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Addressing COVID-19 vaccination equity for Hispanic/Latino communities by attending to *aguantarisimo*: A Californian US–Mexico border perspective

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ABSTRACT

With an eye to health equity and community engagement in the context of the initial COVID-19 vaccine roll-out, the COVID-19-related concerns of the Latinx (Hispanic/Latino) community in southern San Diego (California, USA) were examined using 42 rapid, ethnographically-informed interviews and two focus groups conducted in early-mid 2021. An anthropologically oriented qualitative analysis delimited the cultural standpoint summarized as *aguantarisimo*, which celebrates human durability in the face of socioeconomic hardship and the capacity to abide daily life's challenges without complaint. After characterizing *aguantarisimo*, its role in both undermining and supporting vaccine uptake is explored. To avoid diverting attention from the structural factors underlying health inequities, the analysis deploys the theoretical framework of critical medical anthropology, highlighting inequities that gain expression in *aguantarisimo*, and the indifference toward vaccination that it can support. In placing critical medical anthropology into conversation with the cultural values approach to public health, the analysis sheds new light on the diversity of human strategies for coping with infectious disease and uncovers new possibilities for effective vaccination promotion. Findings will be useful to public health experts seeking to convert non-vaccinators and optimize booster and pediatric COVID-19 vaccine communications. They will also contribute to the literature on cultural values in relation to Hispanic/Latino or border health more broadly, both by confirming the vital flexibility of cultural standpoints like *aguantarisimo* and by documenting *in situ* what is to the social science and health literature, albeit not to cultural participants, a novel constellation.

1. Introduction

The CommuniVax project comprises six research teams in five US states and a network of national experts and stakeholders. CommuniVax evaluated the 2021 COVID-19 vaccine roll-out's challenges and successes relating to US health equity while working to support durable, community-centered recovery options. CommuniVax's national reports included both guidance and tools for effective vaccine campaigns (Brunson et al., 2021; Schoch-Spana et al., 2021a; Schoch-Spana et al., 2021b).

This article discusses the CommuniVax-California team's findings, describes the cultural standpoint of *aguantarisimo*, provides examples of its tactical deployment, and explores its role in undermining as well as supporting vaccine uptake. In doing so, this research highlights the

structurally oppressive realities to which *aguantarisimo* gives expression, with reference to insights from Critical Medical Anthropology.

By placing the latter framework into conversation with the cultural values approach to public health, we aim to shed new light on the diversity of human strategies for coping with infectious disease, and to uncover new possibilities for effective vaccination promotion. Findings will be useful to public health experts seeking to convert non-vaccinators and otherwise optimize COVID-19 vaccine promotions. Findings will also contribute to the literature on cultural values in relation to Latinx or border health more broadly, documenting *in situ* what is for social scientists of health and medicine a novel constellation, underlining the plasticity of 'cultural values', and providing guidance on how healthcare professionals might better attend to culture's complexity and dynamism.

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2. Background

While addressing structural factors is essential in combating health inequity, expressing sensitivity to cultural values can be helpful (e.g., Velasco-Mondragon et al., 2016). Botelho and Lima (2020) review major models for doing so, including ‘cultural competency’, which entails the application of *a priori* knowledge about various cultures, and ‘cultural humility’, which includes reflecting on one’s own privilege and biases as well as maintaining humble openness to others’ self-defined cultural needs. The latter, introduced by Tervalon and Murray-García (1998), shifts the focus away from delimited ‘knowledge’ toward a process of lifelong learning. Botelho and Lima go further, prioritizing patients’ choices through ‘cultural respect’ (2020).

Regardless of the specific angle taken, interventions to reduce health disparities for Latinx groups with Mexican heritage generally seek to leverage culturally-anchored behavioral and attitudinal constellations. Perhaps the most famous of these within public health is *familismo*, introduced 50 years ago in nascent form by Moore and Cuellar (1970) and refined into an etic analytic construct by Sabogal et al. (1987). *Familismo* prioritizes kin-based obligations, promotes reliance on the family for support, and requires use of the family as a referent to guide behavior (see Smith-Morris et al., 2012).

This article describes a cultural value constellation not yet well-characterized in the health-related literature: *aguantarismo*, named for the verb *aguantar*, which means to put up with or bear. Whereas *familismo* celebrates “the strong identification and attachment of persons with their nuclear and extended families” (Smith-Morris et al., 2012, p. 36), *aguantarismo* celebrates human durability, or the capacity to abide or withstand and push through—to endure the challenges of daily living without complaint (regarding the few indications of this in prior literature, see Discussion).

The exposition is set against COVID-19’s disproportionate impact on Latinx communities, not only in terms of hospitalization, death, and unemployment but also increased chances for exposure due to employment and living conditions (Dubay et al., 2020; Airgood-Obrycki, 2020). These factors may have amplified the importance of *aguantarismo* in everyday life for many Latinx people, supporting as it does self-protective measures such as handwashing and mask-wearing. But *aguantarismo*’s valorization of self-sufficient self-protection also might point some people away from vaccination. Our exploration takes *aguantarismo*’s potential multi-directionality into account.

In this, we join others in calling out bureaucratized or perfunctory performances of cultural sensitivity that reify what are actually manifold and diversely deployed sets of assumptions or desires. Indeed, culture entails plastic resources that people can use intentionally in a variety of ways: the outcome is never a foregone conclusion.

Further, as Berger and Miller observe in their critique of cultural competency in its various guises, a focus on culture alone “reflects embedded ethnocentrism, perpetuates entrenched biases, and fails to recognize the depth and breadth of systemic racism as these relate to ... the mitigation of health disparities” (2021, p. 1; regarding ethnocentrism cf. Daniels and Schulz, 2006). In this, ‘cultural competency’ not only “perpetuates the very disparities that it endeavors to mitigate” (p.6); the overemphasis on culture diverts attention from the structural factors underlying health inequities.

