaccine doses.



## March 1, 2021

Two weeks later, 92.2% (47/51) of CHWs reported their communities as willing to get the COVID-19 vaccine when they would become eligible, even with the previous reporting of communities' various concerns.

## April 12, 2021

CHWs were again asked if their community members in general were willing to get the COVID-19 vaccine now that everyone was eligible. A month and a half later, 79.6% of CHWs (35/44) responded their communities were willing to get the COVID-19 vaccine, a slight decrease from responses in March, but still representing a majority as willing (see Table 2).

CHWs were also asked to select their communities' overall biggest concern with getting the COVID-19 vaccine. CHWs reported receiving misinformation about the COVID-19 vaccine as the largest concern (34.1% or 15/44 CHWs). The fear of side effects (29.6%) and no appointment or lack of times available to receive the COVID-19 vaccine (20.5%) were also primary concerns. Other concerns included a lack of information about the vaccines being provided (11.4%), the location of the vaccine clinics (2.3%), and one "other" response of not trusting the vaccine in general (2.3%). These reported concerns varied slightly from responses in February, as seen in Table 3.

**Table 2. A Majority of Community Health Workers (CHWs) Reported their Community Members as Willing to Get the COVID-19 Vaccine Between March and April 2021, with a Slight Decrease Between Months**

| CHW response: % selecting their community members as willing to get the COVID-19 vaccine |                                |
|--|--------------------------------|
| March 1, 2021 ( <i>n</i> =51)  | April 12, 2021 ( <i>n</i> =44) |
| 92.2%  | 79.6%                          |

Data source: UDOH Office of Health Disparities COVID Community Partnership (CCP) Project data collected through surveys among CHWs.

**Table 3. Community Health Workers (CHWs) Reported Similar Vaccine Concerns Among their Communities Between February and April 2021 Including Information and Access Concerns.**

| February 16, 2021 ( <i>n</i> =66)<br>*Most Common Concerns   | April 12, 2021 ( <i>n</i> =44)<br>*Top Concerns |
|--|---|
| 1. Fear of side effects  | 1. Vaccine misinformation                       |
| 2. Vaccine misinformation  | 2. Fear of side effects                         |
| 3. Lack of vaccine information   | 3. Lack of appointment times available          |
| 4. Lack of appointment times available   | 4. Lack of vaccine information                  |
| 5. Fear of requirements or citizenship requests  | 5. Location & Other+                            |
| +Other concerns: Mistrust in the vaccine.  |   |
| *Note: On February 16, CHWs were asked to report all community concerns with the COVID-19 vaccine. On April 12, CHWs were asked to report the community's top concern with the COVID-19 vaccine. |   |

Data source: UDOH Office of Health Disparities COVID Community Partnership (CCP) Project data collected through surveys among CHWs.

## Variation Among Communities

Overall, racial and ethnic minority groups represented by CHWs reported willingness across March and April surveys. However, there was prevalent vaccine hesitancy reported by CHWs who served Black/African American communities across the March and April surveys, with all reporting their communities as unwilling to get the COVID-19 vaccine. Furthermore, there was slight variation in responses among CHWs who served Hispanic/Latino communities regarding vaccine hesitancy, with a small number (fewer than five) reporting their communities as unwilling to get the COVID-19 vaccine.

Two additional noteworthy findings included (1) CHWs who served refugee and asylee communities all reported willingness to get the COVID-19 vaccine across both surveys and (2) in the April survey, half (50%) of CHWs who served rural communities reported vaccine hesitancy.

Little variation existed in the largest concerns reported with the COVID-19 vaccine between CHWs who represented different racial and ethnic minority groups. Misinformation about the COVID-19 vaccine and fear of side effects continued to be top concerns among communities overall. Within CHWs who served the same racial and ethnic minority communities, there was notable variation in selection of the largest concerns with the COVID-19 vaccine. CHWs who served Hispanic/Latino communities showed the most variation with a divided selection of concerns between misinformation about the vaccine, fear of side effects, and lack of available appointments. Although most CHWs who served Asian/Asian American, Black/African American and American Indian/Alaska Native communities reported misinformation as their largest concern, several others within each group of CHWs selected fear of side effects. CHWs who served Native Hawaiian/Pacific Islander communities selected a variety of concerns with misinformation as the top concern, followed by a divided selection between fear of side effects, lack of available appointments, and lack of information.

