Utah Department of
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Health Equity

COVID-19 health disparities in Utah 2020–2021

Refugee profile

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List of abbreviations

CDC	Centers for Disease Control and Prevention
COVID-19	Coronavirus disease 2019
DHHS	Utah Department of Health and Human Services
OHE	Office of Health Equity
SARS-CoV-2	Severe acute respiratory syndrome coronavirus 2

Background

Brief overview of refugee resettlement

Refugees are people who are forced to flee their country due to conflict and/or persecution for reasons of race, religion, nationality, membership of a particular social group, or political opinion. Being a refugee is never a choice and often the last means to escape to safety.[1]

Today, there are an estimated 27.1 million refugees worldwide, around half of whom are younger than age 18.[2] The vast majority live in refugee camps or cities often in a neighboring country from where they fled. Fewer than 1% of the worldwide refugee population is offered resettlement[2] to a third country, like the United States. The U.S. is one of more than 30 countries offering third country resettlement to refugees throughout the world.

Since 1975, the U.S. has resettled more than three million refugees from many different countries.[3] Over the last five years, Utah has welcomed an average of 700 refugees into the state each year, with the majority arriving in 2021 due to the emergency evacuation and resettlement of Afghans.[4] Under the current administration, it is anticipated that refugee arrivals in the U.S. will increase in the coming years and Utah will return to welcoming refugees similar to the years before 2017.

Refugee health services in Utah

All refugee arrivals into Utah are supported by one of three refugee resettlement agencies: International Rescue Committee, Catholic Community Services, and Asian Association of Utah. They are the main support system for refugees in their first few months in Utah. Resettlement agencies ensure all refugees have safe and adequate housing, find a job, enroll kids in school, and gain access to health services, among many other services.[5]

The Utah Department of Health and Human Services (DHHS) Utah Refugee Health/TB Control Program seeks to protect and improve the overall health of Utah's most vulnerable populations through improved access to culturally informed quality services. Those services prevent and treat communicable diseases which result in decreased health disparities and increased health equity.[6] This program is also responsible to provide refugee domestic health screenings in the state and contracts with the resettlement agencies and a number of vetted screening clinics to ensure all arrivals have equitable access to a culturally sensitive health screening.

The DHHS Refugee Health/TB Control Program has seven priority areas: 1) health screening; 2) care coordination; 3) mental health; 4) TB control; 5) health promotion; 6) emerging infections control; and 7) emergency preparedness. Populations eligible for health services include: 1) refugees; 2) Afghan parolees;

3) asylees; 4) Cuban and Haitian entrants; 5) certain Amerasians from Vietnam who are admitted to the United States as immigrants; 6) certain Amerasians from Vietnam, including United States citizens; 7) victims of a severe form of human trafficking; and 8) persons with Special Immigrant Visas (SIV).[7]

For convenience, the term "refugee" will be used throughout the rest of the report to encompass all eligible persons. The data reported includes all eligible populations.

COVID-19 and refugee populations

Worldwide, refugees experienced a disproportionate burden of poor health outcomes like increased risk of transmission and mortality due to COVID-19.[8,9] The pandemic exacerbated previously existing structural inequalities, which placed these groups at risk in getting access to COVID-19 vaccination, testing, and treatment.[10] As a result, there is a strong need to ensure refugee populations are better considered in public health responses.

Many factors contribute to refugee populations facing higher risks of COVID-19 and related health disparities. Limited financial and healthcare assistance and lower rates of enrollment in health insurance programs create barriers to healthcare system engagement.[11] Other factors include lack of understanding of the U.S. healthcare system, lack of early access to testing, limited means of transportation, and varying cultural beliefs and practices. Furthermore, the diversity in primary languages spoken among refugee populations impacted the effectiveness of several public health and vaccination campaigns.[11,12]

Considering these factors, it is important to identify and report COVID-19 health disparities in refugee populations. This can inform COVID-19 response efforts to reduce exposure, impact, and mortality rates; which in turn leads to improved health outcomes and quality of life among refugee populations.

