



COVID-19 Vaccine Attitudes among Adults in Immigrant Families in California

Insights and Opportunities to Promote Equitable Access

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As of March 31, 2021, about 12 million Californians, more than one-quarter of the state's population, had been fully or partially vaccinated against COVID-19.¹ However, in early March, California ranked among the states with the greatest inequities in vaccination coverage in underserved counties (Hughes et al. 2021). To promote equitable vaccine access, state officials announced on March 4 that they would begin allocating 40 percent of vaccines to communities considered vulnerable based on their socioeconomic characteristics.² Many residents of these areas are people of color and immigrants, whose labor has been vital to keeping the state and its economy running during the pandemic (Dubay et al. 2020; Gelatt 2020).³ In addition to being overrepresented in essential jobs, immigrants have faced other structural risk factors during the pandemic, including higher uninsurance rates, residence in multigenerational housing and dense urban areas, reliance on public transportation, and lower incomes (Artiga and Rae 2020; Clark et al. 2020).

Immigrants represent about a quarter of California residents, and about half of adults in the state live in households with at least one immigrant family member (Johnson, Perez, and Mejia 2021).⁴ Yet, little is known about vaccine attitudes and access among adults in immigrant families, both in California and nationally. Understanding perceptions of the virus and vaccines among immigrant families, the sources of information they trust, and their connections to the health care system can help state policymakers shape communication and distribution strategies to achieve equitable vaccine access for California's immigrant communities.

Building on previous work on vaccine attitudes among nonelderly adults nationally (Karpman et al. 2021), this brief focuses on attitudes toward the novel coronavirus and COVID-19 vaccines among California adults ages 18 to 64 as of December 2020, before most vaccine distribution began.⁵ We also examine California adults' trust in various local sources for information about the vaccines and their types of health insurance coverage and usual sources of health care. We focus on differences between adults in immigrant families, defined as those born outside the US (foreign born) or living with a foreign-born family member, and adults not living in immigrant families (who we refer to as "other adults" throughout this brief). To do so, we use data from the Urban Institute's Well-Being and Basic Needs Survey (WBNS). Our estimates only include adults who speak English or Spanish (the languages in which the survey was administered) and do not fully capture the diversity of attitudes and experiences across the state's immigrant populations. Additionally, attitudes have evolved since the WBNS was fielded in December 2020, as vaccinations have accelerated in recent months.⁶ We find the following:

- Adults in immigrant families in California were more likely than other adults in the state to be worried they or someone in their household would be exposed to the coronavirus (79 percent versus 67 percent).
- Adults in immigrant families were more likely than other adults in California to report they would definitely or probably get a COVID-19 vaccine (75 percent versus 68 percent).
- Most adults in California trusted their health care providers (74 percent) and state or local public health officials (63 percent) for information about COVID-19 vaccines. Adults in immigrant families were more likely than other adults to trust state or local public health officials (68 percent versus 59 percent), elected officials in the community (40 percent versus 30 percent), and religious leaders (28 percent versus 16 percent) for this information.
- Adults in immigrant families were more than twice as likely as other adults in California to be uninsured (16 percent versus 7 percent) and to use clinics and health centers as their usual sources of health care (35 percent versus 16 percent).

Immigrants' higher uninsurance rates and the ways they connect to the health care system highlight the importance of targeted strategies for vaccine outreach and access, including through community health centers, which more than one-third of adults in immigrant families in California use as a usual source of care.