## DISCUSSION

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Contrary to national narratives of racial and ethnic minority groups' hesitancy toward the COVID-19 vaccine, this snapshot data indicated vaccine hesitancy may not be the only determining factor in vaccine uptake or disparities in vaccination rates among all racial and ethnic minority communities in Utah.

Overall, this snapshot data reported on community concerns related to both COVID-19 vaccine hesitancy and barriers to vaccine access, which may help explain disparities in vaccination rates. This data further highlighted the risk of assumption and reinforced the importance of a multifaceted approach to effectively address these disparities.

There are many risks in assuming vaccine attitudes among racial and ethnic minority populations.

When trying to increase vaccine uptake through an assumed approach of combatting hesitancy, the wrong factors may be addressed at the wrong time. In particular, barriers to access may be overlooked.



This snapshot data collected on March 1 and April 12, 2021 reported a large majority of community members were willing to get the COVID-19 vaccine when they became eligible. At the time of the March 1 survey, only healthcare workers, adults older than age 50, and those 16 and older with underlying health conditions (i.e., diabetes, BMI of 30+ or chronic kidney disease) were eligible. By the survey on April 12, everyone older than age 16 was eligible to access the vaccine.

In addition to reporting overall willingness, the data also highlighted community concerns including lack of available appointments and the location of vaccine clinics. These concerns highlighted access and information barriers that might affect vaccine uptake.

The lack of available appointment times might indicate some vaccine clinics only offered a traditional 9-5 schedule. Variable working hours, working multiple jobs, or less flexibility to leave work might prevent some individuals from accessing these clinics. The location of vaccine clinics might suggest vaccine clinics were located too far from individuals' homes or work sites or in unfamiliar areas. Lack of available transportation to locations might be a barrier, and even cultural and linguistic barriers might exist in accessing some modes of transportation, such as ride sharing services.

Additional access barriers, which might prevent communities from being vaccinated if not addressed, might include: lack of access to technology to schedule and register for appointments, language and cultural barriers in the registration and onsite clinic processes, and vaccine staff without training to provide services to vulnerable populations.

Misinformation and fear might spread through communities when officials fail to address barriers to access in a timely manner. If vaccination access is not provided to communities when they are willing, as more time passes, racial and ethnic minority groups might develop vaccine hesitant attitudes. A misdirection of efforts and resources focused only on hesitancy instead of on access barriers may stigmatize communities as unwilling to receive vaccination. This could create and perpetuate self-internalized messages of hesitancy and mistrust that were not initially a concern.

Findings from this snapshot data indicated vaccine willingness decreased slightly between March and April 2021. This might be partially due to emerging safety concerns with the Johnson and Johnson vaccine. In addition, the rest of the unvaccinated community may be more representative of a vaccine-hesitant population.



Despite this slight decrease over time as vaccine access opened up to everyone, CHWs continued to report the majority of their communities were willing to get the COVID-19 vaccine. However, disparities in vaccine uptake among racial and ethnic minority communities has persisted, with lower rates of these communities getting the COVID-19 vaccine when compared with Utahns overall.

In any event, consideration of access barriers is vital to equitable vaccination distribution and addressing disparities in vaccination rates among racial and ethnic minority populations. Addressing these barriers enables willing populations to access the vaccine and may further promote uptake in these communities.

However, top concerns with the COVID-19 vaccine reported in this snapshot data still include misinformation, lack of information, and fear of side effects. These concerns suggest factors contributing to these concerns should be considered as vaccine distribution moves forward and vaccine hesitancy becomes more prevalent in the unvaccinated population. Factors may include: lack of culturally relevant information, lack of trust in government agencies disseminating the information, lack of technology to access information, lack of access to accurate information, and insufficient reach to some of these populations.