Guide to this profile

At the onset of the COVID-19 pandemic, the Utah Department of Health and Human Services (DHHS) Refugee Health/TB Control Program mobilized and adapted its efforts to support Utah's refugee populations affected by COVID-19. In March 2020, the Refugee Health/TB Control Program, local resettlement agencies, and wraparound service providers began collaborations to support refugees to quarantine/isolate with COVID-19. The Refugee Health/TB Control Program worked in partnership with DHHS contact tracers to identify refugees in need of assistance. The Refugee Health/TB Control Program then coordinated with community health workers at resettlement agencies and refugee-serving organizations to provide resources, education, and support to individuals and families with COVID-19. Other activities included community health worker education and mobilization, mobile testing/vaccination sites within refugee neighborhoods, development and distribution of multilingual resource guides, and development of COVID-19 data tracking and analysis of positivity rates and vaccination rates within Utah's refugee communities.

The DHHS Office of Refugee Health/TB Control Program in collaboration with the DHHS Office of Health Equity (OHE) worked on this report. Data and visualizations in this report provide an opportunity to understand the scenario of COVID-19 among refugee populations in Utah.

The population data used to calculate vaccination rates has limitations. The DHHS Refugee Health/TB Control Program only tracks the initial screening data of refugee populations. There are no mechanisms in place to track all migrations or mortality rates that are inevitable within the community. Due to this, we can only produced a limited picture of the COVID-19 burden among refugee populations. The data reported in this profile includes all COVID-19 positive cases entered into the system by December 31, 2021.

How was COVID-19 data identified among refugee populations?

COVID-19 data on refugee populations is based on data merged from Utah's disease tracking system (EpiTrax) and its refugee arrival database (RHOS) by comparing the names and dates of birth between the two systems. Occasionally, there are issues with the data match when the names do not match exactly. For example, the spelling or order of the names may be different in the two databases or the last name has changed. As a result, it is likely the numbers reported in this report are underestimated.

What COVID-19 indicators are analyzed in this report?

- **COVID-19 cases**: A confirmed coronavirus disease 2019 (COVID-19) case is any person with a positive SARS–CoV2 PCR or antigen test. The DHHS assigns case status following the Centers for Disease Control and Prevention (CDC) national case definition, with an exception of considering positive antigen tests as confirmed rather than probable cases.[13]

- **COVID-19 hospitalizations:** COVID-19 hospitalizations represent the total number of COVID-19 cases who are admitted to hospitals. Hospitalization counts are either reported automatically if a person is an inpatient at the time of a positive lab or identified through local public health investigations.[13]

- **COVID-19 deaths:** Death due to COVID-19 is confirmed only if COVID-19 is a cause of death or underlying cause of death and is confirmed by the DHHS Office of the Medical Examiner. DHHS uses the "CDC Guidance for Certifying Deaths due to Coronavirus Disease 2019 (COVID-19)" to determine which deaths are due to COVID-19.[13]

COVID-19 cases

By December 2021, 2,146 COVID-19 cases were recorded within refugee populations in Utah. The majority (52.8%) of cases were reported among males. (Table 1).

Table 1: COVID-19 cases by sex among refugee populations, Utah, 2020–2021

Total cases	Male	Female
2,146	1,134 (52.8%)	1,012 (47.2%)
Data source: DHHS COVID-19 refugee surveillance data		

Figure 1 shows monthly COVID-19 cases within refugee populations from March 1, 2020, to December 31, 2021. The monthly case counts were higher in the first half of the pandemic when compared to the second half.