A corrective for this significant elision is found in Critical Medical Anthropology (CMA), which emerged alongside HIV/AIDS (e.g., Baer et al., 1986; Singer, 1994; Farmer, 1992)—a disease that, like COVID-19, has been particularly pernicious amongst disadvantaged groups worldwide. CMA questions the ways in which power affects the production of health differentially, in part by exploring what culture encodes or conveys and what it accomplishes in relation to the structural inequities that fuel health disparities. Culture here includes scripted narratives or stories we use to make sense of our experiences as well as small and often habitual acts of daily life, or “the socioscape of routine” (Reis, 2002, p. 733). CMA examines how narratives and habits are

shaped by—but also resist and even refuse—the political economy, often giving voice to knowledge regarding how structural oppression works.

CMA also seeks to show how health-related ideas and practices, as well as health conditions themselves, can reinforce social inequality, sometimes synergistically. For instance, while alcohol use may be a proactive form of self-medication among the under- and unemployed, it can also become problematic, fostering downward spirals of interrelated troubles (e.g., domestic, legal, dental, medical) and leading, sometimes, to death (Singer et al., 1992). Self-reinforcing exacerbations are “amplified in populations that face extreme structural, political, and social vulnerabilities”, and aggravated by related delays in seeking—and gaining—medical care (Mendenhall, 2017, pp. 899–900). COVID-19 is more deadly among those with pre-existing conditions such as obesity, diabetes, hypertension, and heart disease; and these occur at higher rates among poor people of color, whose COVID-19 outcomes are worsened concurrently by pre-existing social and infrastructural barriers (Singer and Rylko-Bauer, 2021).

COVID-19’s synergies are seen clearly in San Diego, California, where the Latinx population (whose self-professed preferred ethnic identifiers generally are: Hispanic, Latino) has been hard hit. Given current political-economic arrangements (see Singer and Rylko-Bauer, 2021), Latinx persons in the USA are 1.7 times more likely to contract COVID-19 than non-Hispanic White counterparts; they are 4.1 times more likely to be hospitalized and 2.8 times more likely to die from the disease (Zamarripa and Roque, 2021). Accordingly, San Diego County’s ‘South Region’, which is located coastally just north of the US-Mexico border and is two-thirds Hispanic/Latino (SDCHSU, 2021a), has the County’s highest COVID-19 case, hospitalization, ICU admission, and mortality rates (SDCHSU, 2021b).

Even before *el Covid*, residents in South Region suffered: average incomes there have long been the County’s lowest (SDCHSU, 2021a). With the pandemic, however, came massive job loss, food and housing insecurity, and educational forfeitures as well as deaths. The heightened potential for exposures among those who did keep their jobs was compounded not just by the type of work done (e.g., as cooks, cleaners, clerks, shelf-stockers, and in other ‘high-proximity’ and ‘essential’ roles; see Dubay et al., 2020) but by shared housing arrangements: Hispanic/Latino-headed households are more likely than others to be multigenerational and ‘overcrowded’ (Airgood-Obrycki, 2020). This makes self-isolation, when indicated, extremely challenging.

Large, multigenerational households entail higher exposure risk; but having *familias fuertes* (strong families) has been a key theme in literature regarding Hispanic/Latino resilience. Family members provide one another material and social-emotional support as well as reminding each other what they hold in common culturally (Bermudez and Mancini, 2013). Important here are *dichos*: sayings offered as longstanding, culturally derived wisdom regarding how the world works (Durána et al., 2020). *Dichos* “provide inspirational words of encouragement ... Parents [share] *dichos* as cultural forms of moral and emotional support and advice about how to confront and cope with difficult situations in one’s life” (Marrun, 2020, p. 174): for instance, *perro que no anda no encuentra hueso* (a dog that does not go out does not find the bone).

Current *dicho* research generally focuses on familial pedagogy, positioning *dichos* as “funds of knowledge” that can both boost forbearance and serve “as expressions of ethnic identity in [mixed ethnicity] settings” (Espinoza-Herold, 2007, pp. 262, 265). Many *dichos* promote positivity and determination: “They foster a sense of unity in the face of challenge and adversity, and the belief and pride in having the ability to be strengthened by life’s challenges” (Bermudez and Mancini, 2013, p. 217).

Given COVID-19’s recency and front-line demands, published research regarding the pandemic’s intersection with Hispanic/Latino cultural values remains scant. A pilot study did report that *simpatía*, operationalized as a patient’s perception that the provider was friendly, and *respeto*, operationalized as deference and believing “It is the healthcare professional’s job to know what to ask,” were positive

predictors of COVID-19 vaccine acceptance (Henry et al., 2020, p. 2; cf. Zamudio et al., 2017). Note here that *respeto* also is expected from providers; it entails, for instance, using proper forms of address toward patients (Juckett, 2013; Zamudio et al., 2017). Providers also should demonstrate a level of *personalismo*, or formal but welcoming warm friendliness, versus treating clinic visits as business-like transactions or factory processes (Machado, 2014; cf. Flores et al., 2022).

Familismo also has emerged as relevant to the pandemic—in ways that demonstrate the dangers of treating cultural values as if simply held, monolithic, or ossified relics. As Smith-Morris and colleagues have shown, “*familismo* as expressed in narratives is a more contested and evocative concept than most quantitative and behavioral literatures tend to suggest” (2012, p. 37). Behavioral and ideational patterns can be helpful tools when bundled and labeled like ‘*familismo*’ is; but the oversimplification entailed can blind theorists (and so intervention planners and practitioners) to a given cultural value’s complex entailments and generative potentials.

