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Meanings of health and healthcare in a U.S. border region: a culture-centered approach to health disparities

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Health disparities influence health and health-related outcomes in a multitude of ways, and can be attributed to the unequal distribution of social, political, economic, and environmental resources. This study uses the culture-centered approach (CCA) to illuminate health experiences, meanings, and negotiations of 15 individuals residing in a border region of southern California. Through a qualitative semi-structured interview process, the study identified four main themes: the impact of structural deprivation and stress on health, barriers to U.S. healthcare and transborder negotiations, confronting English hegemony in healthcare interactions, and turning to traditional medicine when biomedicine is unavailable. The study contributes to health disparities research by providing a nuanced exploration of how power dynamics and systemic inequalities shape the experiences of cultural communities as they resist, negotiate, and adapt to inequitable health and healthcare environments. Through amplifying the voices of cultural participants, the study opens alternative pathways for constructing health and puts forth a vision of healthcare rooted in relational and anti-capitalist models of healthcare.

KEYWORDS
critical health communication, culture-centered approach, immigrant health, health literacy, border health

1 Introduction

In public health research, the term “health disparities” refers to inequities in health and healthcare experienced by populations based on social, racial, ethnic, economic, and environmental characteristics (Gee and Ford, 2011; McClaran et al., 2022; Riley, 2012). Health disparities are typically attributed to the unequal distribution of social, political, economic, and environmental resources (World Health Organization, n.d.), also known as the “social determinants of health” (SDH) or “nonmedical factors” that influence health (Akerman et al., 2011; Cohen et al., 2000). For the last 20 years, the U.S. federal *Agency for Healthcare Research and Quality* (ARHQ) has published reports on healthcare quality and disparities across more than 250 measures (e.g., patient safety, person-centered care, and effective treatment) (ARHQ, 2024). There has also been a proliferation of health disparities research evidenced in journals such as *Journal of Health Disparities Research and Practice* with disparities measured in terms of incidence, prevalence, mortality, and burden of disease. Much of this research, however, has been conducted within a positivistic paradigm, emphasizing generalizability, objectivity, and quantifiable outcomes. While statistical data play an important role in identifying what health disparities exist and where they occur, they often fall short in capturing the lived experiences and contextual realities of those affected by these inequities. Indeed, health disparities research runs the risk of becoming reified if proper attention is not given to how communities experience, understand, and resist violations of their health. Without identifying underlying power dynamics that shape quantitative accounts, such research can reinforce the scientific gaze and erase the embodied subjectivities and resilience of cultural communities (Chowkwanyun, 2011).

The culture-centered approach (CCA) to health communication (Dutta-Bergman, 2004; Dutta, 2018), rooted in critical and postcolonial theories, does important work interrogating the entanglements of culture, structure, and agency in the health experiences of individuals impacted by structural marginalization and health disparities. In contrast to the positivistic paradigm, which emphasizes quantification, objectivity, and neutrality, the CCA operates from a critical and postcolonial perspective, emphasizing subjectivity, power inequities, and the decolonization of hegemonic narratives, structures, and knowledge as central to advancing health and social justice. The CCA proposes that the starting point for addressing health disparities is the co-creation of "legitimate spaces for recognition and representation of hitherto erased meanings" (Dutta, 2018, p. 241). By focusing on the "interpretive etiological frames used to talk about disparities by members of such communities" (Dutta et al., 2017, p. 1241), the CCA intervenes upon the objectifying hegemonizing gaze of science revealing opportunities for transformation.

Drawing on the CCA, this interview research study explores how participants from diverse cultural backgrounds living in a border region of the United States understand, negotiate, and communicate meanings of health. The study offers a unique contribution to health disparities research by shifting away from the traditional positivistic paradigm and offering insights into health disparities at the intersection of culture, structure, and agency and rooted in day-to-day experiences, history, and memory. Through the co-creation of interview spaces, this study democratizes health disparities research by centering the voices, experiences, and realities of individuals and highlighting how health exists within a complex matrix of systemic factors that are experienced collectively. Identifying structural barriers to good health and how health is defined, constructed, and negotiated can pave the way for policy that can better address the needs of marginalized populations (Dutta, 2008).

The San Diego region provides a compelling context for exploring how socially disadvantaged populations experience health disparities because of its rich racial, cultural, and linguistic diversity. Not more than 20 miles from the U.S.-Mexico border, San Diego is a multicultural region with 3.2 million residents and a large immigrant population born outside of the U.S. (approximately one third of residents), of which nearly 67,900 are undocumented (Wong and Sanchez, 2020). Demographically, 74.4% of the population in San Diego County is White, 35% Hispanic or Latino (Hispanics may be of any race, so also are included in applicable race categories), 13.1% Asian alone, 5.6% Black, 1.4% American Indian and Alaskan Native alone, 0.6% Native Hawaiian or Other Pacific Islander alone, and 5% two or more races (United States Census Bureau, 2023). 40% of San Diego residents speak a language other than English at home, nearly double the national average of 21.1% (City of San Diego, n.d.). In terms of socio-economic status, 10.7% of the population lives in poverty (United States Census Bureau, 2023), with 8.2% of households, and 13% of households with children under 18, receiving SNAP food benefits (Tableau Public, 2024). In terms of healthcare, 7.4% of those under 65 do not have health insurance, 47.4% of the population relies on employment plans, 16.8% on Medicaid, 9.77% on Medicare, 3.72% on military or VA plans, and 14.9% on non-group insurance plans (Data USA, 2022).