Figure 1: Monthly COVID-19 cases within refugee communities, Utah, 2020–2021

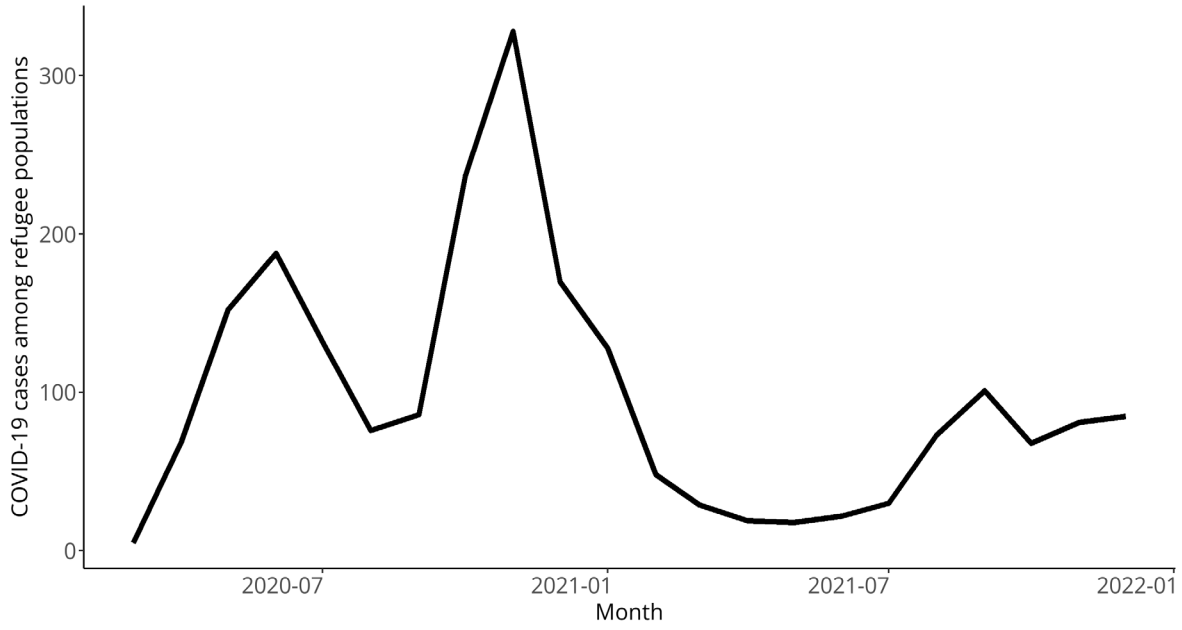
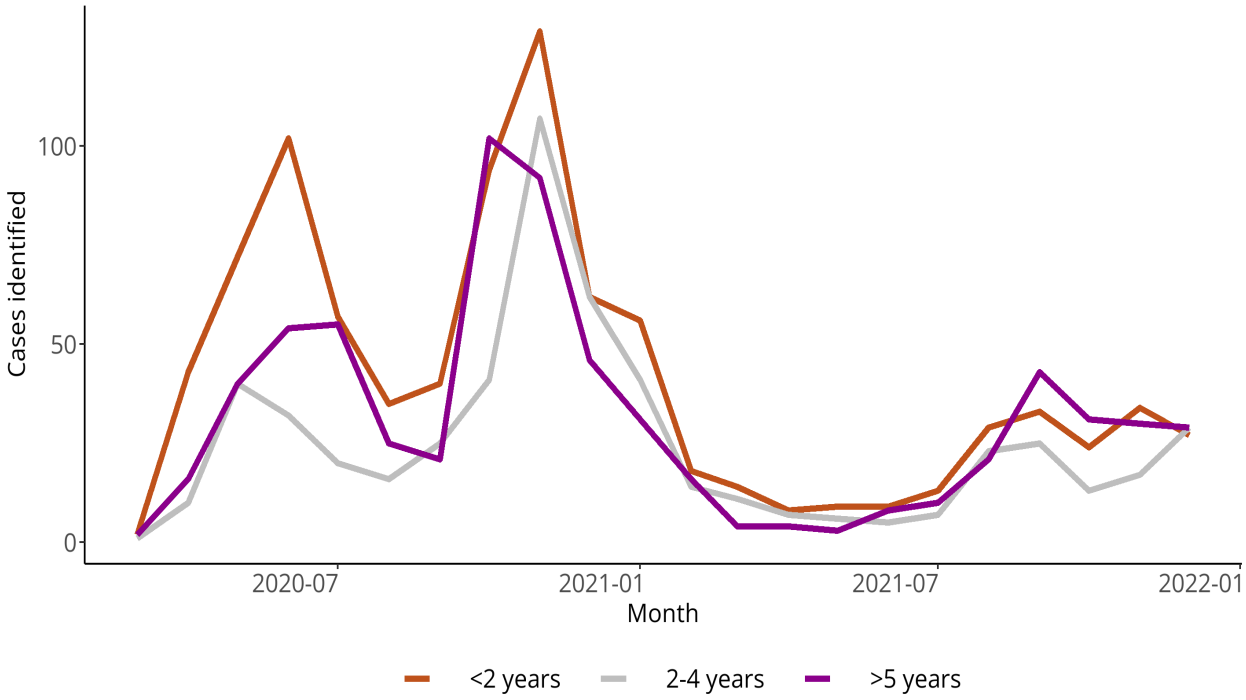


Figure 2 shows monthly COVID-19 cases identified within refugee communities in Utah by length of stay in the U.S. Among refugee populations with less than two years of length of stay in the U.S., a spike in COVID-19 cases was observed during summer and winter 2020. Case counts among refugee populations with length of stay between two and four years also spiked during winter 2020.