For instance, pandemic-related campaigns tailored to Hispanic/Latino communities leveraging *familismo* have appealed productively to the value of protecting other family members, whether through COVID-19 testing (Garcini et al., 2021) or vaccination (Garcia et al., 2021). And perhaps due to *familismo*, an intervention asking vaccinated individuals to spread pro-vaccine messages in family and other social networks had the best results in Latinx circles (Marquez et al., 2021).

However, findings show *familismo* working in the opposite direction also. A study amongst farmworkers found that *familismo* impeded masking and social distancing where doing so would be considered rude; in this, appeals to *familismo* can increase people’s risk for coronavirus infection (Quandt et al., 2020). Likewise, *familismo* can be experienced in terms of surveillance and pressure, such as for the individual with a non-conforming sexual or religious identity (Smith-Morris et al., 2012, p. 38).

In other words, *familismo*—and, by extension, other cultural values—can ramify dynamically in varied and sometimes contradictory directions, depending on situational factors. Therefore, although cultural values can influence people’s actions, and while they offer scholars and intervention planners “broad guidance” (Smith-Morris et al., 2012, p. 39), context matters. Structural factors affect the expression of culture, as do people’s individual preferences, aims, and related readings of a situation. Too often, ‘cultural competency’ initiatives blunt their own effectiveness by failing to recognize nuance.

The need for more scholarship notwithstanding, *el Coronavirus* demanded a quick response; and on January 18, 2021, South Region’s COVID-19 vaccine roll-out began. Access barriers, such as complicated online scheduling systems, lack of access to technology, inaccessible distribution locations, and English-only systems and forms slowed uptake. However, in addition to addressing technical barriers and offering more sites with relative speed, the County leveraged the efforts of community health workers (CHWs), known locally as *promotoras*, to assist. By April, County vaccination sites allowed walk-ins as well. By the end of 2021, South Region’s vaccination rate was the County’s highest.

Nevertheless, with emerging variants continuing to threaten progress, it is important not to rest. Further, outreach must target not just remaining unvaccinated individuals but also those past due for subsequent doses or boosters, and parents of eligible children. Success hinges not only on maintaining access gains but better understanding culture’s role.

3. Methods

In late 2020, our team began an environmental scan assessing local and state infrastructure, COVID-19 disease burden, and COVID-19 vaccination policies in relation to the Hispanic/Latino community in San Diego’s South Region. This work included public records/data reviews as well as formative conversations with key representatives of community, governmental, and corporate organizations involved in the

vaccine roll-out. We also drew on the team’s deep knowledge of the community, based both on heritage (all staff were bilingual members of San Diego’s Hispanic/Latino community) and as gained through community-based demonstration/technical assistance projects undertaken within the County since the early 2000s via San Diego State University’s Institute for Public Health.

In Spring 2021, with Institutional Review Board approval (#HS-2021-0066), the team began a rapid assessment of people’s COVID-19 experiences in South Region, using well-established, anthropologically oriented rapid qualitative interview and focus group methods (see Sobo, 2009). This choice was informed by the disaster context and our immediate need for data (Henry, 2005) and the related rapid assessment paradigm (Sangaramoorthy and Kroeger, 2020).

To elicit information about the community’s experience of the COVID-19 vaccine roll-out and of the pandemic more broadly, the interview entailed four open-ended questions:

1. Tell me what you think about COVID vaccines. Do you have questions or concerns? Are you planning to get one? Why or why not?
2. How do people in your community get COVID vaccines? What does the process involve from beginning to end? Are there parts of that process that will be/were more difficult for you personally?
3. Taking a step back from COVID vaccination, tell me more about how your life has been affected by the pandemic. What has your personal experience with the pandemic been like? Have you had the disease or known anyone who has? Have you struggled financially or emotionally?
4. In your opinion, what will be needed for the pandemic to come to an end? Similarly, what will be needed for life in your community to return to normal?

Interviewees received resource handouts afterward, to ensure their access to accurate information regarding vaccinations and local support services. They also received \$25 gift cards.

All Hispanic/Latino adults living or working in South Region were eligible. Recruitment was via word of mouth, including through social media and with the aid of community and health department contacts. To ensure broad inclusion in our convenience sample, and a good span of ages as well as equitable gender participation, the team also solicited participation in front of South Region grocery stores and recreation centers, and at two home improvement stores where men, some of whom are undocumented, wait for work.

The project manager Griselda Cervantes fielded 90 expressions of interest, securing informed written consent as per institutional standards with 46 successful enrollments. Ultimately, 42 individuals were interviewed (four missed their appointments and had not yet been rescheduled when we reached data saturation). Of the rest, 25 were unreachable despite repeated attempts; eight, lost to follow-up; ten, ineligible; one, not interested.

After intensive training with the first author, Elisa Sobo, the interviewers (graduate students Diego Ceballos and Sarah Song, each of whom had prior research experience) conducted and recorded the semi structured interviews via telephone ($n = 32$), Zoom ($n = 7$; no video saved); WhatsApp ($n = 1$; no video); and in person ($n = 2$). The average duration was 57.5 min (range: 22–127 min). Twenty-eight participants were women; 14, men. Twenty interviews were done in Spanish and 22 in English (language determined by interviewee).

To triangulate interview findings, Ceballos, Cervantes, and Song conducted two focus groups via Zoom (in Spanish) with Hispanic/Latino CHWs/*promotoras* from South Region. *Promotoras* are community members seen by most as trustworthy and wise, in ways akin to a beloved aunt; they are characterized by their affinity for service *se hace de corazón* (from the heart) (Flores et al., 2022). Fourteen *promotoras* self-referred to attend at either of the two pre-announced times and were pre-consented as above; 13 attended: six and seven, respectively, all female (as is typical of *promotores* [the gender-neutral term]). Some may

have known each other but this did not surface as salient.