2 An overview of health disparities, barriers to healthcare, and migrant health

According to the National Institute on Minority Health and Health Disparities (NIMHD),

> A health disparity is a health difference that adversely affects disadvantaged populations in comparison to a reference population, based on one or more health outcomes. All populations with health disparities are socially disadvantaged due in part to being subject to racist or discriminatory acts and are underserved in health care (2024, para. 5).

Populations may be disadvantaged due to race, ethnicity, national status, and socioeconomic status, leading to differential health outcomes in comparison to a reference population. Some examples of health outcomes tracked by health disparities research include incidence and/or prevalence of disease, earlier onset or more aggressive progression of disease, premature or excessive mortality from specific health conditions, and worse outcomes on validated self-reported measures for specific conditions (NIMHD, 2024). Health disparities research goes beyond biological and individual factors to examine environmental influences, "social determinants" (or nonmedical factors), and/or healthcare or systemic factors impacting health (Centers for Disease Control and Prevention, 2023b, 2024). According to the NIMHD (2024), the central core of health disparities research involves identifying how race, ethnicity, and socioeconomic status interact with social determinants, individual behaviors, the physical and cultural environment, and biological systems, to lead to differential clinical and population health outcomes.

Key social determinants that influence health (Akerman et al., 2011; Cohen et al., 2000) include financial, structural, and cognitive barriers, which can prevent socially disadvantaged populations from fulfilling their healthcare needs, acquiring health knowledge, and gaining access to basic health resources (Carrillo et al., 2001). Financial barriers deal with the cost of health and how being uninsured or underinsured affects the ability to schedule medical visits and afford necessary medications, tests, or treatments among vulnerable populations (Carrillo et al., 2001; Levy and Meltzer, 2008). Structural barriers refer to the availability and location of healthcare services, facilities, transportation, and childcare (Beal et al., 2007; Stoddard et al., 1994). For example, Black patients who live in racially segregated areas are more likely to receive surgery at lower-quality hospitals than white patients, suggesting that "black-white disparities in mortality are attributable to differences in hospital quality" (Dimick et al., 2013, p. 1046). Cognitive barriers relate to patients' health literacy, awareness of accessible health services, patient-provider communication, and linguistic challenges that arise in the process of navigating the healthcare system (Bach et al., 1999; Betancourt et al., 2002; Carrillo et al., 1999; Stanton, 1987; Stiles et al., 1979). These barriers impact health outcomes experienced by communities resulting in health disparities. Disadvantaged social groups further experience a lower quality of healthcare due to discrimination and bias (Shepherd et al., 2018). Healthcare providers may provide differential care because of biased beliefs or attitudes toward patients' race and culture (Shepherd et al., 2018). For example, one study found that discrimination was related to decreased quality of care and unmet healthcare needs (Benjamins and Whitman, 2014). Discrimination is also associated with poorer physical and mental health status due to possible psychosocial stress (Williams et al., 2003) and lowered pregnancy outcomes for women (Adebayo et al., 2022).

Migrant populations face increased intersectional challenges navigating healthcare on account of race, immigration and employment status, and linguistic concerns; some barriers include worries about missing work, lack of cultural competency, fear of deportation, language barriers, fear and distrust of healthcare, and logistical/transportation concerns (Derr, 2016; Hacker et al., 2015; Pereira et al., 2012). Many immigrants, even those who are eligible, struggle to navigate complex health insurance application procedures and, as a result, may remain uninsured (Alarcon, 2022; Anderson and Olson, 2018). For example, one health communication study sought to understand how low-income Bangladeshi immigrants in New York City navigate health issues amid structural disparities (Dutta and Jamil, 2013). Participants' experiences highlighted the systemic shortcomings of healthcare, exposing critical gaps such as inadequate resources to address cultural and language barriers, as well as the limitations of health insurance in providing comprehensive services and treatment options. These challenges often compelled participants to rely on social and community networks for support (Dutta and Jamil, 2013). Health disparities research further illuminates how social determinants can have a profound impact on the health of immigrant communities and children. For example, one study revealed the sizable range of challenges immigrant families experience, including poverty, food insecurity, housing instability, limited educational opportunities, restricted access to healthcare, stigma, marginalization, difficulties with acculturation, and fear of deportation (Chang, 2019). The study concluded that physicians have a crucial responsibility to be aware of the social determinants of health and to provide culturally competent care tailored to the needs of vulnerable populations.

3 The culture-centered approach and health disparities

The CCA falls within the area of critical health communication because of its focus on power inequities in relation to material structures, knowledge, and discourse. The CCA argues that current theories and approaches to health communication, rooted in Eurocentric ideology, offer cognitive-behavioral approaches as tools for preventing illness and disease, but rarely consider the role that environments and power structures play in ill health (Dutta, 2008). The CCA illuminates how the three components of "culture," "structure," and "agency" cohere in the constitution of health and health practices of communities (Sastry et al., 2019). "Culture" is defined as community values, practices, and meanings negotiated through meaning-making processes, "structure" involves the systems of organizing that either provide or deny access to resources, and "agency" refers to the enactment of daily choices and decisions amid structural constraints expressed through communication, negotiations of structures, and the transformative politics of resilience and resistance (Dutta, 2008).