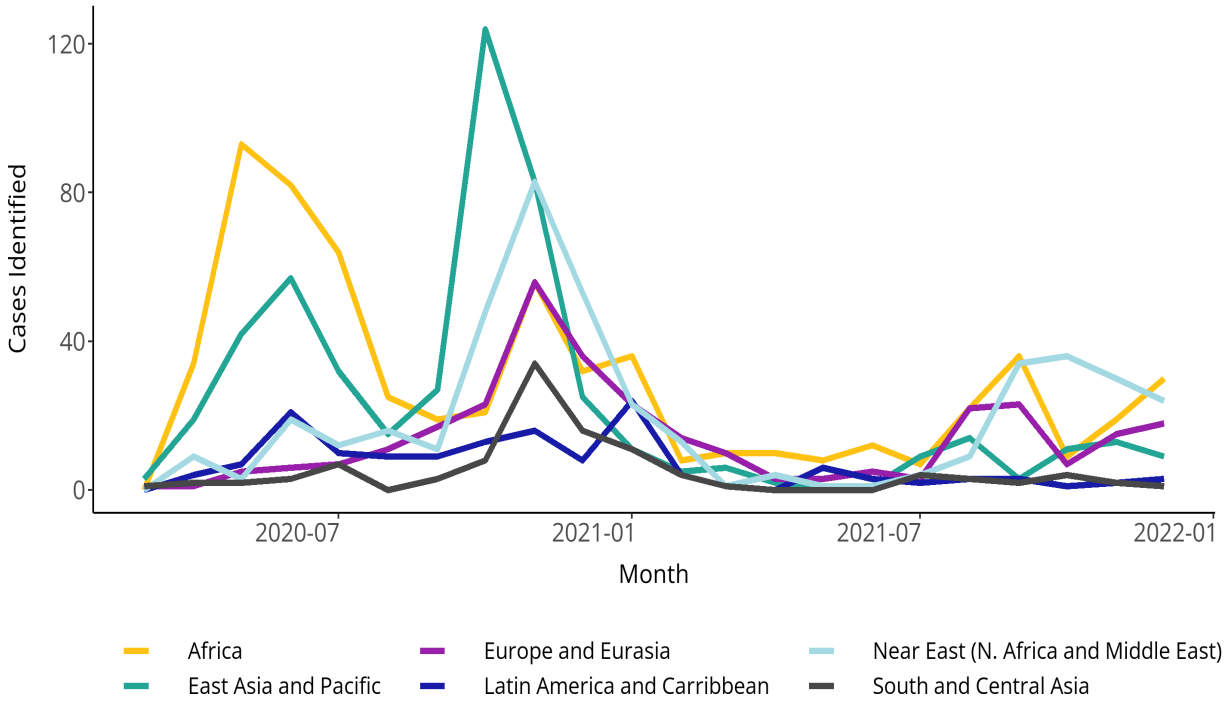
Figure 2: Monthly COVID-19 cases identified within refugee communities by length of time in the U.S., Utah, 2020–2021



Data source: DHHS COVID-19 refugee surveillance data

Figure 3 shows monthly COVID-19 cases identified within refugee communities in Utah by region. In the first half of 2020, a spike in COVID-19 cases was observed among refugee populations from the Africa region. In the second half of 2020, a spike in COVID-19 cases was observed among refugee populations from East Asia and Pacific regions. In 2021, similar trends in monthly COVID-19 cases were seen among refugee populations from all regions.

Figure 3: Monthly COVID-19 cases identified within refugee communities by region, Utah, 2020–2021



Data source: DHHS COVID-19 refugee surveillance data

Note: The DHHS Office of Refugee Health/TB Control program classified countries into six regions; namely Africa, East Asia and Pacific, Europe and Eurasia, Latin America and Caribbean, Near East (N. Africa and Middle East), and South and Central Asia. Please refer to Table 7 in the appendix for the classification.

COVID-19 hospitalizations and deaths

By December 2021, 111 hospitalizations due to COVID-19 were recorded in refugee communities in Utah. Among those who were hospitalized, 27 were admitted in the ICU. Ten deaths as a result of COVID-19 were reported in refugee populations.

