

Addressing COVID-19 Vaccination Equity and Recovery Among the Hispanic/Latino Population in the Southern California Border Region

San Diego, California

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CommuniVax

A Coalition to Strengthen the Community's Role
in an Equitable COVID-19 Vaccination Campaign



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Executive Summary

Thanks to a high level of community responsiveness and the dedicated efforts of San Diego’s health workforce, the Hispanic/Latino population in San Diego’s south region has achieved impressive vaccination rates. This report summarizes best practices so that other regions may follow suit and provides recommendations for enhancing and supplementing practices already in place so that even more community members become fully vaccinated. Emerging variants of COVID-19 have made it imperative to reach unvaccinated individuals as well as those past due for their second dose and those due for a booster.

CommuniVax, a national consortium focused on strengthening COVID-19 vaccination efforts by putting communities of color at the center of its efforts, examined the local experience of vaccine uptake among the Hispanic/Latino community in San Diego. We identified successful vaccine uptake strategies as well as important multilevel barriers to vaccine uptake relevant to Hispanics/Latinos.

[CommuniVax’s national report](#) contains information on the following overarching equity-related recommendations, which our work supported:

A. Overarching National Recommendations

1. Humanize delivery and communication strategies for COVID-19 vaccines, centering in key community settings (eg, churches, clinics), trusted messengers (eg, physicians, faith leaders), and tailored approaches to vaccine messaging.
2. Anchor COVID-19 vaccination efforts in hard-hit communities in a holistic “whole person” recovery process. This is an opportunity to set forth lasting change.

This site-specific report, based on 9 months of rapid, community-focused research, provides a framework for success with local, community-informed, targeted strategies for increasing vaccine uptake in the Hispanic/Latino population in California and other regions with a high proportion of Hispanic/Latino people. These recommendations are based on successful strategies implemented in the area as well as gaps identified through the data collection process:

B. Targeted Recommendations for Hispanic/Latino communities in the United States

1. Elevate community health workers (also known as *promotores* or *promotoras*) to a central position in the public health enterprise.
2. For cities that border Mexico, ensure that vaccination sites feel safe, welcoming, and accessible to all who seek the vaccines.

3. Invest in and implement educational efforts at multiple levels that teach technology skills and promote digital media, scientific, and health literacy.

These recommendations will not only boost pandemic recovery, but also enhance the community's health infrastructure, allowing the community to more easily and effectively respond to future health emergencies and challenges.

Introduction

This report supplements the CommuniVax’s national report, [*Carrying Equity in COVID-19 Vaccination Forward: Guidance Informed by Communities of Color*](#)¹ (see the national recommendations in **Appendix A**), detailing findings specific to the local South San Diego region and the Hispanic/Latino community. The report includes a call-to-action with recommendations, along with specific actions that can be implemented by public health officials, government officials, healthcare professionals, academic institutions, community-based organization (CBO) and faith-based organization (FBO) leaders, and community health workers (CHWs)/*promotores(as)* in regions similar to San Diego. While conducting our research, San Diego County implemented a host of interventions to increase vaccine uptake in the south region of San Diego. These interventions were largely successful, resulting in a high rate of vaccination among Hispanic/Latino people in this region. The recommendations in this report, therefore, are largely aimed at ensuring that these efforts can continue and are implemented in other regions in California and other states with similar demographics.

Problem

Black, Hispanic/Latino, and Indigenous populations in the United States have endured disproportionate impacts from the COVID-19 pandemic. While these communities would benefit greatly from safe and effective COVID-19 vaccines, they face long-standing biases and barriers that often limit their access to, and acceptance of, vaccination.

CommuniVax is a national alliance of social scientists, public health experts, and community advocates working to strengthen COVID-19 vaccination efforts by putting communities of color at the center of their endeavors. Since early 2021, the San Diego CommuniVax team has been listening to members of the Hispanic/Latino community in the south region of San Diego, working with them to support the development of stable, local governance systems that enable underserved groups to exercise collective agency over their own health and wellness during this pandemic and going forward.

Local Background

Early in the pandemic, data pinpointed San Diego’s hardest-hit areas, which were predominantly communities of color.² COVID-19 disproportionately impacted the Hispanic/Latino population of San Diego County. Despite comprising 34.1% of the county’s 3.34 million residents,³ by September 27, 2021, Hispanic/Latino individuals had accounted for:

- 51.3%⁴ of the county’s 355,346² COVID-19 cases
- 49.3%⁵ of the county’s 17,617² hospitalizations
- 44.4%⁶ of the county’s 4,054² deaths

Disparities were also seen in the south region of San Diego, where Hispanics/Latinos make up 61.3% of the region's 505,243 residents (**Figure 1**).⁷ The COVID-19 case rate (per 100,000 people) among Hispanic/Latino south region residents (14,100.5) far

exceeded that of non-Hispanic White residents in the region (5,922.4) by late September 2021.⁸

Since vaccine rollout began, San Diego’s south region experienced success in many vaccination equity efforts that have contributed to the region having the highest vaccine uptake of all 6 San Diego County regions. Some of these efforts have since been expanded into other regions with comparatively lower vaccine uptake. For example, Project SAVE (Scheduling Assistance for Vaccine Equity) has shifted CHW/*promotor(a)* vaccination outreach efforts to the eastern and northern regions, where uptake among Hispanics/Latinos lags regional averages by about 10 percentage points.⁹

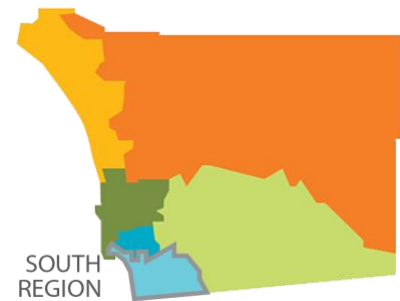


Figure 1. Map of San Diego County regions.

With emerging variants that threaten progress in the region, it is important to take immediate action to reach unvaccinated individuals, those past due for their second dose, and those now due for a booster. These efforts are imperative because the majority of the current COVID-19 cases are among those who are not fully vaccinated (see **Table 1** below with data from March 1 to September 18, 2021).

Table 1. COVID-19 Cases Among San Diego County Residents by Vaccination Status Since March 1, 2021^a

	Fully Vaccinated	Not Fully Vaccinated	Total Cases
Cases	17,586 (20.7%)	67,333 (79.3%)	84,919
Hospitalizations	90 (3.9%)	2,245 (96.1%)	2,335
Deaths	41 (13.8%)	257 (86.2%)	298

^a Data Updated September 18, 2021.

On June 15, 2021, California ended the use of the color-coded tier system that categorized the level of COVID-19 risk in the community, which then dictated what nonpharmaceutical interventions were required. If this system had still been in place through late July 2021, 36 of California’s 58 counties would have fallen under the most restrictive “purple” tier, indicating widespread transmission. This transmission was likely due to the surge of the Delta variant, which spreads quicker and more easily than previously circulating strains (see **Figure 2**).¹⁰ Utilizing CDC levels of community transmission, as of September 22, 2021, San Diego County is categorized as having high rates of transmission. This leaves unvaccinated individuals vulnerable to infection.¹¹ From the beginning of the pandemic through September 28, 2021, 1 in 9 people in San Diego County had been infected with SARS-CoV-2.¹²

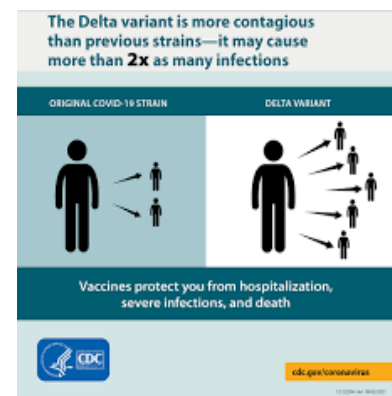


Figure 2. COVID-19 Delta variant transmissible rate.