Results

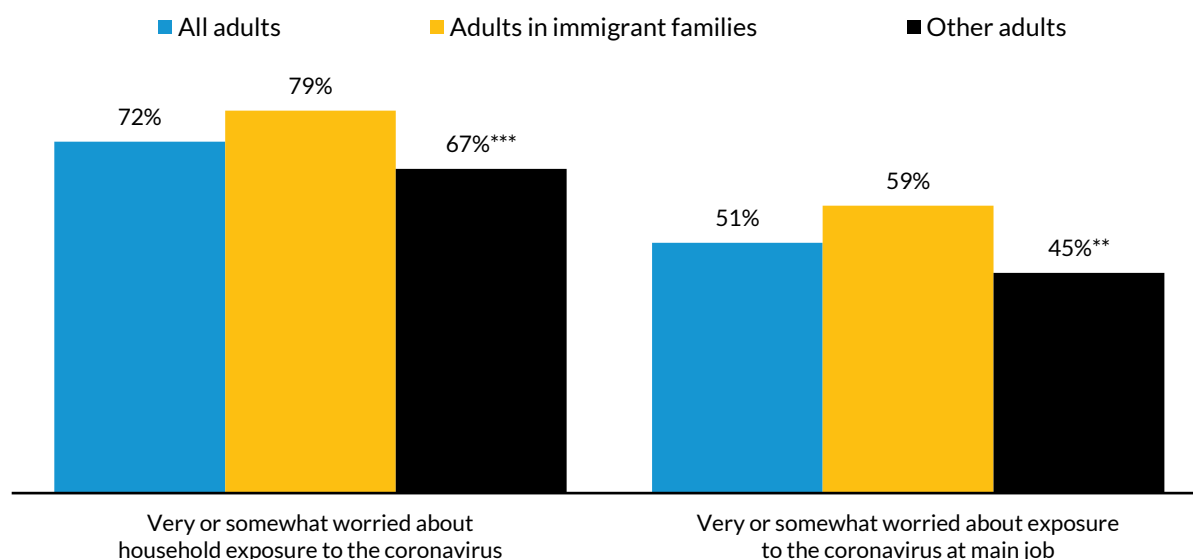
Adults in immigrant families in California were more likely than other adults in the state to be worried about exposure to the coronavirus.

In December 2020, nearly three in four nonelderly adults in California (72 percent) reported being very or somewhat worried they or someone in their household would be exposed to the coronavirus (figure 1). About half of all working adults in California reported they were very or somewhat worried about exposure to the virus at their main job (51 percent).

Compared with other adults in California, adults in immigrant families were more likely to report being worried about household exposure to the virus (79 percent versus 67 percent). Employed adults in immigrant families in California were more likely than other employed adults in California to worry about exposure at their main job (59 percent versus 45 percent).

FIGURE 1

Share of Adults Ages 18 to 64 in California Very or Somewhat Worried about Exposure to the Coronavirus, December 2020



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Source: Well-Being and Basic Needs Survey, December 2020.

Notes: "Other adults" are those not in immigrant families. Estimates for worry about exposure to the coronavirus at a main job are for adults who were working at the time of the survey. Estimates exclude adults who do not speak English or Spanish because the survey was only administered in those languages.

*/**/** Estimate differs significantly from that for adults in immigrant families at the 0.10/0.05/0.01 level, using two-tailed tests.

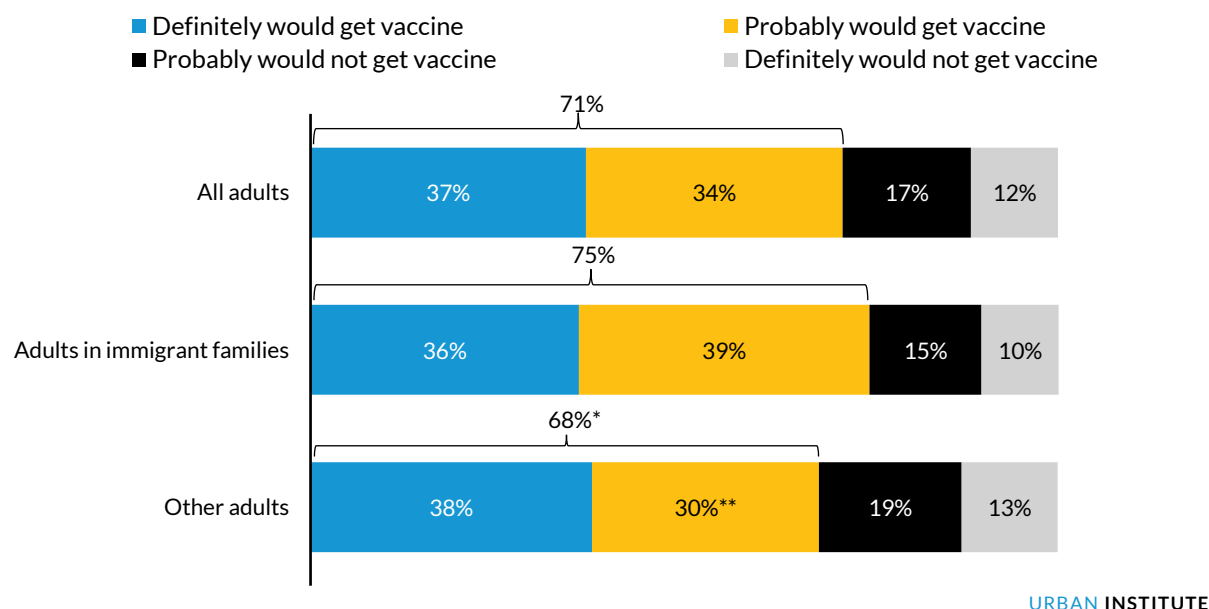
Adults in immigrant families were more likely than other adults in California to report they would definitely or probably get a COVID-19 vaccine.