The CCA has been used to examine the material and communicative processes by which communities are marginalized in the health arena. For example, one CCA study in the Global South focused on health disparities related to hunger in West Bengal, India, addressing barriers to food access and structural inequities within those cultural communities (Dutta et al., 2013). Another study explored the interdependence of context, access, and communication in health meaning-making among rural men in West Bengal (Dutta and Basu, 2008). The study found that disenfranchised men engaged with their available structural resources and enacted agency, formulating communicative strategies to take care of their health needs and those of their families. In the Global North context, a CCA study explored how African American residents in Indiana experienced and made sense of stress, discovering that many stressors were grounded within existing social structures, including struggles in the pursuit, maintenance, or sustainability of employment (Dutta et al., 2017). Across these studies, the voices of participants attest to the complexities of health disparities and how disparities are connected to structural contexts with short- and long-term consequences for marginalized communities.

The CCA considers meaning-making processes of marginalized community members as central to understanding alternative pathways to health and healing (Dutta, 2008; Sastry et al., 2019). The CCA critiques the hegemonic discourses of biomedicine arguing that the fields of medicine, public health, and health communication are rooted in reductionist Eurocentric ideology, where health is reduced to the absence of pain and biomedical markers (Dutta, 2008). Mainstream public health discourses also tend to focus on "personal responsibility" and "individual lifestyle changes" (i.e., eating healthy and exercise) as central to health and well-being, while disregarding the social, cultural, and structural determinants of health (de Souza, 2024). While mainstream public health discourses have evolved to address structural determinants of health (e.g., NIMHD, 2024), many still overlook the importance of co-creating meaning and developing epistemological frameworks that challenge the status quo. The CCA highlights power dynamics and actively engages communities in articulating the forms of oppression that threaten human health at the margins, while working toward transforming these structures. For example, one CCA study examined how the Indigenous Santali people living in West Bengal, India articulated health meanings; it found that health was attributed to the availability and provision of food for the family, access to modern medicine, and the wellness of forests and environments; health was also linked to activating and organizing for access to resources (Dutta-Bergman, 2004). Another study of low-income families in Singapore explored how limited financial resources presented agentic challenges forcing participants to prioritize daily basic needs of food and housing over other needs such as education and transportation and in doing so, developing critical consciousness around political economic issues (Tan et al., 2017). Overall, the studies demonstrate how health meanings are continually constructed through negotiation with material disenfranchisement related to health and wellness, intertwined with ongoing processes of meaning-making around these challenges.

While much CCA work has been done in the South Asian context, the entanglements of culture, structure, and agency among U.S. cultural communities living in marginalizing contexts remains unexplored, with a few notable exceptions (e.g., Carter and Alexander, 2020; Dutta et al., 2017; Yehya and Dutta, 2015). This study seeks to fill this gap by attending to the local constructions of health meanings in underserved communities living in a U.S. border region. By using the voices of cultural participants to theorize power dynamics that produce health disparities, the study seeks to intervene upon the objectifying gaze of scientific, medical, and public health research that often fails to capture the agentic struggles cultural communities confront in healthcare contexts.

4 Method

The findings reported in this paper are part of a larger study seeking to understand health, food, and related structural vulnerabilities among individuals living in a U.S. border region. In-depth interviews were conducted by trained undergraduate health communication students between February and April 2023 in San Diego County. A total of 34 participants ranging in age from 18 to 62 were interviewed, with 27 identifying as female and 7 identifying as male. Twelve participants self-identified as white and 15 as nonwhite (i.e., 10 Latino/Mexican/Hispanic, 2 Middle Eastern, 2 mixed race, and 1 Asian). Verbal and written consent were received from all participants (IRB Protocol #: HS-2023-0138).

Notedly, while the study included interviews with 34 participants, this paper reports on the interview transcripts from 15 participants who self-identified as belonging to racially or ethnically disadvantaged groups (i.e., participants were asked to use their own terms/label for their racial/ethnic identity). We excluded participants who identified solely as white because after coding all transcripts, we noticed a clear pattern where participants belonging to racially/ethnically disadvantaged groups or who identified as "white and another race" articulated barriers to healthcare more frequently and consistently than white only participants. Consistent with the CCA and given the saturation of stories and anecdotes around healthcare barriers, we felt it would be more valuable to foreground the experiences of these participants. As with most qualitative work, we acknowledge that our personal backgrounds, positionalities, and subjectivities played a role in these methodological decisions (Ellingson, 2017).

Considering the fluid and complex nature of racial/ethnic identity in this border region, and potential concerns about disclosing national status, we did not require participants to choose among preexisting racial/ethnic categories, rather participants were invited to self-identify their race/ethnicity and primary language spoken at home. Participants were asked to use their own terms/labels for their racial/ethnic identity. So, for instance, some would state their identity as "White and Mexican" or "Black and Asian." In the paper, we refer to participants as "cultural participants" rather than "immigrants" or "migrants" because of individuals' varying relationships to the U.S. state; some participants had spent their entire lives in the U.S., while others had migrated here after childhood and moved fluidly across the border on a regular basis.

The semi-structured interview protocol consisted of 22 questions designed to elicit participant's meanings, interpretations, and experiences related to health, healthcare, and other structural vulnerabilities. Interview questions were open-ended such as: Would you consider mental health an important part of your overall health and well-being? And what does the phrase "healthy lifestyle" mean to you? Except for two interviews, all were conducted in person and lasted 30–75 min. Participants were asked to choose pseudonyms for themselves.