Both local and national data demonstrate that the COVID-19 vaccines are working, but it is evident that many people are still not getting vaccinated. This report highlights some of the reasons for the lack of uptake shared by the Hispanic/Latino community in the south region of San Diego County.

Approach

In late 2020, the California CommuniVax local team set out to identify durable solutions to long-standing barriers underlying the health inequities revealed by COVID-19, with a focus on the Hispanic/Latino community in South San Diego.

Data collection

Late January 2021, we began work by conducting an **environmental scan** (see **Appendix B**) using publicly available information to assess local and state infrastructure, COVID-19 disease burden, and COVID-19 vaccination policies. As part of the scan, we also conducted interviews with 11 key informants—individuals who could speak for various governmental and nongovernmental organizations and CBOs/FBOs involved in vaccine rollout efforts.

Key informants included:

- San Diego County Health and Human Services Agency employees involved in supporting vaccine implementation
- A lead physician at the forefront of vaccination efforts from the largest network of federally qualified health centers in the region
- County Board of Supervisors representatives active in promoting vaccine efforts in the south region
- Chief executive officers and staff of CBOs engaged in efforts to promote vaccination
- School district leaders implementing vaccination days at schools for grades 6 through 12
- The health coordinator for the Mexican Consulate
- Members of the San Diego County Health Equity Task Force
- CHWs/*promotores(as)*
- Community advocates/physicians actively involved in organizing community vaccination events

Team members also utilized other research and public health practice efforts in San Diego that were involved in vaccine uptake efforts. These included the San Diego State University site of the National Institute of Health-supported Community Engagement Alliance Against COVID-19 Disparities project, the National Institute of Health-supported Rapid Acceleration of Diagnostics-Underserved Populations Communities Fighting COVID!, and Project SAVE-Communities Fighting COVID!

During April through June of 2021, we conducted a **rapid, ethnographically informed assessment** of the South San Diego community's experience of these resources and of COVID-19, using well-established rapid qualitative methods¹³:

1. **Semistructured Interviews** were completed with 40 Hispanic/Latino individuals from South San Diego. The average duration of each interview was 58.28 minutes (22 minutes to 127 minutes), 28 of which were with women. Twenty were done in Spanish and 20 were in English with the language determined by interviewee. These were the primary data of our community assessment. Brief **follow-up surveys** were completed with a portion of these 40 participants to identify factors that may influence vaccination status and decisions.
2. **Focus groups** were completed with 2 groups of CHWs/*promotores(as)* in Spanish. *Promotores(as)* are community members who are seen as trustworthy and wise individuals—a bit like a grandmother, mother, or aunt figure. The focus groups had 6 and 7 CHW attendees, respectively, each of whom worked specifically with the Hispanic/Latino population in South San Diego. In our focus groups, as is typical, all of the participants were women. Fortunately, men are also taking on this role now, which is essential in trying to reach and connect with Hispanic/Latino men in the community.

The research protocol was approved by the San Diego State University Institutional Review Board (HS-2021-0066). To preserve privacy, we use only pseudonyms when presenting the findings from community members, and we have excised or altered any details that might comprise identifying information.

Data analysis

Interviews and other qualitative data were analyzed for this report using anthropologically informed thematic analysis methods.¹³ The national working group provided all local teams with a preliminary codebook based on the interview protocol and the scientific literature. We tested this codebook against 2 sample interviews (as did all sites), and the working group then made necessary revisions to the master codebook.

Using the revised codebook, our coders established consensus before working independently. Following established processes, our protocol involved iteratively coding interviews and other texts and, in conjunction with the principal investigators, refining the coding scheme to reflect local realities more accurately. This led to the addition of a number of emergent themes that could not have been foreseen but will have particular relevance to vaccine uptake moving forward (see below).

We submitted coded data halfway through the project, and the research committee used these data to identify 3 code families—COVID-19 vaccine perceptions and experiences, vaccine access, and equity—as most pertinent to national and local reports. We subsequently submitted the full data set for the National Working Group’s use in the national report. Below, we concentrate on vaccine uptake; data regarding COVID-19’s overall impact are contained in **Appendix C**.

Local Observations

Background

As the above data indicate, vaccine uptake in the south region is impressive, but situations of nonuptake remain, and the use of the term “vaccine hesitancy” simplifies the reality that decisions about vaccinations are individualized and complex.

The primary observation presented in the national report is that “naming vaccine hesitancy as ‘the problem’ obscures a more complex set of realities.” For example:

- Many people who have concerns (“hesitations”) regarding vaccines still get vaccinated.
- There are many reasons for nonvaccination, which the blanket phrase “vaccine hesitancy” masks.
- Much of what is cast as “hesitancy” actually has to do with a lack of or impeded access.
- The phrase also assigns *blame* to individuals in the guise of “mistrust,” overlooking structural aspects of the health system that can contribute to mistrust.

Our data show that nonvaccination involves a range of concerns that can vary from person to person. While some of these concerns are about COVID-19 vaccines, others have more to do with the disease than the vaccination, or with past or present negative experiences within the healthcare or other systems. Concerns also vary regarding the depth of belief with which they are held.

In our region, vaccine concerns are influenced by a binational context: many who live or work in the south region have family on both sides of the border or cross the border for work. In addition to US pandemic messaging, people also took in information about the pandemic from Mexico; some also considered relatives’ and friends’ experiences outside of the United States. By paying attention to context, we learned that concerns that sound similar can in fact express quite different underlying worries for different people, and they can differentially influence the decisions of the people expressing them.

Below, we characterize the range of vaccination standpoints shared with us (using pseudonyms). The breadth of this range speaks directly to the second observation in the national report: *assuming that communities of color are homogeneous is a critical error*. It also bolsters the third national observation, which flags *the need for a hyper-local response*.

What Drives Vaccination?

Having an effective vaccine for COVID-19 “doesn’t solve everything,” as *transfronteriza* Serena noted; “It’s 1 less concern. It’s nothing more.” Even so, having just 1 less concern was a palpable wish for many.

Here, we delineate the main ideas (eg, themes, standpoints) underlying vaccine acceptance or adoption. In our Recommendations section, we highlight how these ideas—normalization, *familismo*, freedom, and hopeful speculation—might be leveraged to promote higher uptake.

What we do (normalization)

For many, accepting vaccination was simply pragmatic or the easy option, such as when a workplace recommended, offered, and/or supported it. Some cast it as simply routine to follow vaccination recommendations, such as Laura, who said, “All my life there’s always been vaccines for everything; chicken pox, whooping cough, measles.” Julissa said, “When the vaccines are ready, I will get them.... I never went around investigating.” Similarly, Silvia said, “I’m not second guessing ... I just got it. And I’m good.”