In December 2020, before most vaccine distribution began, 71 percent of nonelderly adults in California reported they would definitely or probably get a COVID-19 vaccine if it were available for free to anyone who wanted it (figure 2). This is a higher share than that for all nonelderly adults nationally, 65 percent (Karpman et al. 2021). Notably, adults in immigrant families were more likely than other adults in California to report they would definitely or probably get vaccinated (75 percent versus 68 percent). About 36 percent of adults in immigrant families in California reported they would definitely get vaccinated, and an additional 39 percent would probably get vaccinated. By comparison, 38 percent of other adults in California indicated they would definitely get vaccinated, and 30 percent would probably get vaccinated.

Among adults in California who reported in December 2020 that they would definitely or probably *not* get a vaccine, 87 percent reported side effects were an important reason for not getting vaccinated, 85 percent reported wanting to know how well the vaccine works was important, and 63 percent reported not needing the vaccine was important (data not shown). We do not present these estimates by family immigration status because of sample size restrictions.

FIGURE 2

Likelihood of Getting a COVID-19 Vaccine among Adults Ages 18 to 64 in California, December 2020



Source: Well-Being and Basic Needs Survey, December 2020.

Notes: "Other adults" are those not in immigrant families. Estimates are not shown for the 0.3 percent of California adults who did not report whether they would get a COVID-19 vaccine. Estimates exclude adults who do not speak English or Spanish because the survey was only administered in those languages.

*/**/** Estimate differs significantly from that for adults in immigrant families at the 0.10/0.05/0.01 level, using two-tailed tests.

Most adults in California trusted their health care providers and state or local public health officials for information about COVID-19 vaccines. Adults in immigrant families were more likely than other adults to trust state or local public health officials, elected officials in the community, and religious leaders for this information.

Among all nonelderly adults in California, 74 percent reported they would strongly or somewhat trust their usual doctor or health care provider for information about a COVID-19 vaccine. As shown in table 1, this share did not differ significantly between adults in immigrant families and other adults (76 percent versus 73 percent).

Nearly two-thirds of California adults (63 percent) would trust their state or local public health officials for information about the vaccines, and this share was higher among adults in immigrant families than among other adults in the state (68 percent versus 59 percent). Fewer adults in California reported they would trust elected officials in the community (35 percent) or religious leaders in the

community (22 percent) for information about the vaccines. Adults in immigrant families were more likely than other adults to report trusting elected officials (40 percent versus 30 percent) and religious leaders (28 percent versus 16 percent) for this information.

TABLE 1

Trust in Sources for Information about COVID-19 Vaccines among Adults Ages 18 to 64 in California, December 2020

	All adults	By Family Immigration Status	
		Adults in immigrant families	Other adults
Usual doctor or health care provider	74%	76%	73%
State or local public health officials	63%	68%	59%**
Elected officials in the community	35%	40%	30%**
Religious leaders in the community	22%	28%	16%***
Sample size	1,079	550	529

Source: Well-Being and Basic Needs Survey, December 2020.

Notes: "Other adults" are those not in immigrant families. Estimates are for the share of adults who would strongly or somewhat trust each source. Estimates exclude adults who do not speak English or Spanish because the survey was only administered in those languages.

*/**/*** Estimate differs significantly from that for adults in immigrant families at the 0.10/0.05/0.01 level, using two-tailed tests.

Adults in immigrant families were more than twice as likely as other adults in California to be uninsured and to use clinics and health centers as their usual sources of health care.

Most nonelderly adults in California reported having health insurance coverage through an employer (53 percent; table 2). About 1 in 5 (22 percent) reported having Medi-Cal (the state's Medicaid program) or other public coverage, 1 in 7 reported having coverage through a private nongroup plan or an unspecified type of coverage (14 percent), and just over 1 in 10 (11 percent) was uninsured.

But, adults in immigrant families were more than twice as likely as other adults in California to report being uninsured (16 percent versus 7 percent), suggesting they may be more likely to face barriers to health care access.