Imelda Sing handled transcription and translation. Like Ceballos, Cervantes, and Song, Sing is bilingual and bicultural but, for efficiency, de-identified audio files were machine-transcribed via NVivo (released March 2020). Spanish transcriptions were then translated verbatim into English with DeepL Pro Advanced (released March 2018). All transcriptions/translations were audited and corrected as necessary in relation to audio playback. *Dichos* with English equivalents (e.g., ‘The early bird catches the worm’) were fully translated; those without were presented in Spanish, with verbatim translations in brackets; and all identifying information was eliminated (pseudonyms are used in presenting the findings). Audio files will be destroyed at the study’s conclusion.

Ceballos and Song coded the transcripts as each became available, starting with a basic coding scheme developed by the national working group (of which Sobo was a member) from the first dozen interview transcripts collected nationally. After coding three cases in parallel and then comparing results over the course of four 1.5-h training sessions with Sobo, the interviewers established inter-rater consensus of >75% agreement on all codes applied (including 100% on many—meaning that neither coder missed an instance that the other found). The two then divided and coded the remaining transcripts independently, using HyperRESEARCH software (version 4.5.2, 2021). Separately but concurrently, Sobo undertook an iterative review of the transcripts.

In keeping with the rapid ethnographic orientation (Sangaramoorthy and Kroeger, 2020), the team met weekly until the majority of transcripts had been reviewed. We refined the coding scheme to better reflect local realities, including insights gained in the context of the broader project’s capacity building and technical assistance efforts. Transcripts underwent additional coding as needed (after agreement training similar to that described above).

Sobo completed the analysis, leveraging over-familiarization and iteration in documenting the range of responses, identifying themes (ideas shared frequently enough to become anticipated), ascertaining their situational salience for participants, and interpreting this given the socio-cultural environment of the community in question. Constant comparison and attention to disconfirming or negative instances helped ensure analytic rigor (Glaser and Strauss, 1967), as did frequent vetting of results by the team. Codes were used for data retrieval; but this kind of anthropological analysis is qualitative, not quantitative (see Bernard, 2011; Sobo, 2009; see also Castleberry and Nolen, 2018; Sullivan and Sargeant, 2011).

4. Findings

In the analysis, the importance of agentic forbearance as a life strategy emerged as paramount. Therefore, after summarizing vaccine uptake-related findings (expanded upon elsewhere), that is this section’s focus.

4.1. Standpoints on vaccination uptake

Vaccination was supported by people’s (1) felt need to protect household members and relations (*familismo*); (2) desire for freedom from confinement in the home (this overlapped with *familismo* for those who prioritized gathering with relatives); (3) view of vaccination as standard practice or routine (normalization): “All my life there’s always been vaccines for everything; chicken pox, whooping cough, measles” (Laura; all names are pseudonyms). There were also accounts in which acceptance was simply pragmatic or the easy option, such as when a workplace recommended, offered, and/or supported it.

Yet, ‘vaccine hesitancy’ remained. Importantly, many participants had vaccine concerns (‘hesitations’) but still got vaccinated. For instance, when asked what gave her the confidence to vaccinate, 53-year-old Angie replied: “It’s not that I have confidence. I look at different things and I ask different people.” Moreover, much of what could have been cast as ‘hesitancy’ in fact reflected remaining access issues or experiences or knowledge of structural factors that undermined the trustworthiness of portions of the health system. Finally, people offered many and diverse reasons for non-vaccination, which the blanket phrase ‘vaccine hesitancy’ masks.

That said, most standpoints on non-vaccination fell within four broad categories, a detailed breakdown of which is shown in Table 1. Categories are shown in order of resistance to vaccination: the first involved none, while the last entailed active resistance. Providing the percentage of transcripts in which each category arose conveys a sense of salience; however, summary statistics should be interpreted with caution: they are generally inappropriate for hypothesis-generating research such as this (see Methods).

Beginning with Category 1, some participants eager for vaccinations could not achieve access despite County efforts to provide easy-to-reach clinics in areas considered safe, with ample vaccine supply, walk-in options, and straightforward ways to make appointments. Their access was impeded by other factors, such as being unable to forfeit a day’s pay, or having nobody to care for their dependents should they suffer temporary side effects.

Table 1
Barriers to Vaccination: Categories and Subcategories (N = 44 transcripts).

Category	Subcategory
1. Impeded access (n = 12, 28.6%) - Desire is to procure vaccination	Need to work (no time off; need money) Child/eldercare responsibilities Lack of insurance (e.g., in case of complications) Immigration related concerns/lack of documentation Fear of needles
2. Indifference/low motivation (n = 16, 38.1%) - Vaccine desire is absent	Not on radar Not required yet Not belonging to a high-risk group Already preventing
3. Cautious delay (n = 22, 52.4%) - Desire is to avoid vaccination	Too soon Currently contraindicated (pre-existing conditions) Waiting for more choices
4. Active resistance (n = 25, 59.5%) - Desire is to avoid vaccination and this desire is intense	US healthcare has problems Healthcare worker resistance Profiteering and fearmongering Religious opposition Political opposition (‘Red values’)

Active desire to vaccinate infuses this category ('impeded access'); in 'cautious delay' and 'active resistance' the active desire is to wait or not vaccinate, respectively. Those individuals cautiously delaying (Category 3) were said to want to hold off due to unanswered questions or uncertainty that the vaccines had been around long enough to have been proven safe and effective, or the conviction that they would exacerbate existing health problems. More active resistance (Category 4) related to past experiences of discrimination in the US healthcare system leading to poor quality care, and friends and family working in healthcare who advised against the vaccine, although some participants did tell of relatives or close associates actively refusing vaccines due to disinformation.