Table 2: COVID-19 hospitalizations, ICU admissions, and deaths among refugee populations, Utah, 2020–2021

Hospitalizations	ICU admisions	Deaths
111	27	10
Data source: DHHS COVID-19 refugee surveillance data		

Table 3 shows the number and percentage of COVID-19 hospitalizations among COVID-19 cases by age group. Although the number of COVID-19 cases was higher in the age group 0–44, the percentage of COVID-19 cases hospitalized was higher among refugee populations in the age group ≥ 65.

Table 3: COVID-19 hospitalizations by case counts and age group among refugee populations, Utah, 2020–2021

Age group	Number of COVID-19 cases	Number of COVID-19 hospitalizations	% of COVID-19 cases hospitalized
0–44	1,542	42	3%
45–64	500	45	9%
≥ 65	104	24	23%
Total	**2,146**	**111**	**5%**
Data source: DHHS COVID-19 refugee surveillance data			

Table 4 shows the number of COVID-19 ICU admissions and deaths due to COVID-19 among refugee populations by age group. Among the 111 refugees who were hospitalized due to COVID-19, 27 were admitted to the ICU. Ten deaths as a result of COVID-19 were reported in refugee communities in Utah.

Table 4: COVID-19 ICU admissions and deaths by hospitalizations and age group among refugee populations, Utah, 2020–2021

Age group	Number of COVID-19 hospitalizations	Number of COVID-19 ICU admissions	Number of COVID-19 deaths	% of COVID-19 deaths among ICU admissions
0–44	42	7	0	0%
45–64	45	13	4	31%
≥ 65	24	7	6	86%
Total	**111**	**27**	**10**	**37%**
Data source: DHHS COVID-19 refugee surveillance data				

Note: The percentage of ICU admissions that result in death give us an idea of the difference in risk for these different age groups, however they are based on very small numbers so should only be considered a general estimate of the true risk in this population.

COVID-19 vaccinations

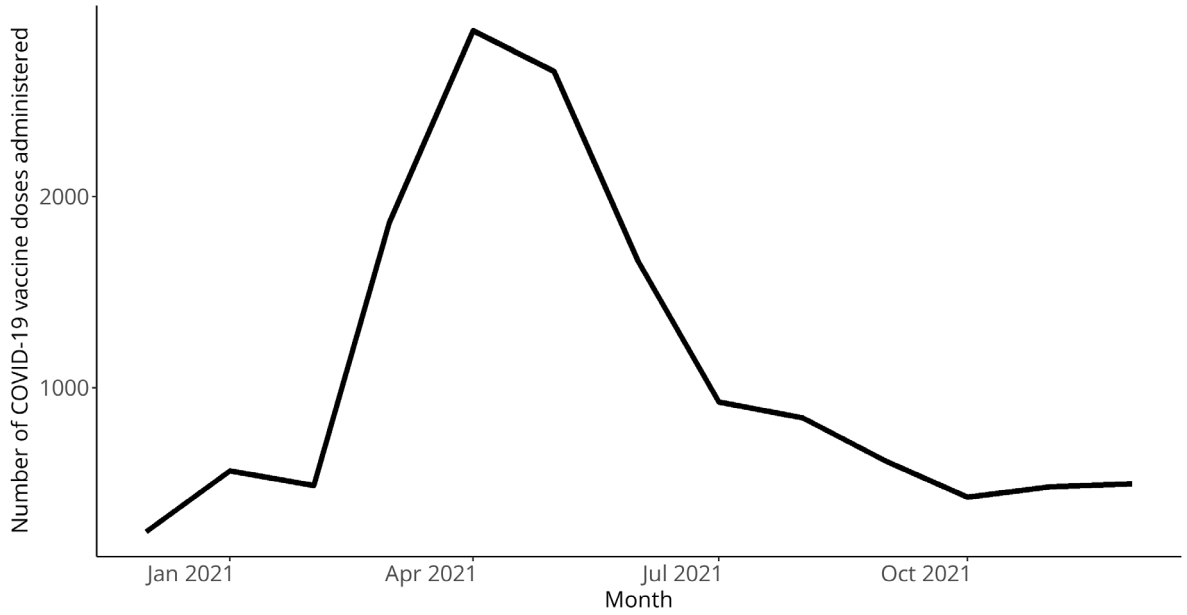
As of December 2021, 14,135 COVID-19 vaccine doses were administered among refugee communities in Utah. Pfizer–BioNTech made up about three-fourths (73%) of the total vaccine doses (Table 5).