The interview data were analyzed using phronetic iterative data analysis, where phronesis is concerned with developing contextual action-oriented knowledge, while iteration refers to a cyclical analytic process moving between data, literature, and theory (Huffman and Tracy, 2018; Tracy, 2018; Tracy and Hinrichs, 2017; Tracy, 2020). This process allows for a more flexible approach allowing the researcher to address practical problems through the data (Tracy, 2018). The first step involves a line-by-line coding of a sample of the transcripts or "descriptive primary cycle coding," where the researchers attend to the data setting aside analytical questions (Huffman and Tracy, 2018). At this time, two researchers (i.e., first author and undergraduate student author) performed a detailed line-by-line coding of a sample of the transcripts ($n = 6$) coding for initial descriptive codes that captured key ideas and meanings. Some examples of codes included: lack of geographic access to food, high cost of nutritious food, and work stress/work life balance. Discrepancies between researchers during this process were resolved through consensus. The next phase involved "secondary-cycle coding" or moving the data from descriptive to analytic "second-level codes" (also known as focused codes, axial codes, or themes) (Tracy, 2018). This process was conducted by the first author and involved interpreting, organizing, and theoretically synthesizing codes. For example, the codes "geographic access to food" and "work stress/work life balance" were brought under the umbrella theme of "structural deprivation/barriers." A code book was created, where each axial code was defined/explained along with the various codes that fit within each conceptual theme and an example of each code. The rest of the data were subsequently coded and categorized under conceptual themes.

Once the data from the 34 transcripts had been through the secondary cycle coding, the authors engaged in a more abductive style of reasoning, which included sifting through the data, thinking through the axial codes, their key meanings, and how they related to the CCA. It was at this time that the authors uncovered the pattern where participants who self-identified as belonging to a marginalized racial or ethnic group articulated similar barriers to health and healthcare. Consistent with the flexibility offered by phronetic iterative analysis (Caiata-Zufferey, 2018; Tracy, 2020), at this time we removed the transcripts of white-only identifying participants to focus analytic attention on the data of cultural participants. This meant re-reading the original transcripts of cultural participants and asking if we had missed anything theoretically relevant. Through an iterative process, we organized our initial themes into more theoretically significant findings (e.g., "confronting English hegemony") to mirror the critical roots of the CCA. Finally, we used the "jeopardy question" technique (Huffman and Tracy, 2018) to formulate the research question; this is a research technique, in which researchers generate questions that the data is already well-positioned to address. Based on this heuristic, the research question ultimately settled upon was: How do cultural participants construct meanings of health and healthcare?

5 Findings

Overall, participant narratives underscored a deep awareness of the social determinants of health, and these nonmedical factors impacted their day-to-day health and well-being. Participants discussed four main concerns: the impact of structural deprivation and stress on health, barriers to U.S. healthcare and transborder negotiations, confronting English hegemony in healthcare, and turning to traditional medicine when biomedicine was unavailable. Dutta (2008) conceptualizes "structures" as social contexts that both constrain and enable access to health. In this study, participants' understandings of health were deeply influenced by structural forces beyond their control; nevertheless, they demonstrated resilience by actively resisting and navigating these oppressive forces to manage their health.

5.1 Impact of structural deprivation and stress on health

Participants echoed the social determinants of health discourses by invoking broader structural factors (i.e., policies, systems, institutions, and environments) that impacted their health. Specifically, participants brought up the importance of safe housing, clean water, and the environment in shaping their health and health behaviors. Lewis (23, M, Black/Asian) described how having financial means is the primary step to attaining a healthy lifestyle:

> I think there are several factors that play into my upkeep of a healthy lifestyle. Being able to have adequate finances is a big one for me, like being able to pay for clothes and definitely being able to properly feed myself with nutritious items, not just empty calories. Having access to a gym or just a location where it is safe enough to work out and be physically active. Having access to clean water and safe housing to sleep goes unrecognized sometimes, but it plays a crucial role. Just being in a demographically safe environment enables me to take care of my health.

Other participants described challenges of finding healthy food options and the cost of food as a primary barrier to maintaining a healthy lifestyle. Betoy (56, M, Filipino) noted: "The challenges I face [in maintaining a healthy lifestyle] include finding healthy food options in my area and the high cost of healthy food, which can make it difficult to maintain a balanced diet." Living in "food deserts," defined as areas with restricted access to affordable and nutritious food (Dutko et al., 2012), was a persistent concern for participants, not surprising given the fact that 25% of San Diego County is classified as a food desert (County of San Diego, 2019). In lower-income communities, fast food outlets and convenience stores are disproportionately prevalent, while wealthier and predominantly white communities typically have greater access to supermarkets and produce markets (Hilmers et al., 2012). These disparities in access to food illuminate racialized food injustice as a critical determinant of health (Pine and de Souza, 2023). In this study, the inequitable distribution of nutritious food shaped how participants engaged with healthy behaviors, causing some to resort to eating unhealthy food due to its accessibility and affordability. Participants were unable to exercise personal agency, as they lacked the freedom and capacity to make healthy decisions within structures that severely constrained their access to resources (Dutta, 2008).

The role of stress and work-life balance came up frequently in the discourse of cultural participants. For example, in discussing work stress, Lisa (24, F, Mexican) invoked biochemical pathways through which stress weakened the immune system. She stated, "If you are feeling mentally well or you are not mentally prepared for something, then your physical body is going to feel it in the end. Let us say you have a lot of stress in your day or in your week, maybe at the end of the month you are going to get a flu or you are not going to be that much energetic." R.O. (20, F, Filipino) worked 30 hours a week while also taking 20 credits at college: "I do not have time for myself and to me, a healthy lifestyle is about balancing everything and so that's a challenge I have in maintaining that." Articulating her understanding of a healthy lifestyle, Sandra (27, F, Hispanic/White) stated:

> Going outside, eating properly, you know, not being too stressed… I try to work out a couple of times a week at least and then you know, my eating habits are probably not aligned with the healthy lifestyle just because of how busy I am with work and everything.