Protecting family and others (*familismo*)

Some vaccinated themselves to reduce the chances of getting others sick: said Serena, “You’re going to regret your whole life for bringing that virus into your home and infect any of your children.” Another participant decided on vaccination because “I live with my parents.... They’re both in their 60s. And so, they’re like, ‘You need to do it for us.’”

Ending confinement (freedom)

A frequently cited reason for vaccinating was to return to “normal,” which meant things like “having a work schedule ... have sociable activities you had. Your exercise. To be able to feel free ... having your family gatherings.” Christina spoke of taking her children to parks or the zoo and going to church. These kinds of desires were strong among many.

Hoping for health (speculation)

When contrasted with the threat posed by *el COVID*, some accepted vaccination with the hope that it was the better choice. Lucia explained, “I did vaccinated myself not because I wanted to, but because I’m exposed every day talking to so many people because of my work.” Ricardo declared, “You have to take risks for the sake of your health. Right?”

Importantly, *some hesitancy was present* when people cited *familismo* or freedom as reasons to get vaccinated. In theme 4, hoping for health (speculation), however, it was manifest. In terms of hopeful speculation, there were potential costs or risks on either side; vaccination was a gamble, but agreeing to it seemed the better bet.

What Drives Nonvaccination?

Participants also expressed a range of standpoints on nonvaccination. These fell within 4 broad categories: impeded access, cautious delay, low motivation or indifference, and active resistance. A more detailed breakdown is in **Table 2** and in the text that follows.

Table 2. Barriers to Vaccination: Categories and Subcategories

Category	Subcategory
Impeded access	Need to work
	Child/eldercare responsibilities
	Lack of insurance
	Immigration related concerns/lack of documentation
	Fear of needles
Indifference/low motivation	Not on radar
	Not required yet
	Not belonging to a high-risk group
	Already preventing – taking recommended action, using traditional medicine, via religion
Cautious delay	Too soon
	Currently contraindicated (preexisting conditions)
	Waiting for more choices
Active resistance	US healthcare has problems
	Healthcare worker resistance
	Profiteering and fearmongering
	Religious opposition
	Political opposition

Impeded access

Having access to vaccinations involves setting up strategic locations with adequate availability, such as nearby clinics with ample vaccine supply, walk-in options, and straightforward ways to make appointments. In the early days of the pandemic, these sites had not yet been firmly established, but the County of San Diego reacted quickly to ensure these logistics were in place, removing these barriers to vaccination. Access to vaccination can, however, be impeded by other factors, such as the need to work, responsibilities to family, concerns about insurance coverage, immigration issues, documentation, and a fear of needles.

Need to work

Many of our informants reported that inflexible employment parameters interfered with getting vaccinated. Christina, a partially employed woman with a young family, explained, “People don’t have time to leave their job. They have to feed their children.... They can’t leave work, like my husband, like he can’t leave his job in the middle of the day to get a vaccine and then go back. It doesn’t work that way.”

Child/eldercare responsibilities

Many informants also expressed concerns that the vaccine side effects would affect their capacity to fulfill role obligations. As per a *promotora* in a focus group, many “tell me ‘I have small children. What will happen if I get sick? What will happen if they have to take me to the hospital?’ So, it’s a real fear they have.” Parents and breadwinners were not the only people with such worries. Carlos referenced his ill, elderly father when explaining why he was unvaccinated: “I’m the one that does everything clean ... cook, drive—everything. So if I took my vaccine and I got sick, he’d be screwed.... Then who’s going to take care of him? And there’s no one here ... nobody ... I’m just going to wait.”

Lack of insurance

Participants also spoke of worry over not being able to pay for follow-up care after a vaccine, should it be necessary, due to lack of insurance or funds. Angie shared, “and since most of them [the undocumented] don’t have ... health insurance or anything ... when they go to a clinic, they have to pay. So if they get sick, unless they are dying, they go to a clinic. If they are not dying, they get cured with anything else. They look for something to cure themselves, to get better because they can’t go to the doctor, because they can’t afford it.”

Immigration-related concerns

Individuals in the United States without documentation, or those with family members in the country illegally, may be afraid of visiting vaccination sites for fear of being questioned or being cast as a public burden (“public charge”), which might affect visa, residency, or citizenship applications/processing. When this issue came up in a focus group, a CHW/promotor(a) summed things up as follows:

So [the health department] started this campaign to get [Latinos] to go and get the vaccines. What happens? They are afraid. Why? Because they say, “I’m going to go, they’re going to ask me for my information.” They’re not supposed to ask for Social Security ... none of that [is] needed. But nevertheless, the fear of being deported was what was holding them back because they were saying, “OK I’m going to go there, they’re going to be seeing me around, ICE [US Immigration and Customs Enforcement] is going to come by right away, they’re going to report me, they’re going to deport me.”

Unfortunately, we heard of many cases in which, despite a “don’t ask” policy, people were questioned—and denied vaccines. A *promotora* recounted this story:

I asked why they were denied. “They asked us for the ID.” I said, “But why? They didn’t have to ask you guys for your ID, just your name, and date of birth.” And he said ‘No, they also asked for social security. They told us no, that. That we were not from here, from the United States, and that they were not going to give it to us.’

Of course, many without documentation are too afraid to even try. It is worth noting that rumors of tracking devices mean something different (more potentially punitive) to the undocumented than they do to a citizen. Further, not all Hispanic/Latino immigrants in San Diego are from Mexico or speak Spanish. Some are impeded by a lack of information in, for instance, Mixtecan or other Indigenous languages.

Lack of documentation

Sometimes, the understanding that valid documentation would be required for a vaccination led even those who knew they were qualified to avoid trying for a vaccination. Frida explained, “I cannot go because my ID expired because the DMV

close with the pandemic and right now it's gonna be full.” (Visiting a Department of Motor Vehicle office can be an all-day affair.)

Fear of needles

Focus group data also revealed that fear of needles (trypanophobia) is a major barrier to vaccination for some individuals. A *promotora* shared about a client “who has not been able to get the vaccine because he is afraid ... of the needle more than anything else.”

Indifference or low motivation

Another primary reason for nonvaccination relates to a feeling of indifference or low motivation. For these individuals, active vaccination rejection is absent.

Not on radar

For some individuals, vaccination is not a high priority. In some cases, these informants had not been exposed to public health information through a social institution, like a school, or an employment site. Self-employed entrepreneurs, for instance—particularly if they do not follow current events or use social media—may not realize their risks or options. In other cases, people who had observed only mild cases of COVID-19 or positive tests without symptoms had low motivation to vaccinate.

Not required yet

Some had not been vaccinated yet because it was not required for anything they need or want to do (eg, travel, work, school); they simply had not yet found reason enough to seek it out. Leonardo, who at first said, “I don't plan to get vaccinated,” added, “If it is required as to be able to enter the United States ... I have to do it.” Ricardo added: “I am a custodian. So the time will come when [the site will reopen and] I will be required.”

Not in high-risk group

Some felt that the initial messaging around priority groups (eg, the elderly population being marked as high risk) led some people to feel as though they didn't really need a vaccine: a participant's sibling told her, “I'm healthy, I'm 37. I'm not, like, top priority.” In the focus groups, too, we heard of indifference among the young, who “were told at the beginning that they were not, they were not going to get it” and so “they don't take it seriously.”