It is important to remember that vaccine attitudes can vary between and among different communities, including racial and ethnic minority communities. Vaccine concerns reported by CHWs in this snapshot data indicated diversity both within and among racial and ethnic minority groups. In particular, CHWs serving Black/African American communities reported unwillingness toward COVID-19 vaccination, which is comparable to the national narratives and historical research on vaccine hesitancy. In the February 16 survey, a CHW serving Black/African American communities wrote that past targeting and experimentation on Black/African American communities continues to be a prevalent concern with the COVID-19 vaccine.

The variability suggests targeted approaches are needed rather than a singular approach for all racial and ethnic minority communities. Approaches developed and adapted for many different racial and ethnic minority groups may more effectively respond to unique vaccine concerns of these communities.



Overall, this snapshot data suggests a multifaceted approach that accounts for both vaccine hesitancy and access barriers is crucial in effectively addressing disparities in vaccination rates. Vaccine distribution approaches must be inclusive and responsive to variation over time, as the vaccine hesitant population shifts to become a larger share of the remaining unvaccinated population. In addition, targeted approaches should acknowledge the diversity of vaccine attitudes within and among racial and ethnic minority communities. Strategies should be responsive to any variation to those who are vaccine hesitant and remain unvaccinated. Local data is necessary to inform strategic approaches that effectively reach vulnerable communities and promote timely vaccine uptake.

## Additional Local Data

Snapshot data collected in a Utah Public Health Association (UPHA) CHW section training on February 9, 2021 showed the majority (80%) of CHWs (28/35) responded their communities were interested in getting the COVID-19 vaccine. However, 28.5% (10/35) responded their community members did not trust the vaccine.<sup>10</sup> The most prevalent issues identified by CHWs that would prevent communities from getting the vaccine included a fear of side effects (86.1%), a lack of trust in the vaccine (75%), and lack of information (63.9%). UPHA data findings were similar to snapshot data findings in that the majority of CHWs reported their communities were interested in the COVID-19 vaccine before all groups became eligible. It is important to acknowledge that many of the CHWs involved in data collection with UPHA were involved with the COVID Community Partnership (CCP) project.

Regarding overall Utah vaccine attitudes, Envision Utah and Intermountain Healthcare conducted an online survey with 604 individuals older than age 18 across the state to better understand how Utahns felt about the COVID-19 vaccine and possible barriers preventing access between January 20 and February 21, 2021.<sup>11</sup>

Among their published results, 55% of respondents said they were likely to get the vaccine, with Hispanic respondents mirroring these results with 56% as likely. Noteworthy findings showed those who lived in rural areas, had lower education, identified as Hispanic, or were divorced/separated/widowed were more likely to receive the vaccine after exposure to COVID-19 vaccine messaging. This further supported the importance of strategic messaging and education.

Comparison of additional data to this snapshot data showed Utah's racial and ethnic minority communities were no more hesitant than Utah overall, but disparities in vaccination rates with lower uptake among vulnerable populations point to barriers in access that need to be addressed.



10. UPHA Community Health Worker Section. (29 February 2021). *Vaccine Training Part 2 Survey Results*.

11. Envision Utah. (February 2021). *COVID-19 Vaccine Message Testing Online Survey Results*. Envision Utah.

# **LIMITATIONS**

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There were several limitations noted in gathering this snapshot data. Surveys were conducted in weekly staff meetings where CHW attendance varied each week, resulting in a variation of CHW responses to each survey. Although CHW respondents were representative of the demographic distribution of Utah's racial and ethnic minority communities, more representation for Hispanic/Latino communities and less representation for American Indian/Alaska Native and Black/African American communities existed. Participating CHWs represented both community-based organizations serving target communities, as well as local health departments (LHDs) across Utah. Because CHWs came from LHD settings, it was more difficult to distinguish representation, as they serve their geographic jurisdiction instead of specific racial and ethnic minority communities. In addition, CHW responses were self-reported in representing their community, which may be inaccurate, biased, or limited.