With these depictions, we see how health is in fact, a privilege that is challenging to obtain and sustain when encountering structural constraints. Balancing the work of a full-time job that is physically and mentally pressing yet does not pay sufficiently, the pressures of providing for one's family, and living in a resource-deprived area are few among numerous factors that prevent individuals from achieving a healthy lifestyle. While participants agreed that structural factors (e.g., food, physical environments, employment/work) were essential to leading a healthy life, these factors were often out of reach for most participants, as a result maintaining one's health was an ongoing negotiation of agency and resilience amid challenging environments.

5.2 Barriers to U.S. healthcare and transborder negotiations

Participants discussed ongoing struggles navigating and negotiating U.S. healthcare; they used the healthcare system sparingly because of concerns around cost and quality of care. Across the board, participants noted that they only saw a provider when they had acute health problems, "extreme emergencies," and had already lived with the pain for a while. Their reluctance to use the healthcare system was influenced by a host of factors including the "prioritization of health risks" referring to the idea that "health is managed - and understood - as a constant set of choices and sacrifices among essential goods and services" (Dutta et al., 2017, p. 1248). When asked if she sees a provider right away, Sandra (27, F, Hispanic/White) noted the delicate balance of prioritizing risks:

> I don't normally go right away. Honestly, I think I wait too long because you know, I'm busy with a lot of stuff to do at work and at home. I don't really have the time unless I know that it's something I actually need to go there for.

In this instance, Sandra's demanding schedule prevented her from seeing a healthcare provider promptly, as other responsibilities took precedence. Lisa (24, F, Mexican) discussed trying to self-medicate in the hopes that the problem would go away and she could avoid the "whole process." Andrea (21, F, Pakistani and Filipino) described the multiple hidden costs involved with seeing a healthcare provider in the U.S.:

> And imagine the cost of everything! The costs aren't like the medical bills themselves, but also the time that you take to get out of work and that's like less money in other ways. But just not

> getting a proper solution right away, it's just really inefficient, so why even bother to go through the hassle if it's going to be like that?

Here we see how unjust labor markets exacerbate the inefficiencies of healthcare. The issue is particularly acute for workers without paid sick leave, who are three times more likely to forgo medical care compared to those with paid sick leave (DeRigne et al., 2016). Service, retail, and hospitality jobs often place low-income workers at the highest risk of delaying medical care for themselves and their families (DeRigne et al., 2016). For participants in this study, precarious employment meant that they often left health issues untreated, furthering their health risks.

Health insurance was another factor that determined whether participants sought care. Lewis (23, M, Black/Asian) noted that the U.S. healthcare system was extremely confusing for lay people with the complexities of insurance types and billing, referrals, specialists, and medical jargon. Many discussed being underinsured or not wanting to utilize insurance because of out-of-pocket costs. Chave (61, F, Mexican) stated that without insurance, her cholesterol medication was nearly $900 a month and her pre-diabetic prescription close to $1,000 a month; she constantly struggled to get the insurance company to cover the medications. A few participants, who served in the military, compared their experiences in different healthcare systems. Chris (23, M, Mexican) noted how he only sees a physician now if the pain was "constantly noticeable," but when he was in the military: "I could wake up in pain and walk across the street to the medical facility on base and meet with someone."

In addition to access, participants mentioned the lack of care and respect they experienced in the U.S. healthcare system on account of a more "business-like" model being used. Angela (37, F, Latino/White) explained that when she goes to see the doctor, she does not feel like a priority, rather "You're just kind of in there to get what you need and go":

> I wait until I can't take it because the doctor's office I go to is kind of like you're in and you are out… She does answer my questions, but at the same time, it feels like you are just getting the answer to shut you up. I mean it's hard to find a really good doctor.

Clarissa (21, F, Middle Eastern) similarly noted being hesitant to reach out to providers:

> I haven't had many that act like they are really there for my well-being and care, but instead it's just like a business and so I feel bad wasting their time when they make me feel like I'm wasting their time, especially if it's an issue that will resolve on its own.

In this excerpt, Clarissa illuminates the importance of genuine caring relationships in healthcare. Maintaining a professional relationship that fosters care and understanding between patients and providers contributes to patients' well-being showcasing how health is rooted in relationships and healthcare providers are gatekeepers of health and well-being (Dutta and Basu, 2008).

In this border region, several participants of Mexican heritage noted traveling to "TJ" (Tijuana, Mexico) and other regions in Mexico for healthcare. Traveling across the border could take anywhere between 1–6 hours depending on traffic and length of wait times at border security. Despite this, participants felt it was a more efficient and affordable option. Gomez (22, M, Latino) shared a time in which he had flu-like symptoms, and instead of visiting the doctor in the U.S., he "took a quick trip to TJ" to get medicine, and "felt so much better within the coming days." M.R. (26, F, Mexican) spent the first half of her life in Mexico and compared how easy it was to get care there. When someone is unwell, she explained, they can visit "very accessible little clinics" to take care of their needs:

> I've had healthcare there [Mexico] for the first half of my life. It actually wasn't a healthcare system where I pay like a month-to-month plan. It was basically you got sick and you would go to the clinic and in Mexico, they have very accessible little clinics you could go to and it's not expensive like urgent care in the U.S. It's more economically accessible, just readily available whenever you need it. Literally, inside pharmacies, there are doctors for you.