Already preventing

Participants referenced methods of self-protection that would help them to fend off the virus or hasten recovery should they fall ill. They saw COVID-19 as a threat, but the need for a vaccine seemed minimal at best because their prevention efforts appeared to be working so far.

This perspective is magnified among some Hispanic/Latino people by the cultural value placed on not complaining about daily struggles and doing what it takes to endure tough situations—*aguantar* in Spanish. This perspective can be seen in many immigrant or impoverished populations, where getting sick or injured can lead to household ruin through job loss and unpayable medical bills.

Taking recommended actions. Many south region Hispanic/Latino people are essential workers who have taken recommended actions to prevent COVID-19 and feel that this will offer enough protection, particularly if paired with natural remedies. A janitor told us:

I never stopped working, even during COVID, 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 ... not visiting family ... And vitaminize, take my vitamins and so we are believers of herbs, of ... natural medicines ... vitamin C, nutritional supplements to strengthen the immune system, the respiratory system, pills to strengthen all that.... We all always drank water, water with lemon.... In the meals we would add a lot of, a lot of garlic. So there are many, many plants that are good for strengthening the system ... I used to take one... that alkalinizes your blood.... You need it to be healthy to be ready for any virus in general, not just COVID[-19].

In another instance, 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 and when Carlos decides to get the vaccine, he plans to offset the chances for side effects and will “upgrade my nutritional element and decrease whatever negativity” in preparation.

Traditional medicine. Some had faith that nonbiomedical treatments could cure COVID-19. Angie reported, “One of my brothers got COVID[-19]. 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.” When asked what her mother had smeared on and injected her brother with, Angie was unable to explain.

Religion. Self- or home-care involved not only *materia medica* (homeopathic remedies), but prayer or religion as well. Although some churches have promoted the vaccine, a number of people reported associates saying they did not need a vaccination because, as Roberto put it, “God is their protector.” In a statement reflecting the binational connections of many in our region, Victoria reported, “The president of Mexico ... he said that with a holy card of a saint or of a virgin, that with that, it protected you and that you were not going to get COVID and people believed it.”

Cautious delay

Some individuals had questions or concerns about the vaccine leading them to cautiously delay getting vaccinated. They often held off due to unanswered questions or well-considered reasons, such as being unsure that the vaccine had been around long enough to know it was safe and effective, worrying that it would exacerbate existing health problems, or wanting to choose a different vaccine than they could access. It is

possible that by now these individuals may feel that these questions have been answered sufficiently, converting them to the “better safe than sorry” position.

Too soon

Some individuals reported a “wait and see” perspective, wanting longitudinal proof of vaccine safety and effectiveness, particularly with the newly emerging strains. As a mother stated regarding a pediatric option: “You need information in order to make informed decisions”; and she added, “nobody wants to be the first one to do it. And I personally am not going to put my children at risk first ... *a ellas no*” (not them).

Currently contraindicated

Others were concerned vaccination would exacerbate preexisting health conditions. Aimee spoke of her “dad, not that he doesn’t believe in it, he’s just scared to get it because he already has so many health problems. He feels that if he gets that vaccine that it’ll make him sick, and he might die.... He’s worried that his body won’t be able to fight those side effects.” In many cases participants indicated that a doctor’s direct advice to vaccinate would be heeded—unless one had a prior bad experience in the healthcare system.

Waiting for more choices

Some were delaying vaccination until such time as they were allowed to decide which vaccine to get; at many clinics, only 1 option was available. Lucia specifically wanted a Pfizer vaccine “because it has domestic compounds such as potassium, phosphate, sodium, sucrose, fluoride, etcetera. Moderna, on the other hand, on the other side, have more chemicals that are more alien to us.” Likewise, Conchita mentioned having decided upon the Johnson & Johnson vaccine just before its administration was paused due to safety concerns.

Active resistance

Some community members expressed more active resistance to the vaccine. Some cited concerns about discrimination in the US healthcare system; others noted that they had friends and family working in the healthcare field who advised against the vaccine; some felt that the vaccine was created to earn a profit or to instill fear; still others noted religious and political objections to the vaccine.

US healthcare failings

Interview participants often praised US vaccination offerings, particularly in contrast to options in Mexico. One believed, for example, that in Mexico “They are just giving water. They are giving an injection without anything.” But many also mentioned that they felt the process to get vaccinated in the United States was discriminatory. For instance, Lucia said that the system was full of “obstacles,” including extensive paperwork demands and suspicions that “we’re lying.” “If you don’t speak English,” she said, “they don’t tell you anything.”

Healthcare worker resistance

Some individuals told us that their decision not to vaccinate was informed by friends and family working as healthcare professionals. Conchita noted that some “have family members that work in, that are nurses and doctors and that they’ve told them ‘no.’ And that’s because vaccines are experiments and that they don’t know yet what the future effects are going to be.” Conchita also noted that “about 20% of those who work in healthcare have not been vaccinated.” When visiting her brother in the hospital, she observed “a nurse doesn't even carry a face shield or anything, just a face mask. And I [asked], ‘You don’t have people with coronavirus?’ And the nurse said ‘Yes, I’ve had it twice, coronavirus. Look, we’re not afraid anymore. At first we were afraid. Today we are not!’ And [she] told me she didn’t have the vaccine.”

Profiteering and fearmongering

A few participants saw the vaccines as only being marketed for profit, whether directly or, as a *promotora* in a focus group reported having heard, “because they are extracting a lot of money from the Medi-Cal.” Others pointed out that current vaccines were not proven to ward off new mutations. Said Christina, “Well, then why am I getting this?” Likewise, some saw recommendations for booster shots as overkill and lamented that “there are cures in alternative medicine, but it is mostly eradicated” by the dominant healthcare system. And some discourse suggested vaccine promotions were just fearmongering: Aimee reported “even my coworkers being like, ‘Oh, it’s not a big deal’, and ‘If your kids get, they’re fine, they’re going to survive, I mean the chance of dying are like 1 million.’”

Religious opposition

While we did not speak with anyone avoiding vaccines for religious reasons, various churches were cast as sources of resistance via misinformation spread by their members. Some said that members of some churches were telling people that the vaccines contained aborted babies and/or microchips. Aimee, whose mother goes to a church that preaches against vaccines, noted that “a lot of the churches were kind of against even the COVID-19 precautions. You know ... they’re not going to close their doors because they have God to protect them.”

Political opposition

Some reasons given for not getting the vaccine seemed to be reflections of political polarization. One participant’s friend, for example, turned against vaccination because her husband “very, like, does not like the government telling them what to do.” This participant herself initially resisted as an expression of freedom: she was “getting a little pressure on my employer side ... it doesn’t sound like it should be legal for your employer to tell you what to do with your body. So I [was] like, ‘you can’t tell me what to do,’ to my employer ... to stick it to them.”

Although the CommuniVax focus has been decidedly nonpartisan, research and other forms of reporting have firmly established that vaccination nonuptake is a politically polarized issue, with conservative groups much more likely to adopt an anti-vaccination stance. This polarization has increased over the past several months.¹⁴ Context

information from our project confirms that this is true in Hispanic/Latino communities as well as in White communities.