In contrast to categories 1, 3, and 4, agentic desire/aversion is absent from 'indifference/low motivation' (Category 2), as summarized in the *dicho* "si sirve, no lo repares" (if it works, don't fix it). There is no saliently perceived need for vaccination, and/or no perceived pressure to have it—it just isn't on one's mind. For some individuals, particularly those who speak only Spanish or another Mexican language (Huichol, for instance) this reflects a lack of exposure to public health information through a social institution. Others—self-employed entrepreneurs, for instance—may be overtly unconcerned regarding their risks or options because no employer provides notices; the same can hold true for those without children in public schools. Lack of institutional exposure to motivating public health messaging is compounded when people have little or no media exposure, as can happen among impoverished immigrants with language barriers and thin local networks.

In other cases, low motivation to vaccinate was tied to having seen only mild COVID-19 infections, or positive tests without symptoms. And some individuals had not been vaccinated yet because, as they told us, it was not required for anything they needed or wanted to do (e.g., travel, work, school); they simply had not yet found reason enough to seek it out.

Reflecting on others they knew, some reported that the initial messaging around priority groups (e.g., the elderly) led various people to deprioritize themselves to the point of feeling vaccination wasn't needed: one participant's sibling told her, "I'm healthy, I'm 37. I'm not, like, top priority." Focus group members also reported indifference among the young, who "were told at the beginning that they were not ... going to get it" and so "they don't take it seriously."

Many participants referenced methods of self-protection that would help them fend off the virus or hasten recovery should they fall ill. They saw COVID-19 as a threat; but, for a subset, vaccinating seemed superfluous because self-protective efforts appeared to be working so far.

4.1.1. *Debemos aguantar* [We must withstand]

The preference for self-strengthening self-protection seemed to be reinforced by a cultural value placed on doing what it takes to endure tough situations (*aguantar*). This vantage also paired with a deeply held work ethic and tendency to accommodate daily struggles without complaint. As 44-year-old Alejandro explained regarding job options:

You got a family? to feed? So you've got to pick that McDonald's job. It might not pay ... but [with no job you have] zero. ... So you take that job. ... At least you got a job! It may not be the best job [so maybe you find a] different smaller place [to live] ... make it work ... you accommodate. And sometimes two parents have to get a job. Both of them. Yeah, to pay the rent. And sometimes the teenager got to pay. ... Make it work. I always did. At my first job I was doing the paper route. ... 100 bucks a week. ... And I got 50 for my mom 50 for me.

Forty-nine-year-old Leonardo took the same attitude, even when the pandemic came: "I had to go to get money to eat. I was not interested in COVID, I was interested in feeding my children, [and if COVID] killed me or did not kill me, it was the same thing: I had to get food for my children." Despite his efforts, he could not earn enough; he drove from Los Angeles to San Diego in Fall 2020 seeking more. At first he slept in

his car, but after it was stolen (along with his immigration documents) he began sleeping in the canyon near the corner where he often went to offer his services as a day laborer.

Leonardo had been on his own since the age of six, often unhoused and always scrambling to survive. COVID-19 exacerbated his precarity. And even when living in the canyon he soldiered on: "I always have to find a job somehow or other. Even cleaning windows. ... I work, work, work."

Leonardo's situation was extreme but there was something of his struggle in many participants' narratives due to structural factors. Bianca, a 31-year-old mother of two, was able to telecommute ("so ... my personal experience is a bit privileged"); but still her family had to use a food pantry. She observed that, vaccine or not, there will still be "people struggling to pay paycheck to paycheck for rent."

Regarding forbearance, Bianca noted that "our community has always been really good at, like, trying to ... better ourselves" but she questioned the idea of "going back to normal [if it means] that we just accept certain disparities ... that COVID kind of exasperated." Having noted with laughter that "systemic racism will never go away because of the vaccine," Bianca observed:

That's like the sad part, right? Like going back to normal means we're still going to go back to the same problems that we had previously. ... We have the highest rates of COVID yet we were the last ones to get the vaccines. You know, this [area is] low income, and that's why the contagious rates were so high because there's multi-generational homes ... It's the most economically viable [household form] for people who live on minimum wage or low low wages.

In the context of multigenerational households, many participants took preventive recommendations very seriously. Sola, a 36-year-old non-vaccinating student living with her sister, her parents, and her grandmother, said "I use my face mask, huh? Since before COVID I've always used my [sanitizing] gel. It's just a habit. I try to just go out for basic errands and not go to places where there are a lot of people. And ... I always put my distance between one person and another."

Liberty, a 39-year-old non-vaccinator living with her parents, had a collection of face masks. She did not enjoy wearing them, but knew they would help ensure "the spark of another person's sneeze doesn't reach you." Regarding the vaccine, Liberty expressed ambivalence. It was new, for one thing. For another,

Even if you go get the vaccine, you still have to take your precautions. Take a look at that! In other words, there is no end, honestly. ... My dad and my mom were told that they still have to take care of themselves. Can you believe that? Then what are the vaccines for? ... I don't understand, I mean, if you are going to get vaccinated it is because you can live free without the face mask. Well, to be normal. Because that is why you are getting vaccinated. ... So what is the benefit ... ? No, no, no, no, I don't really see the point.

Neither Sola nor Liberty were employed: Latinas suffered the greatest employment decrease of all race/ethnic and gender categories in the pandemic's first year (Zamarrípa and Roque, 2021). Those in South Region who did manage to maintain employment or fulfill the need to (quoting Leonardo) "work, work, work" often did so in close proximity with others (Dubay et al., 2020). Every participant who talked about workplace hygiene rules reported taking actions to prevent COVID-19.