TABLE 2

Health Insurance Coverage Status and Type among California Adults Ages 18 to 64, December 2020

	All adults	By Family Immigration Status	
		Adults in immigrant families	Other adults
Employer-sponsored insurance	53%	46%	59%***
Medi-Cal or other public coverage	22%	25%	19%
Private nongroup or unspecified coverage	14%	13%	15%
Uninsured	11%	16%	7%***
Sample size	1,079	550	529

Source: Well-Being and Basic Needs Survey, December 2020.

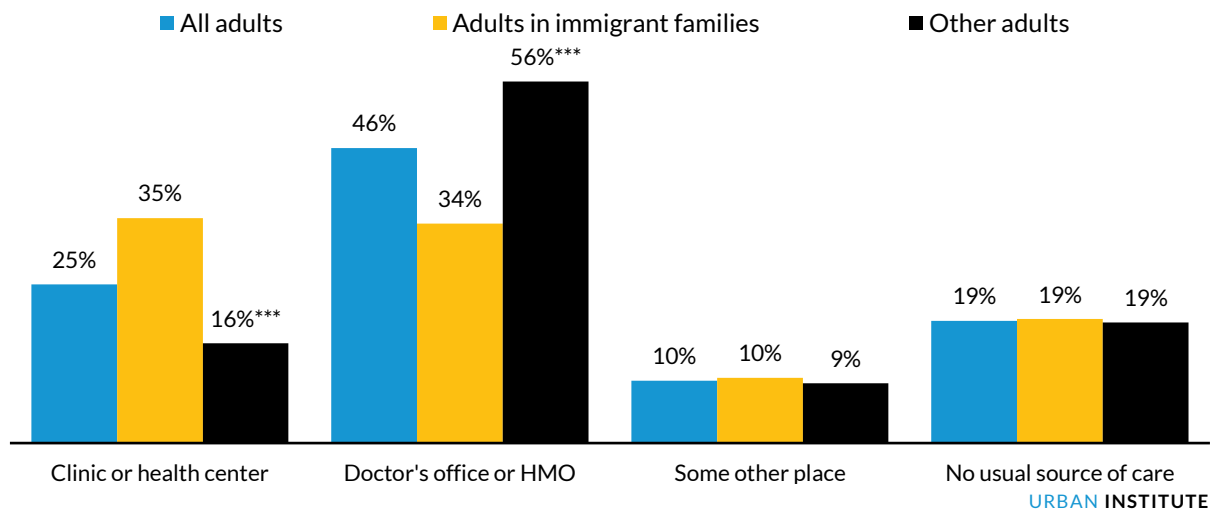
Notes: "Other adults" are those not in immigrant families. Adults who do not speak English or Spanish are excluded from these estimates because the survey was only administered in those languages.

*/**/** Estimate differs significantly from that for adults in immigrant families at the 0.10/0.05/0.01 level, using two-tailed tests.

About 8 in 10 adults in California (81 percent) reported having a usual source of health care (figure 3), a share that did not vary by family immigration status. But adults in immigrant families were more than twice as likely as other adults to report their usual source of care was a clinic or health center (35 percent versus 16 percent) and were less likely to report a doctor's office or health maintenance organization as their usual source of care (34 percent versus 56 percent).⁷

FIGURE 3

Usual Source of Health Care among Adults Ages 18 to 64 in California, December 2020



Source: Well-Being and Basic Needs Survey, December 2020.

Notes: HMO is health maintenance organization. "Other adults" are those not in immigrant families. "Some other place" describes the following usual sources of care: hospital emergency rooms, hospital outpatient departments, urgent care clinics, retail store clinics, and other unspecified places. Estimates are not shown for adults who did not report whether they had a usual source of care or the type of their usual source of care. Estimates exclude adults who do not speak English or Spanish because the survey was only administered in those languages.

*/**/** Estimate differs significantly from that for adults in immigrant families at the 0.10/0.05/0.01 level, using two-tailed tests.

Discussion

Though studies have found large gaps in COVID-19 vaccine hesitancy by race and ethnicity, political party affiliation, and other characteristics (Funk and Tyson 2020; Hamel et al. 2021; Karpman et al. 2021), to our knowledge, no data have been published on attitudes toward the vaccines among adults in immigrant families. Our findings show English- and Spanish-speaking adults in immigrant families in California were more likely than other adults in the state to say they would definitely or probably get a COVID-19 vaccine in December 2020, before most vaccine distribution began, and reported relatively high levels of trust in public health officials and health care providers. Attitudes toward the vaccines among adults in immigrant families may be partially related to their greater concerns about exposure to the coronavirus. Disproportionately higher uninsurance rates and reliance on clinics and health centers as usual sources of care among adults in immigrant families underscore the importance of thoughtful and targeted vaccine outreach and access strategies.