Based on the Univision.com 2020 voter affiliation data,¹⁵ the ratio of Republicans to Democrats in the south region may be about 1 to 3. Chula Vista's Hispanic/Latino vote tally¹⁶ shows a slightly higher proportion of Republicans. Notably, the Republican presidential vote was 6 to 10 percentage points more common among Hispanic/Latino men than women nationally in 2020—a fact that must be considered in devising interventions or making recommendations, to which we now turn.¹⁷

Recommendations

Vaccine efforts in the south region of San Diego have been highly successful. Drawing insight from our local findings, the success of efforts in the south region, and our conversations with community leaders, we offer 3 specific recommendations that can inform efforts in many Hispanic/Latino communities across the United States to ensure an equitable vaccine campaign.

As noted in the national report, we emphasize the need to humanize delivery and communication strategies for COVID-19 vaccines, drawing in centers of community (eg, churches, clinics), trusted messengers (eg, physicians, faith leaders), and utilizing tailored approaches to vaccine messaging. In addition, it is imperative to anchor COVID-19 vaccination efforts for hard-hit communities in a holistic “whole person” recovery process. This means that efforts should consider the broad range of circumstances and needs of individuals that would allow them to more fully engage in their health and wellbeing (inclusive of, but not only, vaccination).

Table 3 details the locally relevant overarching equity-related recommendations from the CommuniVax national report, which our work supported, along with a list of locally informed actions that can be implemented to achieve the desired ends. The table also indicates who or which organizations (actors) can take the suggested actions.

Table 3. National Overarching Recommendations and Specific Recommendations

	Public Health	Government Officials	Healthcare	Academic Institutions	CBOs	FBOs	CHWs/promotores(as)
OVERARCHING RECOMMENDATIONS							
Recommendation 1: Humanize delivery and communication strategies for COVID-19 vaccines, drawing in centers of community (eg, churches), trusted messengers (eg, physicians, barbers), and tailored approaches to vaccine messaging							
Specific Action(s)							
Partner with and empower organizations with local repute and continuous community presence to develop and implement interventions.	X	X	X	X			
Establish home visitation services to deliver PSA or informational materials	X			X	X	X	
Create opportunities for conversations at local business places that serve as gathering spots (eg, hairdressers, coffee houses, bars)	X		X		X	X	
Tailor conversations and communication	X	X	X		X	X	X
Place more emphasis on modeling vaccination and advocating pro-vaccine messages	X	X	X		X	X	

	Public Health	Government Officials	Healthcare	Academic Institutions	CBOs	FBOs	CHWs/ <i>promotores(as)</i>
Promote the extensive benefits of vaccination and advocate for vaccination requirements where appropriate, engage stakeholders throughout the planning and implementation process	X	X	X	X	X	X	X
Recommendation 2: Anchor COVID-19 vaccination for hard-hit areas in a holistic recovery process							
Specific Action(s)							
Enable the recovery of whole persons by providing vaccinations alongside other critically needed goods and services	X	X	X	X	X	X	X
Bring vaccines to the people and do so in ways that are efficient but not reminiscent of military campaigns or factory production; possible methods include: home delivery, delivery at schools or trusted sites (eg, churches, barbershops), Meals on Wheels, laundromats, canvassing	X		X		X	X	

Abbreviations: CBO, community-based organization; CHWs, community health workers; FBO, faith-based organization; HCW, healthcare worker; PSA, public service announcement.

The targeted recommendations include many suggestions that have already been implemented in South San Diego. The recommendations are based on our findings, conversations with community leaders and frontline workers, and the expertise of the research team. These may be relevant to other areas of San Diego County as well as in jurisdictions that are similar to San Diego. These were developed in sync with the overarching recommendations.

1. **Elevate CHWs/*promotores(as)*** to a central position in the public health enterprise.
2. For cities that border Mexico, **ensure that vaccination sites feel safe, welcoming, and accessible** to all who seek the vaccines.
3. **Invest in and implement educational efforts** at multiple levels that teach technology skills and promote digital media, scientific, and health literacy.

Table 4 details the local targeted recommendations along with a list of actions that can be implemented to achieve the desired outcomes. It also outlines who can take the suggested actions.

Following the table, we offer specific examples of actions that can be taken. We also note that most of these recommendations can also be applied in other communities with low uptake.

Table 4. Targeted Recommendations and Specific Actions

	Public Health	Government Officials	Healthcare	Academic Institutions	CBOs	FBOs	CHWs/promotores(as)
TARGETED RECOMMENDATIONS							
Recommendation 1: Elevate CHWs/promotores(as) to a central position in the public health enterprise							
Specific Action(s)							
Make CHWs/promotores(as) a part of the core public health/healthcare team	X	X	X				
Provide institutional support to researchers and groups committed to community engagement that integrates CHWs/promotores(as)	X		X	X			
Develop local funding proposal teams or hubs	X	X			X	X	
Recommendation 2: For cities that border Mexico, ensure that vaccination sites feel safe, welcoming, and accessible to all who seek the vaccines							
Specific Action(s)							
Develop deliberate policies and actions that separates health systems (or social service systems during a pandemic?) from immigration and law enforcement systems (public charge rule)	X	X	X				
Provide sensitivity training and accurate information to HCWs at vaccination sites to communicate with and treat people with respect and dignity (eg, undocumented, nonpriority groups) or frontline workers	X		X	X			
Provide culturally relevant, values-leveraging messaging to support vaccination							
Avoid having law enforcement visible or present (eg, ICE, border patrol, police officers) to lessen the fear of communities of color in going to the sites	X	X	X		X	X	
Recommendation 3: Invest in and implement educational efforts at multiple levels that teach technology skills and promote digital media, scientific, and health literacy							
Specific Action(s)							
Develop and fund digital training	X	X		X	X	X	
Implement digital training	X				X	X	X
Develop and fund media and science literacy programs in schools, libraries, community meeting places (eg, churches, barbershops, beauty salons), and other places where people congregate/socialize	X	X		X			

Abbreviations: CBO, community-based organization; CHWs, community health workers; FBO, faith-based organization; HCW, healthcare worker; ICE, US Immigrations and Customs Enforcement.

Targeted Recommendations

Recommendation 1: Elevate CHWs/*promotores(as)* to a central position in the public health enterprise

Action: Make CHWs/*promotores(as)* a part of the core public health/healthcare team

It is essential that we train physicians, nurses, and other clinical care workers in pro-vaccine messaging and ways to encourage open dialogue about vaccine hesitancy. It is also essential to remove from duty those who display the kinds of resistance reported by some of our participants. Yet, we must also redefine who is a critical part of the healthcare profession.

Since the beginning of the pandemic, CHWs/*promotores(as)* have taken a central role in San Diego's local response. CHW/*promotores(as)* have been on the frontlines, working in efforts related to contact tracing as well as in community COVID-19 testing and vaccination efforts. Many of the reasons given by our participants for not getting vaccinated can be and have been addressed by CHWs/*promotores(as)*. As trusted members of the community, they are able to answer questions and address concerns in a manner that is relevant to the people with whom they interact, which is particularly important with hard-to-reach populations. They can also offer local resources that increase access to vaccines. We believe the efforts of CHWs/*promotores(as)* have contributed greatly to the success of vaccination efforts in South San Diego. It is critical to advocate for and implement policies that integrate CHWs/*promotores(as)* as part of core teams in public health, as opposed to ancillary and temporary personnel.