Moreover, many participants reported that their preventive actions offered enough protection, particularly if paired with home or natural remedies. Ricardo, the janitor introduced above, told us:

I am an essential worker. I never stopped working, even during COVID, from the beginning. From the beginning. So we had to take care of ourselves. ... I would come home and I had to be taking care of my wife not to bring the virus into the house, right? So from the beginning we took care of ourselves and we took all the precautions ... using face masks, taking distance, not going out. ... And

vitaminize, take my vitamins and so we are believers of herbs ... natural medicines and vitamins [and ...] nutritional supplements to strengthen the immune system, the respiratory system, pills to strengthen all that. ... We all always drank water, water with lemon ... A lot of citrus fruits like oranges, tangerines, lemons. In the meals we would add a lot of, a lot of garlic.

As Ricardo's testimony suggests, people often paired authorized preventive measures with natural or lifestyle approaches to self-protection. For instance, 66-year-old Carlos spoke of "a couple of herbs and plants that are good for the lungs" but his main approach was staying hydrated and eating well. If Carlos gets his vaccine, he plans to offset the chances for side effects by taking steps to "upgrade my nutritional element and decrease whatever negativity" in preparation.

While Carlos' use of non-biomedical treatment was complementary and preventive, some had faith that non-biomedical treatments could cure COVID-19 by themselves. Fifty-three-year-old Angie reported, "One of my brothers got COVID. Mom came and cured him, took care of him, smeared him [and injected him] several times, but so that they couldn't, the virus wouldn't [flare] up." "God knows what it is," she said of the medicine; it was something her mother bought from a pharmacy. This was certainly more cost-efficient than paying for medical care: "My mom, never took us to the doctor, she always cured us."

Angie's mother's self-reliance was not atypical; when the pandemic hit "everyone was making masks, because they could not buy masks ... People learned to make hand sanitizer because they could not buy it," she said. Likewise, Aimee, a 38-year-old whose family members (like those of many participants) differed regarding vaccination's value, said, "People found a different route to take ... to make ends meet. I mean, people even started doing those outdoor picnic things, where they go and set up a picnic for you. Like there's just so many side businesses that people have come up with recently because of COVID."

Creative strategies for survival pervaded the ways households cared for ill members, too. For example, when Brenda's husband got COVID-19, he took the bedroom; and she was the only one to assist him directly:

We didn't want to take turns because I told them I'll do it, I'll take care of bringing him the food because what if I get sick? So it's better that only one of us gets sick and not all of us, so we try to handle it that way. ... [I would] stay and do the food with my [husband] and they were in charge of going to the errands.

Such self-reliance makes sense in the context of poverty where, as Ricardo explained, people "just have to take care of it." Said David (a 30-year-old living with his parents), "Well, why do you complain, you know, because the other options is dead, you know? Like, you just have to hold it, you know"—to bear up, push through. Leonardo, the day laborer introduced above, said,

I have gone through many things alone and here I am. I have gone through many things alone. I have a cut on one foot, I cut my foot open like this! When I was about seven years old. [Interviewer looking at scar: Oh wow! About two inches!] More! Like three, four inches. I was like eight years old. You know how I cured the cut all by myself? [How?] With just newspapers! With newspaper because I was already living on my own. Then God knows. Of course, I cut myself with a nail. ... And why didn't I die that day? The nail was rusty ... I could not even walk because it lasted for months, because the heel hurts so much that a nail gets buried there. ... A lot of bad things have happened to me, but I am alive."

Regarding COVID-19 particularly, for which he remained unvaccinated, Leonardo said, "I believe that I have been with infected people and thank God here I am with you. So *hierba mala nunca muere* [weeds never die; sometimes expressed as 'weeds are not killed by the frost']. He had become very hardy indeed.

5. Discussion

The blanket construct 'vaccine hesitancy' fails to accommodate the hesitance expressed by many who vaccinated and inaccurately fuses the many varied standpoints underlying non-vaccination for COVID-19. Regarding the latter, those we documented conformed broadly to what has been seen nationally: they reflected impeded access, cautious delay, and active resistance. However, themes of indifference/low motivation (Category 2 in Table 1) were novel, having not yet received attention in the vaccination literature. A recent exception is Wood and Schulman (2021), but even there the focus was on 'apathy'. Indifference as seen in the South Region data did not take on this kind of negative valence.

Indifference sometimes was attributed to a lack of exposure to public health messaging or having no vaccination requirement, but a sense that actions already being taken would suffice ('Already preventing' in Category 2, Table 1) loomed large for many. The latter is part of a cultural constellation labeled here by us as *aguantamiento*. We offer this analytic label because a literal translation of *aguantar* does not fully encapsulate the standpoint that participants enacted and described. *Aguantamiento* entails holding up and more: it entails a pervasive willful capacity to endure difficult circumstances without complaint and to do what is needed to maintain self-sufficiency, including enacting rites of self-protection.

A similar perspective may be seen in many immigrant or impoverished populations where perceived entitlement is low and getting sick or injured can lead to household ruin through job loss and unpayable medical bills. It seems to take a particular sheen among those with Mexican heritage due to an *a priori* cultural matrix.

As Machado notes, "Latino apprehension about healthcare goes deeper than issues of access. It also partially derives from ... a tradition of privacy and individual pride that makes many Latinos believe we have no need to ask for help" (2014, para. 6). Others, too, write of the self-sufficiency cultivated through Latino familial pedagogy (e.g., Espinoza-Herold, 2007). In the context of pervasive material and practical barriers to care, this tradition—codified here as *aguantamiento*—helps explain why Hispanic/Latino individuals have been more likely than members of other race/ethnic groups to report working while ill, and to delay both testing and presentation in a clinic setting when suffering the symptoms of COVID-19 (Podewils et al., 2020; Cervantes et al., 2021).