According to the WBNS, about 1 in 6 adults in immigrant families in California was uninsured in December 2020. Research on receipt of the flu vaccine shows uninsurance is associated with lower vaccination rates (McMorrow and Thomas 2021). Hispanic/Latinx adults, who form the plurality of our California sample of adults in immigrant families, face especially high uninsurance rates and are currently underrepresented in the vaccinated population (Tolbert, Orgera, and Damico).⁸ To encourage vaccination, public officials and other stakeholders can emphasize that the vaccines are available at no cost to all, regardless of health insurance coverage and immigration status.

Adults in immigrant families in California were also much more likely than other adults in the state to rely on clinics or health centers as their usual sources of care. As of March 2021, data show most people receiving a first dose of a COVID-19 vaccine at community health centers are Hispanic/Latinx, Black, and other people of color, highlighting these centers' role in reducing inequities in vaccine access for these populations (Corallo, Artiga, and Tolbert 2021). Such facilities are important both as trusted messengers for information and as administrators of the vaccines. The Biden administration's recent effort to send additional vaccines to these facilities acknowledges their role in improving vaccine access, but challenges remain.⁹ Though increasing vaccine supply for these facilities is critical to reducing inequities for communities most affected by the pandemic, many community health centers are still recovering financially from the pandemic. Further, these facilities reported significant shortages of staff who can administer the vaccine as of early March 2021, constraining their abilities to serve their patients.¹⁰ The American Rescue Plan Act aims to combat many of these challenges by providing \$7.6 billion to support vaccine distribution and administration, COVID-19 testing, contact tracing, mitigation, treatment, workforce expansion, and outreach and education efforts through community health centers. In California, 175 health centers will receive awards totaling \$992 million.¹¹ The act also provides substantial additional funding for vaccine distribution, expanding the public health workforce, and increasing the number of community vaccination centers and mobile vaccination units, with a focus on reaching underserved populations.¹²

Improving access to vaccinations for immigrants will also require continued reassurances that getting vaccinated will not jeopardize immigration status. To encourage vaccinations, US Department of Homeland Security officials stated in early February 2021 that the agency will not conduct immigration enforcement at or near vaccination locations, including pop-up, temporary, or mobile sites.¹³ Further, Department of Homeland Security officials continue to emphasize that COVID-19 treatment or services, including vaccines, will not be considered in public charge determinations. The previous administration's expanded public charge rule was associated with chilling effects on immigrants' receipt of public services (Bernstein et al. 2021), and though the rule was recently halted,¹⁴ education efforts and consistent messaging are still needed to reassure families.¹⁵ Continuing to disseminate these messages, both to immigrants and to the health care providers administering vaccines, will be key to reducing confusion about vaccine eligibility and dispelling misinformation about the impact of vaccinations on immigration status.¹⁶ Collecting comprehensive data on disparate COVID-19 impacts and vaccine uptake across racial, ethnic, immigrant, and language groups will be critical to monitoring and addressing inequities. But given concerns about sharing personal information common in immigrant communities, agencies could minimize the amount of sensitive information (e.g., citizenship status or Social Security numbers) they collect, provide alternative options for identification (e.g., consular identification cards), explain the importance of collecting data for shaping policy responses, and communicate clearly that information collected during vaccination will not be shared with immigration authorities (Artiga, Ndugga, and Pham 2021).¹⁷

Language barriers, misinformation or lack of information about COVID-19 and the vaccines, challenges reaching vaccination sites, the inability to take time off from work to get to a vaccine or stay home if they experience side effects, and other challenges may also limit vaccine access for immigrant families. The Centers for Disease Control and Prevention and other organizations have developed education and outreach materials in multiple languages,¹⁸ and the American Rescue Plan Act includes funding for community outreach and education about the vaccines. Still, effectively rolling out the vaccines requires engaging trusted community voices (NRCRIM 2021). Culturally appropriate communications and outreach to inform communities about vaccine safety and effectiveness and how and where to get vaccinated will likely be most successful when designed to resonate with specific groups and communities among the diverse foreign-born population and delivered by trusted members of specific communities.¹⁹ Finally, eliminating other access barriers could help mitigate logistical challenges, such as providing vaccinations at convenient, accessible locations immigrant families know and trust, like immigrant-serving organizations, or bringing pop-up vaccination clinics to areas where immigrants work for those who cannot take time off to get vaccinated.²⁰