The [State Community Health Worker Models](#) provides an overview of the type of support and resources available to CHWs/*promotores(as)* across various states. This information can be the starting point to identify and expand opportunities for CHWs/*promotores(as)*.

Locally, the Health and Human Services Agency recently established a new department, The Department of Homeless Solutions and Equitable Communities, and 4 offices: The office of Homeless Solutions, the Office of Equitable Communities, the Office of Immigration and Refugee Affairs, and the Office of Strategy and Innovation. This new infrastructure will continue beyond the pandemic, and in recognizing the work that CHWs/*promotores(as)* are doing, they will continue to support the integration of *promotores(as)* as part of the healthcare workforce. Our county has supported the Promotora Model for a long time, but this accomplishment is definitely an equity win.

Action: Provide institutional support to researchers and groups committed to community engagement

The pandemic has challenged traditional processes of conducting research. It confirmed the need to organize, fund, and support community review boards that have adequate autonomy and authority. Such boards will help expedite the delivery of time-sensitive

programs and efforts. Local academic institutions should consider expedited review boards (eg, Institutional Review Boards) that are responsive to time-sensitive public health issues. [Disaster Research Response \(DR2\) Program](#) is one example of this.

Our study required qualitative rapid ethnographic assessments. It was critical to quickly collect data and report findings related to the COVID-19 pandemic. This process was challenging at times due to protocols required for research projects. Time delays for approvals, such as those from institutional review boards, can hinder time-sensitive efforts needed to rapidly collect data. To solve this problem, new models can be implemented, such as “rapid review” committees, in order to meet the needs of the time-sensitive research while adhering to the important oversight required when conducting human subjects research.

Action: Develop funding proposal teams or hubs

One way to support the development of our CHW/*promotor(a)* workforce is to create a center that specializes in working with CHWs/*promotores(as)*. This would include a team that focuses on grant writing and seeking funding to provide sustainable financial support specifically for CHWs/*promotores(as)*, providing them technical support while aligning funders and organizations/agencies. They can streamline recruitment, hiring, and training processes. Knowing exactly where to go would create a pipeline for projects/organizations/agencies that want to start integrating CHWs/*promotores(as)*, or simply need to recruit more. The same would be true for community members who want to become CHWs/*promotores(as)*. These actions have the potential to create long-term and sustainable work for CHWs/*promotores(as)*.

Recommendation 2: For cities that border Mexico, ensure that vaccination sites feel safe, welcoming, and accessible to all who seek the vaccines

Action: Bring vaccines to people

It is important to equip trusted and influential leaders with information and resources to combat misinformation and overcome access barriers. Public health efforts should include collaboration with grassroots organizations, churches, barber shops/hair salons, and other storefronts that are frequented by target groups and should address access issues, such as challenges with transportation. Many such efforts are currently underway in San Diego. Additional support may be needed for community canvassing, potentially through coordination between CHWs/*promotores(as)* and firefighters going out together, to reach those who are past due on their second vaccine dose or those who will need a booster dose.

Our findings show that some people are unvaccinated because of access issues – including being unable to take time off from work to get the vaccine or to recover from its side effects. Expanding vaccine access should, therefore, include a continuation of efforts that offer vaccines outside of regular work hours and/or at places where community members, including the undocumented, are employed or seek work (eg, Home Depot parking lots). Efforts to offer vaccines at places where community members spend time (eg, barbershops, churches, and local businesses) should also

continue. Ideally, teams of healthcare workers (HCWs) paired with CHWs/*promotores(as)* can work towards administering the overdue second dose vaccines in these locales—or potentially, as some of our participants suggested, at people’s homes—thereby minimizing access barriers.

Despite efforts to ensure undocumented individuals felt safe at the border, some community members continue to express fear about being deported when trying to access the vaccine. One way that the county increased feelings of safety and decreased barriers related to missed work hours was by sending San Diego County Fire to workplaces like farm fields to help with testing and vaccination efforts. These types of efforts should continue.

CHWs/*promotores(as)* suggest that one-on-one conversations are effective in motivating vaccine uptake. Thus, if the vaccine is immediately available during these conversations, this approach might increase the likelihood of someone getting vaccinated. Examples of successful efforts like these in San Diego include [Shots and the Shop](#), the Chula Vista Fire Department’s [Operation Immunity](#), the Mexican Consulate’s [Ventanillas de Salud](#), and the [San Diego County Promotores Coalition](#).

Action: Provide ongoing training and accurate information to healthcare and other frontline workers

Some of our interviewees told stories of healthcare visits during which they were denied vaccines or given misinformation. This affirms the need to provide ongoing training about culturally and linguistically appropriate patient–provider interactions to health care workers and other frontline personnel. A welcoming healthcare environment that takes the concerns of the public into consideration is vital. Cultural sensitivity trainings should be informed by input from community members and the literature on cultural humility. For example, our informants indicated that when addressing Hispanic/Latino individuals, it is important that HCWs demonstrate a level of *personalismo*, or a formal friendliness, as opposed to a business-like transaction when administering vaccines. Using this approach can build trust and may also result in vaccine recipients encouraging others to get the vaccine.

Public health efforts should also include providing HCWs with up-to-date information that reflects the most recent public health findings. By staying current on the latest information being communicated by local, state, and federal public health agencies, HCWs can maintain the community’s trust by providing reliable, accurate information. Along these lines, HCWs who do not accept authorized information as accurate should be removed from frontline duty.

Action: Provide culturally relevant values-leveraging messaging to support vaccination

Cultural humility and sensitivity are one thing; cultural resonance is another. Some people are amenable to changing their minds about vaccination if provided with reasoned messages that are both compatible with their beliefs/values and help people to maintain “face” or self-esteem in the event of choosing what they once rejected (eg, vaccination). This can be particularly important for people who have taken a public or

known stance against the vaccines. Such messaging frees the individual to change their mind without feeling ridiculous or without compromising their identity as a savvy healthcare consumer or citizen. The recent US Food and Drug Administration approval of the vaccine can provide such an out for many.

People's values can also be leveraged directly. The Hispanic/Latino values emphasized by our participants, such as *familismo* and the penchant to endure (*aguantar*, or “bear up”), can be leveraged; the former with messages regarding our responsibility to protect our family members and the latter with messaging portraying vaccination as a powerful tool to add to the tools already used by individuals (particularly essential 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. Another example would be in churches where the virtue of being one's brother's or sister's keeper has been leveraged to promote vaccination.

Action: Avoid having law enforcement visible or present (eg, ICE, border patrol, police officers) to lessen fear

A common theme in our interviews was that Hispanic/Latino individuals are fearful that visiting a vaccination site may impact their immigration status. Some worry that they may be detained or deported if they visit vaccination sites, particularly if identification is required. Others, who may have immigration applications in process, may be concerned that their applications will subsequently be delayed or denied. It is important to develop protocols and policies that ensure communities of color feel safe at vaccination sites. They must feel protected from any policing and persecution by local, state, and federal law enforcement agencies. Law enforcement operations, such as criminal investigations, immigration enforcements, arrests, and inspections should not be permitted at vaccination sites. In addition, it would be beneficial to refrain from requiring government authorized identification.