For participants, a key difference between the two healthcare systems was accessibility, affordability, efficiency, and effectiveness. Notedly, crossing the border for healthcare is not uncommon in southern California, where nearly 1 million Californians traveled to Mexico for medical, dental, or prescription services during 2007 alone (Wallace et al., 2009). More recently, Miller et al. (2020) evaluated over 400 accounts of individuals who had traveled to Mexico for healthcare finding their primary motivations were quality of care and cost. All in all, these border-negotiations of healthcare illuminate agentic capacities of participants in navigating the U.S. healthcare system, which is often inaccessible and cost-prohibitive. The narratives reveal how Hispanic and Latino-identifying participants demonstrate a strong sense of agency and resilience as they make sense of and negotiate their health and healing.

5.3 Confronting English hegemony in medical interactions

A key concern within participant narratives was the "hegemony" of English in U.S. healthcare; English hegemony refers to a situation in which English dominates over other languages resulting in injustices and inequalities accruing to non-English speaking people (Tsuda, 2008). In the U.S. healthcare system, English is the primary language spoken by medical professionals and most processes, procedures, and paperwork are also performed in English. In this context, participants described confusion, anxiety, trauma, and discrimination stemming from being non-Native English speakers. Betoy (56, M, Filipino) noted his early experiences in the U.S.:

> When I first immigrated to the United States, I did have an uncomfortable experience because my English wasn't the best. My physician at the time did not have the most well-versed outlook to other cultures so to speak, so the pressure, I did not know how to speak English along with having a doctor who didn't really care that I had a problem just filled the room with uncomfortability… This made me feel that my health needs were not being fully addressed and that my healthcare was not as effective as it could be.

English hegemony is amplified in the healthcare system because of the lack of professionally trained and competent interpreters. Although California state law requires hospitals to have interpreters available on-site or by telephone 24 hours a day (California Department of Managed Healthcare, n.d.), it does not guarantee that the interpreter will be culturally competent. As seen in this excerpt by Chave (61, F, Mexican):

> I think for those of us for whom English isn't the first language, we have a very difficult time trying to express your symptoms, your feelings, or your concerns effectively. It's difficult and sometimes we refuse to have an interpreter because they just make it more confusing. I've had interpreters that aren't very good, and they make it more confusing.

Experiences of feeling "othered" because of cultural background also came up in the discourse. When asked if he feels like an active participant, Gomez (22, M, Latino) replied:

> I feel like an active bystander in my healthcare. I do open up and explain how I feel and ask questions, but I feel like my needs are never really addressed. I feel like I'm under a Eurocentric microscope, but honestly I'm just extremely stressed in the medical environment, so instead of explaining myself more I will just take what they say.

In using the phrase "Eurocentric microscope," Gomez reinforces a fundamental argument of the CCA that biomedicine and its associated practices are rooted in Eurocentric, white hegemonic structures that marginalize and "other" those outside the folds of privilege.

Many participants described childhood experiences of being forced to translate and advocate for parents at a young age, resulting in emotional distress. Since parents could not communicate in English and there were no interpreters, children had no choice but to translate as seen by Alicia (20, F, Middle Eastern):

> So sometimes when I was little, I'd have to take my grandparents to doctor's visits, and I would have to speak English for them. So, at a young age, it was confusing and hard translating between two languages and trying to make sure you get the right thing across. Because when your grandpa is saying he has high blood pressure, but translates it as high glucose, it's not the greatest thing for the doctor… So, it's just like, around 15 or 14 years old, taking my grandparents to doctors' offices and being confused. I just had a hard time having to step up for my grandparents.

In the above excerpt, we see the emotional and cognitive burden Alicia faced in having to translate for her grandparents as well as the need for trained medical interpreters to navigate divergent cultural alignments in language, where specific words and phrases may be used in different ways across languages (e.g., Do et al., 2020).

Participants shared experiences where they were called upon to translate for family members in medical emergencies resulting in deep and ongoing trauma. M.R. (26, F, Mexican) described a harrowing experience when her mother underwent gallbladder surgery:

> This was a major surgery, so my dad didn't want to step in because he's not that fluent in English, so everything fell on me. I just remember the doctors giving my mom papers to sign. I remember my mom was just like "read this!," "what does it say?," and "what are they going to do?" I'm 14 years old and I don't know what half the papers say. People are just telling me to sign it and that this paper is for anesthesia and that paper is for another thing. Looking back now that I'm older there could have been a thousand things that could have gone wrong. It's definitely hard because you feel responsible…It's honestly scary to me still because my mom was trusting me with her life, and it was just a lot.

Participant narratives highlight the language labors of children whose parents do not speak English and the trauma that results from it. As M.R. gets older, the true significance of what happened, and its potential disastrous implications weigh heavily on her. Gonzalez et al. (2022) show how in Latino families, bilingual children help immigrant parents obtain urgent and non-urgent health information with intergenerational health information brokering that occurs. While the agency of cultural participants and families in navigating precarious situations is palpable, it is important to name and acknowledge the deep costs of such brokering and the ongoing trauma that children confront because of the hegemonic power of English in the U.S. healthcare system.

The struggle to advocate for their parents continued even into adulthood as described by Lewis (23, M, Black/Asian):

> My mom, from Japan, has a pretty thick accent so it can get hard for others to understand her sometimes. One time, my mom was sick, and was on the phone with a receptionist about her symptoms, and the receptionist was being extremely rude to her. She was ignoring my mother's concerns and was convinced that my mother was not speaking English. This made my mom distressed and caused her to hang up. I called the receptionist back and told her how rude it was for her to shut my mother's concerns down like that. In this case, I had to push someone past their preferred limits and force them to listen, to make sure my mother was given the healthcare that she needed.