Recent national polls show increased enthusiasm for the COVID-19 vaccines since December, when the WBNS was fielded, and data from the US Census Bureau's Household Pulse Survey indicate rising vaccination rates and willingness to get vaccinated among adults in California between January and February 2021.²¹ But equity of access remains a critical barrier, and data show Hispanic/Latinx people are underrepresented in vaccinated populations. The success of California's and the nation's vaccination campaigns will depend on continuing to build confidence in the vaccines and ensuring access to them. Moving forward with equitable vaccine distribution in California will require explicitly

focusing on outreach and access for immigrant communities and families, using the settings, messages, and trusted sources that will reach them, and mitigating the barriers they face to getting vaccinated.²²

Data and Methods

This brief draws on data from a sample of 1,079 nonelderly adults in California who participated in the December 2020 round of the Urban Institute’s Well-Being and Basic Needs Survey, including 550 adults in immigrant families and 529 adults not in immigrant families. The WBNS is a nationally representative, annual survey of adults ages 18 to 64. For each round of the survey, we draw a stratified random sample (including a large oversample of adults in low-income households) from the KnowledgePanel, a probability-based internet panel maintained by Ipsos that includes households with and without internet access. This analysis is based on the WBNS core sample and an additional oversample of noncitizens.

To assess vaccine attitudes in California, we constructed a set of weights for analysis of nonelderly California adults, including those who are foreign born or living with a foreign-born relative in their household, or “adults in immigrant families.” The weights are based on the probability of selection from the KnowledgePanel and benchmarks from the American Community Survey for nonelderly adults in immigrant families in California who are proficient in English or primarily speak Spanish and nonelderly adults in California who do not live in immigrant families. The language criterion is used in the weighting to reflect the survey sample, because the survey is only administered in English or Spanish.²³ Because of this limitation, our results do not capture the experiences of immigrants who do not speak these languages.²⁴ For further information about the survey design and content, see Karpman, Zuckerman, and Gonzalez (2018).

The WBNS assesses concerns about the coronavirus by asking respondents, “How worried are you that you or someone in your household will be exposed to coronavirus?” Respondents could reply they were not at all worried, not too worried, somewhat worried, or very worried. We asked respondents who were working at the time of the survey a similar question about their worries about exposure to the virus at their main job. To assess attitudes toward the COVID-19 vaccines, the survey asks, “If a vaccine that protected you from the coronavirus was available for free to everyone who wanted it, how likely would you be to get it?” Respondents could report they would definitely get, probably get, probably not get, or definitely not get a vaccine. The survey also asked respondents, “How much would you trust each of the following sources of information about a coronavirus vaccine?” Respondents could report they would strongly trust, somewhat trust, neither trust nor distrust, somewhat distrust, or strongly distrust each source. The full questionnaire is available at <https://www.urban.org/policy-centers/health-policy-center/projects/well-being-and-basic-needs-survey>.