Aguantamiento, as we frame it, has been anticipated in a scattering of prior investigations. Mostly, the term '*aguantar*' gets highlighted incidentally. For instance, it pops up in passing in research on how women experience domestic and workplace sexual violence, childbearing, and motherhood (Benson-Flórez et al., 2017; Coffin-Romig, 2015; Menjívar, 2011; Montesi, 2018; Villegas, 2019). It is also used by female migrant farmworkers in Idaho, USA, to describe how they tolerate pain or discomfort given that health care is too expensive (Tarp et al., 2017) and by male Argentinian soccer club members to celebrate physical forbearance, pain tolerance included (Frank-Vitale, 2021, pp.106–7).

To date, only two English-language publications known to us do more with the term. One—Frank-Vitale's dissertation concerning life in the most impoverished neighborhoods in Honduras (2021)—contrasts the collective emic or insider understanding of endurance ("*sabemos aguantar*"; e.g., p.92) with that of 'resilience,' showing how the latter sidesteps structural violence, lending itself to victim-blaming (see Chapter IV). The other concerns migrant farmworkers in North Carolina, USA, who commonly used the phrase *aguantamos* (we endure) in characterizing their experiences of substandard housing and health conditions (Heine et al., 2017). Indeed, their tendency to *aguantar* was so prevalent that it had become a stereotype: "'We put up with it because we're Mexicans. They say that Mexicans put up with more than anyone else'" (p.244). The dangers of naturalizing such stereotypes

notwithstanding (Holmes, 2006, p. 1787), Heine and colleagues theorized participants' view of their forbearance as a form of agentic self-care, in that it enabled some to "bypass the emotional toll of grappling with the aspects of ... life [they] could not change" while enabling them to garner the material benefit of a paycheck (2017, p. 244).

Aguantarismo is also anticipated, however obliquely, in studies focused on *sufrimiento* (suffering). Those most useful in relation to the present research foreground the theoretical construct of 'social suffering' as the outcome of an oppressive and inequitable structural order that constrains choice and agency (e.g., Holmes, 2006; Horner and Martinez, 2015). The critical perspective is crucial: many of our participants themselves referred to structural barriers.

Yet the discourse that we encountered—coalesced here as *aguantarismo* (paralleling *familismo*'s etic construction; Smith-Morris et al., 2012, p. 37–38)—foregrounds active endurance, highlighting people's strengths, not their wounds. The active versus passive nature of *aguantarismo* can be read back into the translations Holmes offers when the verb *aguantar* pops up in his work on the social context of farmworker health. For instance, he casts *me aguantar*, when used to describe working while in pain, as 'I hold out'; and *aguantamos*, when used in relation to pesticide exposure, as 'we are strong' (2006, pp. 1786, 1787). There can also be a sardonically obstinate dimension to *aguantarismo*'s deployment: it can be used consciously to signal self-determination *in spite of* oppressive conditions; recall the *dicho* offered by Leonardo, here paraphrased: 'Your frost cannot kill us weeds.'

Our findings, seen both on their own and in relation to the as-yet limited literature acknowledging the importance, across various Spanish-speaking cultures in the Americas, of the disposition and ability to bear up, support the observation that *aguantarismo* and barriers to care are coeval dimensions of life for many Hispanic/Latino individuals. The tradition of not asking for help from others but enacting self-help (Espinoza-Herold, 2007; Machado, 2014) is adaptive given the access challenges and economic pressures faced daily by the Hispanic/Latino residents of San Diego's South Region (as it is for others in similar circumstances). Hispanic communities are often cast as having "a bank of resilient resources that is conditioned by broad social contextual factors (e.g., SES), and that may help protect against negative health outcomes in adverse circumstances" (Gallo et al., 2009, p. 1731). Findings suggest that *aguantarismo* forms a key part of these reserves—but, importantly, as seen from the vantage of CMA, it is one that draws attention to rather than eliding the structural roots of the problem to which it responds (cf. Frank-Vitale, 2021).

As part of the everyday fabric of life, *aguantarismo* is 'small culture': it is generally unremarked-upon or quotidian. Yet, as Reis argues, "the everyday is the preeminent temporal/spatial domain where non-alienated, culturally and existentially meaningful productivity occur" (2002, p. 732). From this perspective and that of CMA, it is worth attending to everyday expressions of perseverance and to what such expressions say about macro-level forces—particularly when they can underwrite forsaking public health recommendations.

In other words, even mundane cultural practices can have significant effects on lived experience; and they can convey big ideas. *Aguantarismo* does so by indexing, albeit sometimes latently, the transnational political economic arrangements that virtually ensure, through the structural foreclosure of options, that Hispanic/Latino individuals will struggle economically. That is, Hispanic/Latino poverty and the experience of ethnic/racial oppression that reinforces it are generative factors in *aguantarismo*. One might argue that the tactic simultaneously reinforces structures of oppression, but not completely: making such structures visible is a necessary step toward their dismantlement, even if the individuals employing *aguantarismo* are themselves yet unable to make that happen.

In addition to being multivocal, *aguantarismo* is dynamic. As Smith-Morris and colleagues have noted, "cultural ideals—like *familismo*—are not static relics of a common cultural heritage, but are living

value systems that speakers reference, deploy, and manipulate for multiple goals and agendas, even during interviews and surveys" (2012, p. 47). For instance,

The family is named as both a reason to migrate and a reason to stay home; a reason to seek more income, and a reason to be accessible for family gatherings; a reason to go, to stay, to be with, and to escape. Depending on the conversation, speakers may be defending, praising, reprimanding, or actively considering both pros and cons of family events and pressures, through the performance of their narrative (2012, p. 47).

Aguantarismo is similarly plastic; people have choices in how they deploy it. It can drive or be used to justify a desire for preventative vaccination, to ensure that one does not get sick and can keep working. It also can drive or be used to justify vaccination rejection, by making vaccines seem redundant or unnecessary. Choices are made in the context of structures, surely; yet choices still exist.