Our county heard about these concerns early on and partnered with trusted organizations, like the Mexican Consulate's *Ventanillas de Salud*, to offer COVID-19 testing and vaccinations. In addition, ICE was not allowed at vaccination sites. The County also made efforts to let people know that they were not going to be asked about their immigration status. In addition, community leaders provided resources for people to report concerns and ask questions. These types of efforts are vital to lessening fears around accessing the vaccine.

Action: Develop deliberate policies and actions that separate health or social service systems from immigration and law enforcement systems during pandemics or natural disasters

During the pandemic, it became evident that historical distrust in the government combined with unclear policies contributed to COVID-19 disparities. For example, some community members are unclear about whether San Diego has a “public charge rule,” a rule which would penalize people who are seeking visa, residency, or citizenship

applications/processing if they are considered a public burden. This concern keeps some from accessing the vaccine and other types of medical care. Some community members told us, for example, that they became homeless during the pandemic and did not want to seek any services because they feared doing so would impact their residency status.

It is critical to disseminate the most up-to-date information for health/social services or systems as it relates to immigration and law enforcement, especially in border regions. A local public service campaign can be used to widely share accurate information and correct misinformation regarding the public charge policy and immigration policy. San Diego has done much for our immigrant communities but even greater advocacy is needed for policies that ensure that undocumented individuals or individuals seeking residency/citizenship are not affected by the public charge rule during time of emergencies. Creating and distributing informational materials within healthcare facilities and surrounding neighborhoods that clarify misinformation regarding the public charge policy and immigration policy.

Recommendation 3: Invest in and implement educational efforts at multiple levels that teach technology skills and promote digital media, scientific, and health literacy

Action: Develop and fund training about technology and digital literacy

Many participants in our study lamented a lack of computer skills and digital literacy in their community and the ways this undermined vaccine uptake. To correct that, we must develop and implement a training program to provide community members with the skills and tools necessary to utilize technology and to accurately interpret digital information. Digital literacy provides individuals with the capability of interpreting and accurately communicating information found through digital platforms.

The benefit goes beyond knowing how to sign up for a vaccine. Throughout the COVID-19 pandemic, worksites had to quickly train staff on systems that allowed them to work virtually. However, not all community members and, importantly, not all HCWs or CHWs/*promotores(as)* were provided with such opportunities. It is critical to partner with organization leaders to work on proposals advocating the need for digital training for HCWs and CHWs/*promotores(as)*. With government officials working with organization leaders, funding agencies can recognize the importance of funding these programs. One example of this is the World Health Organization's [Digital Education for Building Health Workforce Capacity](#). Researchers could help with identifying grants based on eligibility.

Action: Develop and fund media and science literacy programs in schools, libraries, and community meeting houses such as churches and barbershops/salons

In response to concerns regarding low media and science literacy, it is imperative to create partnerships to implement media and science literacy programs in a wide variety of community settings. These programs will help individuals learn how to identify accurate information and to determine if something is credible. Organizations such as

About Face and the Center for Media Literacy offer programs that can be used as models to develop future programs for media and science literacy. Additionally, online resources are offered by Project Look Sharp, KQED Education, Media Literacy Now, and Canada's Media Smarts.

Conclusion

The COVID-19 pandemic has disproportionately impacted communities of color. In San Diego County, efforts in South San Diego to create effective and equitable vaccine rollout have largely been successful. Our findings and recommendations should help supplement those efforts and provide support for their continuation. In addition, our recommendations may be relevant and applicable for communities in other areas that share some of the characteristics of the south region of San Diego. The types of interventions discussed in this report are needed in all communities, particularly in those that are typically underserved.

The recommendations outlined in this report are meant not only to support recovery from the pandemic but also to ensure collaborative, effective partnerships among key community stakeholders. It is through these partnerships that we will continue to address health equity issues, enhance systems, build trust among communities of color, and support collective agency for overall health and wellbeing moving forward.

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Appendix A. Recommendations from National Report

Urgent Actions: Take immediately to improve vaccine coverage within underserved communities

1. Humanize delivery and communication strategies for COVID-19 vaccines

To reverse the vaccination campaign's current slowdown and persistent unevenness in vaccine coverage, the campaign should support more peer-led and neighborhood-based opportunities for community conversation and for convenient vaccine access. Health systems and health departments should develop and/or strengthen their collaborations with community-based organizations (CBOs), FBOs (faith-based organizations), and community health workers (CHWs) and, importantly, commit to maintaining these relationships after the COVID-19 pandemic subsides. CBOs, FBOs, and CHWs should play a key role in identifying reasons for low vaccination coverage and should be involved in developing interventions to address those issues, such as providing vaccines at locations community members perceive as safe, familiar, and convenient. Groups and people communicating about COVID-19 vaccination should target as many social settings as possible—in person, on air, and on screen—to create multiple opportunities that prompt peer-to-peer conversations about vaccination. Individuals do not make their decision alone, even if they make the final decision about getting the vaccine.

2. Anchor COVID-19 vaccination for hard-hit areas in a holistic recovery process

First, public agencies, hospitals and health systems, nonprofit social service providers, CBOs, FBOs, and CHWs should align themselves around a “whole person” model of recovery to meet underserved communities' self-identified needs (eg, food, housing, jobs, mental health support) and to multiply the benefits of each vaccination encounter. A wraparound service approach provides the sense of safety and security important to informed health decision making. Second, local and state jurisdictions should take immediate steps to plan for long-term recovery and community resilience by: (a) convening a cross-sector council of stakeholders, including Black and Hispanic/Latino leaders, CBOs, FBOs, and CHWs to apply a whole-of-community, whole-of-government approach; and (b) engaging existing data-driven coordinating bodies that already facilitate disaster recovery, economic development, and other long-range planning.

Essential Actions: Execute steadily to create systems-level changes and advance health equity broadly

3. Develop a national immunization program to protect people throughout the life course

During the COVID-19 vaccination effort, public health authorities and government leaders at federal and state levels should capitalize on an already highly successful national immunization program for children, building out systems to provide broader coverage for COVID-19 vaccines and the 13 other vaccines recommended for some or all adults. Tasks include reconfiguring funding systems to support a life-course (versus childhood-only) approach to immunization, facilitating the integration of adult immunization with other health systems and priorities, and developing systems to

monitor program progress and measure social and economic impacts. The funding support must be adequate to ensure health departments have sufficient staffing to oversee progress in enhancing adult immunization uptake and can take corrective actions if progress is judged to be inadequate.

4. Rebuild the public health infrastructure, properly staffing it for community engagement

Political leaders at all levels should allocate steady core funding for the public health infrastructure, sustaining its capacity to respond to future emergencies and address prevalent health challenges (eg, diabetes, heart disease) that affect communities of color in greater numbers. A mandatory national investment of \$4.5 billion per year in a public health infrastructure fund will ensure a predictable minimum capacity at state and local levels. State and local officials should provide steadfast support to agencies that protect the health of their populations. Furthermore, state and local health departments should commit to the strategic goals of promoting equity in their ranks at every level, including their boards of health, and strengthening human-centric competencies through the recruitment of more social and community proficient professionals, such as health educators/promoters, risk communicators, language translators, social media strategists, and sociobehavioral researchers.