Table 5: COVID-19 vaccination doses by manufacturer among refugee populations, Utah, 2020–2021

Total number of COVID-19 doses administered	% of doses by manufacturer		
	Pfizer-BioNTech	Moderna	Johnson & Johnson
14,135	73%	24%	3%
Data source: DHHS COVID-19 refugee surveillance data			

Figure 4 shows monthly COVID-19 doses administered within refugee communities in Utah. The highest number of doses were administered during April followed by May 2021.

Figure 4: Monthly COVID-19 vaccine doses administered within refugee communities, Utah, 2020–2021



Data source: DHHS COVID-19 refugee surveillance data

Table 6 shows the percentage of COVID-19 doses administered within refugee communities in Utah by region. Refugee populations from Africa (32%) had the highest percentage of vaccinations received followed by refugee populations from Near East and South and Central Asia (17%). This was to be expected because around 38% of the refugee population in Utah is from the Africa region and 20% from South and Central Asia region.

Table 6: COVID-19 vaccination by region within refugee communities, Utah, 2020–2021

Region	% of COVID-19 doses administered
Africa	32%
East Asia and Pacific	15%
Europe and Eurasia	14%
Latin America and Caribbean	5%
Near East (N. Africa Middle East)	17%
South & Central Asia	17%
Data source: DHHS COVID-19 refugee surveillance data	

Data notes and limitations

- COVID-19 data on refugee population is based on data merged from Utah's disease tracking system (EpiTrax) and its refugee arrival database (RHOS) by using an R code to compare the names and dates of birth between the two systems. Occasionally, there are issues with the data match when the names do not match exactly; for example, the spelling or order of the names may be different in the two databases or the last name has changed. As a result, it is likely the numbers reported in this report are underestimated.

- The Utah population data on refugee communities also has limitations. The DHHS Refugee Health/TB Control program only tracks the initial screening data of refugee populations. There are no mechanisms in place to track all the migrations or mortality rates inevitable within the community.

- The actual COVID-19 case numbers in Utah are expected to be higher than what is reported. This is due to mild cases not feeling ill enough to get tested and seek care, more people receiving at-home tests which are not reported to DHHS, and limited testing availability particularly during surges. Because of these limitations, it is important to consider other measures along with the case counts for COVID-19 transmission and severity.[13]

- An ICU admission requires the investigator to identify that a COVID-19 case was admitted to the ICU. However, a hospitalization record can populate if the hospital sends over an electronic case report (eCR) without the investigator review.[13]

- Hospitalizations and death counts show the most severe outcomes due to COVID-19. Both outcomes often occur after a person is first diagnosed with COVID-19, so the counts for these indicators lag by days to weeks after case counts.[13]

Recommendations

A primary principle of health equity is to focus resources on the needs of communities most at risk for health disparities while striving for the highest standard of health for all communities. As evidenced by the data in this profile, refugee populations were negatively impacted by the COVID-19 pandemic, which exacerbated already existing health disparities. Additional actions are needed to address disparities experienced by refugee communities to prepare for a more equitable response to future public health crises.

The COVID–19 health disparities in Utah 2020–2021 report outlines recommendations organizations can pursue to advance health equity. These recommendations are based on a health equity mindset and four strategic practices: build internal infrastructure, work across agencies, foster community partnerships, and expand the narrative of what creates health. Below are specific actions to address health disparities among refugee communities.

Ensure public health communications and updates are accessible to refugee communities.

- Address the cultural and linguistic barriers that exist in accessing traditional avenues of communication. Information provided only in English or translated written materials may not be accessible to those with low literacy levels. Examples of alternative communication methods to written/web-based information include small group education, message apps (e.g., WhatsApp) or text messages, and videos. Consult with resettlement agencies and other refugee-serving organizations about translation and communication needs in local refugee communities.

- Establish DHHS as a reliable source of information in refugee communities by providing accessible and culturally appropriate messaging. It is important refugee communities are able to stay up-to-date on public health guidance in order to make decisions, address misinformation, and engage in health promotion and disease prevention behaviors.

Increase cultural responsiveness of healthcare practitioners to better serve refugee communities.

- Support clinicians to provide culturally and linguistically appropriate care. This support can include training, culturally and linguistically appropriate materials, and connections to refugee-serving organizations. A diverse, inclusive, and culturally responsive healthcare workforce can foster greater trust among refugee patients and increase long-term utilization of healthcare services. Long-term utilization of the healthcare system can improve health outcomes and reduce health disparities in refugee populations.