6. Implications

In the COVID-19 vaccine roll-out, references to 'culture' generally and 'vaccine hesitancy' in particular have often obfuscated the dire need to attend to access barriers (Brunson et al., 2021). Yet, decision-makers can point to cultural differences in justifying certain kinds of programmatic outreach. For instance, since the pandemic began, CHWs/*promotores* have taken a central role in San Diego. As trusted members of the community, South Region's *promotores* have answered questions and addressed concerns in a locally-relevant manner, contributing greatly to South Region's high vaccine uptake rates. While not forgetting the need for structural change, it is critical to advocate for and implement policies that integrate CHWs/*promotores* into the public health team core. In other words, 'culture' does not just come into play through training offered to healthcare workers and other frontline personnel regarding best practices for patient-provider interaction when cultural backgrounds differ. In addition to focusing broadly on skills such as cultural respect, sensitivity, and humility (Botelho and Lima, 2020; Tervalon and Murray-García, 1998) and eschewing the deficit model for health education (see National Academies, 2021), attending to cultural resonance or 'goodness of fit' between program elements and the target community's cultural orientation is paramount.

To encourage vaccination, public health efforts also must provide, via dialogue, information that is compatible with a target group's beliefs/values. Further, when choosing vaccination requires relinquishing a tightly-held position, interventions can help people maintain 'face' or self-esteem (see National Academies, 2021). This can be particularly important for people whose social identity entails being against vaccines (Sobó, 2016). Supportive messaging frees people to change their minds without feeling ridiculous or compromising their self-positioning as savvy healthcare consumers. For example, the recent US Food and Drug Administration's formal approval of the vaccine and the emergence of new variants seem to have provided face-saving justifications for many.

People's cultural values can also be leveraged directly. The Hispanic/Latino values emphasized by our participants, including the penchant to *aguantar*, or 'bear up' (the focus of our exposition), can be catalyzed. For instance, vaccination can be discussed as a powerful wellness tool that can supplement tools already used by individuals (particularly essential/vulnerable workers) to help themselves push through or endure the burdens and challenges of daily life. Prior examples of success with this approach are seen in Native American and Indigenous communities that leveraged the idea of cultural preservation to get first their elders and then other community members vaccinated (e.g., Foxworth et al., 2021). Another example concerns churches where the virtue of being one's brother's or sister's keeper has been leveraged to promote vaccination (e.g., Gilbert, 2021).

7. Limitations

While the corpus of data was robust (42 interviews, two focus groups), the analysis did not include any directly ethnographic data. It cannot offer the kind of deeply nuanced exposition often prioritized in CMA investigations of dissenting health understandings. Nor does it offer solid insight into what might drive the deployment of *aguantarismo* toward or away from a desire to vaccinate. This and the community or socio-economic context in which *aguantarismo* blossoms are topics for future research.

Notwithstanding, in describing *aguantarismo* our analysis brings together and builds upon scant existing literature to delimit a novel cultural standpoint and tactic, extending our understanding of Hispanic/Latino cultural values. It speaks directly to the call for additional and more nuanced research regarding “which aspects of culture are most relevant to health in Hispanics, ...the positive and negative effects of cultural factors, and the specific pathways (e.g., health behaviors, social support) that explain their connection with health” (Gallo et al., 2009, pp. 1731–32). Further, in demonstrating the generative nature of *aguantarismo* (e.g., the power it has to obviate the felt need for vaccination among some individuals), this research affirms the necessity of taking a more elastic approach to ‘culture’ in public health initiatives, accommodating the varied ways in which a community’s cultural resources can be deployed while striving to channel them in accordance with public health aims.

8. Conclusion

California’s Hispanics/Latinos face many barriers to health equity. In their scoping review, Velasco-Mondragon and colleagues cite “limited cultural sensitivity” as a key challenge (2016, p. 21). The present analysis demonstrates that one aspect of Hispanic/Latino culture at the US–Mexico border that merits attention in this regard (in tandem with addressing access issues) is peoples’ need to protect their self-sufficiency through a cultural constellation focused on endurance, summarized here as “*aguantarismo*”.

Aguantarismo both expresses and is responsive to the structural vulnerabilities of this population given present political economic arrangements. And, as was recently shown for *familismo* (Smith-Morris et al., 2012), *aguantarismo* is a multivalenced tool for Hispanic/Latino individuals. Likewise not amenable to a simple stereotype (as no cultural value ever should be), *aguantarismo* enhances resilience amongst those who lack other options. Yet, it can undermine resilience when channeled to stymie affordances such as the COVID-19 vaccine.

South Region’s Hispanic/Latino population has a largely Mexican heritage and this, plus its position on the border, suggests that *aguantarismo* will be seen among other Hispanic/Latino communities on or near the US-Mexican border, and perhaps among immigrants from Mexico in other parts of the USA too. In addition, our recommendations may be relevant and applicable for communities in other areas that share some of the characteristics of South Region.

Attending to *aguantarismo* could help support recovery from the pandemic and related antecedent ills while underwriting collaborative, effective partnerships among key community stakeholders. Through such partnerships, communities can attend to health equity issues, enhance systems, build trust, and support collective agency for overall health and wellbeing moving forward.

Author statement

Sobo: Conceptualization, Methodology, Formal analysis, Investigation, Resources, Writing – original draft, Writing – review & editing, Supervision, Funding acquisition. **Cervantes:** Validation, Investigation,

Resources, Data curation, Writing – review & editing, Project administration. **Ceballos:** Validation, Investigation, Data curation, Writing – review & editing. **McDaniels-Davidson:** Validation, Resources, Writing – review & editing.

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