Notes

- ¹ “Vaccination Progress Dashboards,” State of California, accessed March 31, 2021, <https://covid19.ca.gov/vaccines/#California-vaccines-dashboard>.
- ² Rong-Gong Lin li, Luke Money, Colleen Shalby, “California Is Reserving 40% of COVID-19 Vaccine for the Neediest. Who Will Get It?,” *Los Angeles Times*, March 4, 2021, <https://www.latimes.com/california/story/2021-03-04/california-shifts-covid-vaccine-rollout-for-neediest-groups>. For more information on the metrics used to define vulnerable communities for this effort, see the California Healthy Places Index, available at <https://map.healthylivesindex.org/>.
- ³ Sarah Thomason and Annette Bernhardt, “Front-Line Essential Jobs in California: A Profile of Job and Worker Characteristics,” University of California, Berkeley, Labor Center Blog, May 14, 2020, <https://laborcenter.berkeley.edu/front-line-essential-jobs-in-california-a-profile-of-job-and-worker-characteristics/>.
- ⁴ Estimates for the share of adults in California households with at least one immigrant family member are based on authors’ analysis of 2019 American Community Survey data.
- ⁵ The survey was fielded December 8 through 30, 2020, with nearly 80 percent of respondents completing the survey by December 14, when the first COVID-19 vaccines were administered in the US. See Ben Guarino, Ariana Eunjung Chang, Josh Wood, and Griff Witte, “The Weapon That Will End the War: First Coronavirus Vaccine Shots Given outside Trials in US,” *Washington Post*, December 14, 2020, <https://www.washingtonpost.com/nation/2020/12/14/first-covid-vaccines-new-york/>.
- ⁶ Liz Hamel, Grace Sparks, and Mollyann Brodie, “KFF COVID-19 Vaccine Monitor: February 2021,” Henry J. Kaiser Family Foundation, February 26, 2021, <https://www.kff.org/coronavirus-covid-19/poll-finding/kff-covid-19-vaccine-monitor-february-2021/>.
- ⁷ Estimates for most sources of care that are not a clinic, health center, doctor’s office, or health maintenance organization did not vary significantly by family immigration status. However, adults in immigrant families were slightly more likely than other adults to report emergency rooms as their usual source of care (2 percent versus less than 1 percent).
- ⁸ Amy Schoenfeld Walker, Lauren Leatherby, and Yuriria Avila, “What’s Behind the Hispanic Vaccination Gap?,” *New York Times*, March 29, 2021, <https://www.nytimes.com/interactive/2021/03/29/us/hispanic-vaccine-gap.html?referringSource=articleShare>.
- ⁹ Blake Farmer, “Biden Administration Recruits Community Clinics to Help Solve Vaccine Inequities,” NPR, February 11, 2021, <https://www.npr.org/sections/health-shots/2021/02/11/967017129/biden-administration-recruits-community-clinics-to-help-solve-vaccine-inequities>.
- ¹⁰ Farmer, “Biden Administration Recruits Community Clinics to Help Solve Vaccine Inequities,” NPR; Bradley Corallo and Jennifer Tolbert, “Biden Wants to Partner with Health Centers to Promote More Equitable Access to COVID-19 Vaccines,” Henry J. Kaiser Family Foundation, February 9, 2021, <https://www.kff.org/policy-watch/biden-wants-partner-with-health-centers-promote-more-equitable-access-covid-19-vaccines/>; “Health Center COVID-19 Survey,” Health Resources and Services Administration, updated March 12, 2021, <https://bphc.hrsa.gov/emergency-response/coronavirus-health-center-data>; and Corallo and colleagues (2020).
- ¹¹ “American Rescue Plan Act Awards,” Health Resources and Services Administration, accessed April 1, 2021, <https://bphc.hrsa.gov/program-opportunities/american-rescue-plan/awards/ca>.
- ¹² Jennifer Kates, “What’s in the American Rescue Plan for COVID-19 Vaccine and Other Public Health Efforts?,” Henry J. Kaiser Family Foundation, March 16, 2021, <https://www.kff.org/policy-watch/whats-in-the-american-rescue-plan-for-covid-19-vaccine-and-other-public-health-efforts/>; White House, “Fact Sheet: Biden Administration Announces Historic \$10 Billion Investment to Expand Access to COVID-19 Vaccines and Build Vaccine Confidence in Hardest-Hit and Highest-Risk Communities,” news release, March 25, 2021, <https://www.whitehouse.gov/briefing-room/statements-releases/2021/03/25/fact-sheet-biden-administration-announces-historic-10-billion-investment-to-expand-access-to-covid-19-vaccines-and-build-vaccine-confidence-in-hardest-hit-and-highest-risk-communities/>.