[1] In this report, the term "refugee populations" is not limited to refugees but also includes Afghan parolees, asylees, Cuban and Haitian entrants, certain Amerasians from Vietnam who are admitted to the United States as immigrants, certain Amerasians from Vietnam, including United States citizens, victims of a severe form of human trafficking, and persons with Special Immigrant Visas (SIV).

- These efforts must be combined with other methods to promote continued access to healthcare for those who arrived in Utah as refugees, including options for affordable healthcare and insurance after coverage ends.

Improve accessibility of public health services for refugee communities

- Ensure public health and other services are available via walking or public transportation. For example, clinics that support walk-up services can improve access for those who do not or can not use cars.

- If services are unable to be provided in convenient and easily accessible locations for refugee communities (i.e., near resettlement agency buildings), resources should be provided to increase accessibility. An example of this is health screening that can be administered at home.

Support the utilization of social services and resources that address the social determinants of health.

- Build resources with direct aid and quick turnaround time to support the financial health of refugee communities. For example, resources that provide assistance to pay for housing costs or food can be used by refugee populations to meet basic needs in the case of illness, inability to work, or other circumstances that impact financial stability.

- Minimize paperwork and eligibility requirements for services. Low English literacy, lack of access to technology, and other barriers refugee communities may face can prevent utilization of resources. A reduction in requirements can make programs more accessible and provide more timely aid to those who are in need.

Mobilize resettlement agencies, refugee-serving community based organizations (CBOs), and community health workers (CHWs) to serve refugee populations during public health crises and beyond.

- Build strong collaborative infrastructure between DHHS and resettlement agencies/refugee-serving CBOs. These organizations have an understanding and the trust of refugee communities. Their valuable access to refugee populations should be leveraged to provide valuable education about public health measures, how to stay healthy, and how to access services.

- Fund and build capacity of this sector to better serve refugee communities during a public health crisis or otherwise. Provide resettlement agencies and CBOs with the means to administer services in-house (e.g., health screenings or other medical services). Additionally, support the employment of CHWs who provide education, outreach, and connection to resources for refugee communities.

These recommendations are not comprehensive but are a starting place from which organizations can begin to advance toward health equity. Organizations can use these recommendations as a foundation to further build their abilities to serve refugee populations and achieve health equity.

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Appendix

Table 7: DHHS Office of Refugee Health/TB Control program classification for countries

Region	Countries
South and Central Asia	Bangladesh, India, Kazakhstan, Kyrgyzstan, Bhutan, Afghanistan, Nepal, Uzbekistan, Sri Lanka, Tajikistan, Turkmenistan, Pakistan
Africa	Niger, Mali, Congo Republic, Algeria, Egypt, Liberia, So Sudan, Somalia, Kenya, Ivory Coast, Zimbabwe, Guinea, Zambia, South Africa, Malawi, Sudan, Rwanda, Togo, Uganda, Nigeria, Namibia, The Gambia, Mozambique, Swaziland, Ghana, Tanzania, Zaire, Gabon, Cameroon, Central African Republic, Burundi, Botswana, Angola, Chad, Eritrea, Ethiopia, Djibouti, Dem Republic of the Congo, Senegal, Sierra Leone, other
East Asia and Pacific	Chin, Burma, Karen, Rohingya, Kachin, China, Papua New Guinea, Hong Kong, North Korea, Indonesia, Philippines, Mon, Karenni, Myanmar, Arkanese, Shan, South Korea, Vietnam, Tibet, Thailand, Malaysia, Laos, Cambodia
Europe and Eurasia	Georgia, Germany, Denmark, Bosnia, Belarus, Belgium, Italy, Kosovo, Romania, Russia, Moldova, Meskhetian Turk, Malta, Azerbaijan, Austria, Armenia, Serbia, Slovakia, United Kingdom, France, Yugoslavia, Ukraine, Turkey, Spain
Near East (N. Africa Middle East)	Arab, Armenia, Lebanon, United Arab Emirates, Cyprus, Iran, Libya, Kuwait, Tunisia, Kurdish, Yemen, Egypt, Jordan, Qatar, Bahrain, Morocco, Oman, Syria, Suni, Saudi Arabia, Palestine, Israel, Iraq
Latin America and the Caribbean	Peru, Paraguay, Mexico, Haiti, Honduras, Venezuela, Costa Rica, Guatemala, El Salvador, Argentina, Cuba, Ecuador, Colombia, Chile, Brazil