In this example, we see the notion of English hegemony play out where patients are devalued because they do not speak standard English or speak English with accents. Even before Lewis' mom entered the physical space of the U.S. hospital, she experienced discrimination on the phone because of her accent. The lack of empathy, tolerance, and patience with regard to non-English speaking patients is emblematic of the power and racism that English conceals. English is a hegemon not only because it is the most widely used language in the U.S., but because it contains notions of value and worth linked to racist Eurocentric ideologies, which further perpetuates linguistic injustices and health disparities. Language then is not only about the exchange of information but is itself a structure that contains and conceals ideological power—a key source of widening health disparities in the U.S.

5.4 Turning to traditional medicine when biomedicine is unavailable

The use of home remedies and cultural medicine were important to participant's healing practices with hot teas, herbs, oils, and plants frequently brought up; however, even as participants described the value of traditional medicine, they often engaged with these therapeutics because they lacked adequate access to biomedical healthcare. In articulating the value of home remedies, Lewis (23, M, Black/Asian) described himself as "a big believer in tea." Chave (61, F, Mexican) used Chinese herbal medicines such as "roots, flowers, and many other things" stating they had fewer side effects than prescription medications; she also visited the "huesero" (similar to a chiropractor) for problems with her bones, a practice rooted in pre-Columbian tradition and culture in Latin America. Gomez (22, M, Latino) shared how his Latino background influenced how he cared for himself: "If there's anything about a Mexican household, it is that your mom or *abuelita* will have a tea, plant, or traditional method for healing." He shared how his mother would soothe burns by wrapping *aloe vera* leaves around the wound to help with the healing. Chris (23, M, Mexican) explained how his mother would "use orange peels and honey to help with congestion." Across participant articulations, we see the important role that cultural and familial backgrounds play in shaping the alternative care practices participants engaged in.

The analysis uncovered a significant tension in participants' use of traditional medicine: while they valued alternative healing practices, they also turned to these methods because of the inaccessibility of the U.S. healthcare system. For Betoy (56, M, Filipino), herbs and "hilot" were used to manage pain and other symptoms because he could not afford western biomedicine:

> There have been times when I have not gone to the doctor's office because of insurance concerns. One time, I was not able to afford the cost of a specialist consultation because my insurance did not cover the full cost. I ended up not going to the appointment and I tried to manage my symptoms on my own. I resolved the situation by seeking alternative and more affordable healthcare options.

M.R. (26, F, Mexican) did not grow up with access to the U.S. healthcare system, so even though she has access to it today, she continues to use home remedies for fear of a disastrous bill:

> It does take me a while to seek help if I'm feeling bad. I usually rely on over-the-counter medicine. If it's just a cold or a cough, I'll try to do some teas or something like that before I go to healthcare. I think because growing up I didn't have actual healthcare we would actually have to go to a clinic and if you found out that it was something bad you end up paying a lot of money because you need to see a specialist and go to the hospital. You're just always hoping it's something minor, so you try to avoid the doctor…

In these excerpts, we observe how participants relied on traditional remedies for what they considered more minor health concerns, hoping that the issues resolve themselves without the need for professional medical intervention. M.R.'s articulation also reveals childhood trauma associated with the lack of access to healthcare- a bone-chilling fear of finding out something is very wrong, but not having enough money to pay for treatment. This fear is now central to M.R.'s identity and even though she has health insurance today, it lingers on shaping her engagements with the U.S. healthcare system.

Across multiple articulations, the role of familial structural deprivation emerged as a critical factor shaping how participants engaged with biomedical and cultural medicine in the present day. For many, their limited use of the formal healthcare system is traced back to their childhoods, the ways they were socialized by family members, and the traumatic experiences of close family members. Angela (27, F, Latino/White) when asked if she had a spiritual or cultural approach to healthcare, replied "I do not know, maybe … My mom never really took us to the doctor so much either like growing up, so maybe that's why I'm like that." Lewis (23, M, Black/Asian) echoed similar childhood experiences:

> It has a lot to do with what I grew up with. I guess I never had the habit of going to the doctors for every "minor" inconvenience, and my parents never really reached out to doctors immediately. They would definitely try to soothe and fix the problem with other things before running straight to the doctor, so I think I have inherited their beliefs in that sense.

Alicia (20, F, Middle Eastern) grew up with immigrant parents who also did not have good access to healthcare. She explained "our parents really would not take us, me, and my brother to the hospital unless we were dying …" As children, they got "Vicks Vapor Rub rubbed on our chests" and were told to rest. Alicia has a similar relationship to the healthcare system even as an adult stating: "I usually wait to go see a doctor if I'm not feeling well… Unless I'm bleeding out or I have a really big concern."

Some participants accounted for their non-utilization of U.S. healthcare through familial stories of trauma. Andrea (21, F, Pakistani/Filipino) shared how her family would always go to the doctor as "a last resort." Growing up, her friends would get annual physicals, but not her; her mother would tell her to eat healthy and exercise and then "you'll be fine in life." Andrea knew there was something more to the story, but only learned it later in life:

> We came from the Philippines when I was six. When we first got here, I developed this cough that was really bad and it kind of went on for a long time. There were a lot of factors like we didn't have a car at this time and we were staying with my uncles and didn't even have our own space. There were so many external factors that made it so I couldn't go to the doctor. But it got so bad to the point where my mother's co-worker took us, like it was this whole thing. They said I had developed a whooping cough and if I had gone in any later I would have died, like I would have died! That's crazy. My mom cries every time because she feels so bad, but it wasn't just her fault, it was so many things where she couldn't.