5. Stabilize the community health system as the backbone for equity and resilience

Federal, state, and local leaders should take steps to formalize and finance the country's struggling, but promising, community health system. Through community roots and shared experiences, CHWs build trust with clients while navigating health and human services systems, bridge client and provider cultures to adapt service delivery and better meet needs, and advocate for system-level changes that will improve clients' access to care and overall health. In consultation with local, regional, and national CHW networks, federal and state officials should create sustainable financing strategies (including Medicaid reimbursement) for community health work on disease prevention, health promotion, and social determinants of health. To generate opportunities and a career ladder, state legislators should authorize a CHW workforce development plan; public health officials should work with human resources systems to create positions at varying levels of experience. To acknowledge the deep social assets and community organizing abilities of CBOs, FBOs, and CHW-led organizations, public and private funders should provide grants directly to these entities, adapting funding processes and eligibility criteria to create an environment where communities with the greatest need benefit from funding first.

Appendix B. Environmental Scan

In response to the global COVID-19 pandemic, CommuniVax and other local groups in California have reached out to the community in order to evaluate how best to address life-threatening disparities in vaccination uptake in South San Diego, a hot spot of COVID-19 cases. The communities with a long-standing history of disparity have become the most vulnerable, with disproportionate rates of COVID-19 cases. With this in mind, various groups have made efforts to diversify community outreach, tailoring COVID-19 vaccination messaging to reach wider audiences. While the increase in resources and services in the community served to enable many more residents to receive vaccinations, preexisting disparities in the community continue to create barriers. To request a copy of the environmental scan, please email us at communivax@sdsu.edu.

Appendix C. Other Concerns Generated by COVID-19

In addition to data regarding vaccine uptake, we asked community members about other concerns. Many participants found stay-at-home orders stressful, often for the same reasons we hear about nationally: the pressures of homeschooling, lost incomes, increased domestic violence, fears of possibly exposing others to the virus, disparities in how various household members perceived and handled COVID-19 risks, lack of exercise, too many people in the house. They also observed the following.

Isolation and fear of public spaces. Many participants referenced a “Mexican” penchant for big family gatherings when expressing sadness at not being able to see relatives and friends. As Serena, a 62-year-old mother of 3 adult children and *transfronteriza*, said, “Mentally it's affected because they can't have the human contact that we had access to ... a hug, a kiss, a handshake.... A pat on the back. All that human contact is very necessary. Those hugs, those kisses of welcome and goodbye.... That is very important.” Not only the loss of such contact but the effort that went into refraining from making contact caused Serena stress: “you repress yourself and that affects you mentally.” Some also feel frightened to go shopping or to other public spaces. This agoraphobia continues today for many, as we have not yet conquered *el COVID*.

Survivor guilt. The way death had to be handled, given pandemic restrictions, was also stressful. Juliet, a 28-year-old who works in the United States and spends her weekends in Tijuana, Mexico, spoke of a relative's passing: “death is going to happen to everyone. But like that, she had to be wrapped in plastic.... I feel like it takes away a little bit of your dignity as a person ... stripped from her clothes and they wrapped her in plastic ... [The granddaughter] wanted to put, like, nice clothes on her and say ... goodbye to her. But she couldn't ... because I think it [COVID-19] lingers on the body.”

Angie explained it this way:

We were notified, “your sister's brother-in-law died, well, sorry.” “So-and-so's husband died, well, sorry.” “Your cousin so-and-so's brother died, well, sorry.” And so, “sorry, sorry, sorry.” And ... you couldn't do anything. Feel sorry for the people, right? For the ones that were left alive, and the ones that died, well, so what. Well, the people who remain, are the ones who are left with pain with the suffering, remorse if they didn't have clear accounts with that person. Or they also felt bad because they went to the hospital and they were not allowed to enter, their relatives died alone and when they took them out they were given just a little box. They didn't even know if it was really them or not, because they didn't give them the dead, they gave them a little box of ashes and “here it is, this is so-and-so.” That was tremendous, for the relatives of those who had a direct death of someone, it was quite traumatic.

Costs borne by children. Those who depended on less expensive (or, if familial, free) help from people who crossed the border were left in a bind due to US strictures. For instance, Christina’s babysitter could not cross the border to work, which “put a major stress on us with childcare.” Not only adults experience this stress: children also paid a price due to gaps in caregiver attention. Participants expressed distress regarding a perceived “loss of childhood” too. For instance, Aimee (a 38-year-old mother of 2 small children), reported, “There wasn’t really kids playing outside. The parks were empty . . . I also have heard stories about, from family friends, it’s affected their kids mentally, where kids are really depressed and contemplating um suicide, that kind of stuff.” Many expressed worry over basic educational backsliding also.

Educational and informational inequity. Inequity was exacerbated by the pandemic in numerous ways, including through the intersection of school closures and the digital divide. Said Bianca, “Some of the community members that I know, like, that like might be undocumented, they don’t even have an email. So how could they, like . . . their kids need an email to enroll into online classes.”

Another exacerbating factor stemmed from the fact that not all Hispanic/Latino people speak Spanish and that, too, intensified problems, including in regard to communications about COVID-19 itself: Angie (a 53-year-old mother of 3 adult children) highlighted “the lack of resources for, especially for undocumented people, for lack of information. Because, I do not know. It is not in Spanish they speak another language.” (The participant didn’t specify what other languages, but she was likely referring to Indigenous languages such as Mixtec.)

Economic Inequity. The pandemic also laid bare certain forms of inequity that our functioning economy relies upon. For example, Mario (a 65-year-old retired man) said that “a lot of people . . . now they say ‘why am I going to work,’ if those who were earning \$15 an hour were earning much more with the incentives that the government was giving.” Juliet, a student who crossed the border to stay with her parents on weekends, specifically observed how employment practices undertaken in response to the pandemic put unskilled workers at risk in the name of profit. Participants also observed the extra debts incurred when more people were at home during the workweek; for instance, Bianca said “Our utility bill has exploded.”

Health inequity. The pandemic had further impact on health equity. Some said that preexisting health problems, including weight and mental health challenges, were exacerbated by the “confinement” (Angie) or being “locked up” (Conchita). Bianca reported, “My husband has some cousins with preexisting health issues like severe asthma. So they were definitely, they absolutely could not go outside. They didn’t want to risk going outside.”

Regular healthcare visits stopped for many, as well. This was the situation for Bianca’s grandmother:

All her doctor’s appointments had to be canceled because of COVID[-19], because it was too, too high risk for her to go, even if, because she

had some health conditions that she just routinely follows-up on like once a month or once every 2 months. And the doctors just straight up canceled all her appointments. It's not even worth risking her to come down for just a checkup because of COVID[-19]. Yeah, that definitely affected her a lot.

Overwork and exposures in some occupational categories also were highlighted. Juliette spoke of exposures her boyfriend endured working in an establishment that did not enforce the mask mandate for guests. Christian reported “we'd be breathing and Lysol all day.” He also spoke of “the stress, you know, it was physically draining to, you know, just when it first first started, we were working 13-hour days just to, you know, keep up with the flow of people [in the store]. They were just, you know, people would just mass buy. It got pretty hectic.”