- ¹³ US Department of Homeland Security, “DHS Statement on Equal Access to COVID-19 Vaccines and Vaccine Distribution Sites,” news release, February 1, 2021, <https://www.dhs.gov/news/2021/02/01/dhs-statement-equal-access-covid-19-vaccines-and-vaccine-distribution-sites>.
- ¹⁴ Chantal da Silva, “Biden Administration Says It Won’t Defend Trump’s ‘Public Charge’ Rule as It Defies ‘Nation’s Values,’” *Forbes*, May 20, 2021, <https://www.forbes.com/sites/chantaldasilva/2021/03/10/biden-administration-says-it-wont-defend-trumps-public-charge-rule-as-it-defies-nations-values/?sh=5441738570ea>. In addition, the White House issued an executive order requiring federal agencies to review the policy; see *Restoring Faith in Our Legal Immigration Systems and Strengthening Integration and Inclusion Efforts for New Americans*, Exec. Order No. 14012, 86 FR 8277 (2021).
- ¹⁵ US Department of Homeland Security, “DHS Statement on Litigation Related to the Public Charge Ground of Inadmissibility,” news release, March 9, 2021, <https://www.dhs.gov/news/2021/03/09/dhs-statement-litigation-related-public-charge-ground-inadmissibility>.
- ¹⁶ Roxana Kopetman, “Two Undocumented Immigrants Denied Vaccine, Prompting Reminder That Vaccines Are for Everyone,” *Orange County Register*, March 25, 2021, <https://www.ocregister.com/2021/03/25/two-undocumented-immigrants-denied-vaccine-prompting-reminder-that-vaccines-are-for-everyone/>.
- ¹⁷ Joshua Aarons, Eva H. Allen, and Jennifer M. Haley, “Data Are Essential to Prioritizing Racial and Ethnic Equity in COVID-19 Vaccination,” *Urban Wire* (blog), Urban Institute, February 5, 2021, <https://www.urban.org/urban-wire/data-are-essential-prioritizing-racial-and-ethnic-equity-covid-19-vaccination>.
- ¹⁸ “COVID-19 Communication Resources,” Centers for Disease Control and Prevention, accessed March 25, 2021, <https://www.cdc.gov/coronavirus/2019-ncov/communication/print-resources.html?Sort=Date%3A%3Adesc&Search=Facts&Topics=Vaccines>; and “Translated Materials Library,” University of Minnesota, National Resource Center for Refugees, Immigrants, and Migrants, accessed March 25, 2021, <https://nrcrim.org/health-education/translated-materials-library>.
- ¹⁹ Such strategies, for example, were critical to efforts to contain a measles outbreak among children in Somali families in Minnesota, where trusted Somali health care and outreach workers played a significant role in educating Somali families about the vaccine. See Minnesota Department of Health, “Health Officials Declare End of Measles Outbreak,” news release, August 25, 2017, <https://www.health.state.mn.us/news/pressrel/2017/measles082517.html>.
- ²⁰ Miriam Jordan, “Thousands of Farmworkers Are Prioritized for the Coronavirus Vaccine,” *New York Times*, March 3, 2021, <https://www.nytimes.com/2021/03/01/us/coronavirus-vaccine-farmworkers-california.html>; Heidi de Marco, “Dispelling Vaccine Misinformation and Myths in California’s Breadbasket,” *California Healthline*, February 2, 2021, <https://californiahealthline.org/news/article/dispelling-vaccine-misinformation-and-myths-in-californias-breadbasket/>; and “Bringing Vaccinations Directly to Essential Farmworker Communities,” Public Health Institute, accessed April 1, 2021, <https://www.phi.org/about/impacts/bringing-vaccinations-directly-to-essential-farmworker-communities/>.
- ²¹ Hamel, Sparks, and Brodie, “KFF COVID-19 Vaccine Monitor: February 2021,” Henry J. Kaiser Family Foundation. Unpublished Urban Institute tabulations of data from the US Census Bureau’s Household Pulse Survey show the share of adults in California who reported they were vaccinated or would definitely or probably get vaccinated increased from 84 percent to 88 percent between January 6 through 18, 2021, and February 3 through 15, 2021.
- ²² An Urban Institute blog post suggests similar strategies for improving vaccine access in the Washington, DC, area; see Jennifer M. Haley, Joshua Aarons, Eva Allen, and Monique King-Viehlend, “As COVID-19 Vaccine Hesitancy Decreases, Boosting Access Will Be Critical to Reducing Inequity in the DC Metro Area,” *Urban–Greater DC blog*, Urban Institute, April 2, 2021, <https://greaterdc.urban.org/blog/covid-19-vaccine-hesitancy-decreases-boosting-access-will-be-critical-reducing-inequity-dc>.

- ²³ We define adults with English proficiency as those who speak English at least well, as classified in the American Community Survey. Adults with limited English proficiency are those who speak English less than well. This is a broader measure than is commonly used to define English proficiency; in most analyses, a person must speak English very well to be classified as proficient (Wilson 2014). We use the following measures for weighting: gender, age, race and ethnicity, educational attainment, presence of children under age 18 in the household, homeownership status, family income as a percentage of the federal poverty level, internet access, family composition, family citizenship status, respondent nativity and immigration status, and whether English or Spanish is the primary language for Hispanic/Latinx adults in immigrant families.
- ²⁴ We estimate these excluded adults represent between 5 and 15 percent of all nonelderly adults in California immigrant households as defined for this brief; according to the 2019 American Community Survey, about 5 percent of such Californians speak English less than well and speak a primary language other than Spanish.

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