Grouping community attitudes based on CHW responses may lead to generalizations and doesn't account for variation and diversity among groups. It is also important to note changes in the context of the vaccine distribution and rollout processes over time, which included eligibility requirements, limited supply and allocation of vaccines, infrastructure, etc., which might introduce data limitations.

# **RECOMMENDATIONS**

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Interpreted and explained findings in this snapshot data can inform recommendations and actions moving forward. First and foremost, this data highlights the importance of avoiding assumptions of vaccine hesitancy. Equitable vaccine distribution should consider both barriers to access and vaccine attitudes, while being responsive to how the context of vaccine distribution and processes may change over time.

In collaboration with community partners, the Utah Department of Health (UDOH) created the Striving Toward Equity, Utah's COVID-19 Vaccine Distribution Roadmap. Referred to here as the Vaccine Equity Roadmap, it outlines strategies to ensure vaccine equity. These five strategies and how they apply to vaccination barriers identified by CHWs are outlined below.

## **1) Identify priority and higher-risk populations**

Priority and higher-risk populations should be identified to ensure vaccine distribution and needed resources are allocated to those most impacted by COVID-19 with the greatest need. These higher-risk communities, such as the ones served by CCP CHWs, are more likely to experience vaccination barriers.

## **2) Develop messaging that works for all Utahns**

Developing messaging that works for all Utahns is important in disseminating accurate information regarding COVID-19 vaccination. Culturally relevant messaging that reaches all racial and ethnic minority communities in Utah can help address vaccine misinformation CHWs identified as a barrier.

## **3) Reduce barriers at vaccination clinics**

Reducing barriers at vaccination clinics helps ensure clinics are accessible to all, as communities with the greatest need often also face the most barriers. CHWs identified barriers at vaccination clinics for communities, including difficulty with the registration process, lack of access to technology, and fear of citizenship requests.

## **4) Create vaccination sites at locations within the community and routes for mobile vaccination units**

Creating vaccination sites in communities and utilizing mobile vaccination units are two strategies that can increase accessibility for vulnerable and underserved communities, addressing a key access barrier of location of vaccine sites.

## **5) Make vaccination data available to the public**

Making vaccination data available to the public is important to continue to monitor and further understand health disparities among vulnerable groups, including racial and ethnic minority communities. This strategy is also important to create transparency in the vaccine distribution process, and in turn helps build trust among racial and ethnic minority communities.

# CONCLUSION

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In summation, to develop an effective approach to reach racial and ethnic minority communities in Utah, national narratives should not be assumed. Gathering data reflective of Utah's unique communities demonstrates important considerations and barriers regarding lack of vaccine access among racial and ethnic minority communities. The [Vaccine Equity Roadmap](#) highlights important strategies to address barriers to vaccination.

Gathering additional data to further explore variability of vaccine attitudes and barriers within communities may continue to inform equitable vaccine distribution. It is also important to take a closer look at specific factors within communities impacting vaccine hesitancy and uptake, such as cultural and linguistic barriers. Data can further contribute to informed strategies outlined in the Vaccine Equity Roadmap.



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## **Primary Authors**

Allison Cowdell, MSW, MPH, CPH (UDOH Office of Health Disparities)  
Jill Christian, MPH, CHES (UDOH Office of Health Disparities)  
Brittney Okada, MPH, CHES (UDOH Office of Health Disparities)

## **Contributors**

Dulce Díez, MPH, MCHES (UDOH Office of Health Disparities)  
Christine Espinel (UDOH Office of Health Disparities)  
Wenwen Tian, MPH (UDOH Office of Health Disparities)  
Ban Naes (UDOH Office of Health Disparities)  
Matt Huntington, MPH (UDOH Office of Health Disparities)  
Tessa Acker, MPH, RD (UDOH Office of Health Disparities)  
Kevin Nguyen, MPH, CPH (UDOH Office of Health Disparities)  
Charla Haley (UDOH Office of Public Information and Marketing)

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Utah Department of Health  
Office of Health Disparities  
disparities@utah.gov  
[www.health.utah.gov/disparities](http://www.health.utah.gov/disparities)

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