Overall, these articulations reveal participants' reluctance to seek treatment in the healthcare system. The hesitations and fears toward the U.S. healthcare system were influenced by various factors, including affordability of medication, fear of hidden costs, and intergenerational trauma. In these narratives, participants' affinities and orientations toward biomedicine viz-a-vis alternative healing practices (and even public health discourses) were formed through intergenerational trauma experiences linked directly to the lack of access to adequate and high-quality healthcare in the U.S. healthcare system. While using traditional remedies are not harmful in themselves, health consequences may ensue when more serious health conditions that require western medical intervention are overlooked or left untreated. Furthermore, it is possible that when individuals do not go in to see their doctors for annual check-ups or minor ailments, they are also less inclined to seek care for serious emergent concerns because of the discomfort or lack of familiarity with the system.

6 Discussion

This study sought to understand the health meanings, experiences, and negotiations of cultural participants living in a border region of the U.S. The study identified four main concerns: the impact of structural deprivation and stress on health, barriers to U.S. healthcare and transborder negotiations, confronting English hegemony in healthcare interactions, and turning to traditional medicine when biomedicine was unavailable. Across these narratives, we see how "health becomes articulated as a context-rich phenomenon, embedded in the shared meanings and life experiences of the participants and constituted through the dialectical tensions between structures that constrain health, and human agency that seeks to transform these structures" (Dutta and Basu, 2008, p. 561). Specifically, this discussion section will focus on (a) trauma, (b) hegemony, and (c) agency as central to the shared meanings and experiences of participants followed by contributions of the CCA to health disparities research.

6.1 Trauma

A key finding of this study was how fear, distrust, and a disrespect of western medicine were linked to intergenerational trauma experienced within the U.S. healthcare system. Intergenerational trauma has been defined as the emotional and psychological wounding that one generation experiences but is prolonged, affecting the well-being and overall health of the following generations; poor well-being reflects either direct actions of current events, or direct and indirect effects of traumatic incidents experienced by previous generations (Bombay et al., 2009; Cerdeña et al., 2021; Sangalang and Vang, 2017). Intergenerational trauma has been studied in refugee groups (e.g., Sangalang and Vang, 2017), First Nations people in Canada (e.g., Bombay et al., 2009), and in various ethnic groups (e.g., Cerdeña et al., 2021; Lee et al., 2023). While extant literature affirms structural, cognitive, and racial/cultural barriers as well as "historical trauma" linked to health disparities (e.g., Hacker et al., 2015; Walls, 2023), the voices of participants in this study show how using the U.S. healthcare system is itself steeped in trauma that runs through families and cultural communities. The U.S. healthcare system is itself a *site* and *source* of significant trauma for cultural communities. Trauma was related to the fear of unsurmountable medical bills, uncertainty around language and linguistic discrimination, as well as the terror of death and dying in an unwelcome system. Cultural community members were exposed to trauma through their negative interactions with agents working within the system (e.g., medical providers, interpreters, insurance agents, and receptionists etc.) as well as negative health outcomes endured as a result of inadequate care. The healthcare arena meant to offer care was often a site of danger and neglect; indeed, participants used cultural healing practices because like their parents before them, they were too traumatized to re-enter the system.

6.2 Hegemony

The hegemonizing force of English in U.S. healthcare spaces further contributes to trauma experiences by cultural community members. The voices of participants challenged dominant definitions of "health literacy" conceptualized as the degree to which individuals (and organizations) have the ability to find, understand, and use health information and services (Centers for Disease Control and Prevention, 2023a) and is associated with skills such reading fluency, prior knowledge, communication competence, and scientific competence. However, missing in these understandings is an acknowledgement of the hegemony of English that pervades the U.S. healthcare system and how this connects to racism and trauma. This research project took place in a U.S. County where 35% of the population is Hispanic or Latino, yet participants did not have access to Spanish-speaking interpreters. Although California state law requires hospitals to have interpreters available (California Department of Managed Healthcare, n.d.), it does not guarantee that the interpreter will be available in a timely manner or culturally competent. Since competent interpreters were often not available in many instances, children had to do the hard work of medical interpretation and language brokering. Instances such as these, where children were forced to serve as mediators, were looked back upon as confusing and difficult as young family members struggled to understand symptoms, medical jargon, and their own emotions. The social pressures that children faced in translating and advocating for family members, intertwined with the structural inadequacies of healthcare, ultimately affected how they engaged with the system later in life.

Related to English hegemony, this study illuminates cultural nuances in spoken language that often go unrecognized in U.S. healthcare. Even if symptoms are experienced similarly, culture can influence the diverse ways in which health disorders are described, referred to as "cultural alignments" in language (Angel and Thoits, 1987). In some instances, language can operate as a vehicle for stigma; for example, the Vietnamese language does not offer specific words to define mental disorders, but rather uses the stigmatizing term "madness" to refer to mental illness, which can discourage help-seeking behaviors (Do et al., 2020; Leong and Lau, 2001; Wynaden et al., 2005). In this study, participants shared various examples of cultural misalignments in language, such as the names of certain health conditions getting lost in interpretation and frustrations with interpretation services not being culturally cognizant. In medical emergencies, children were faced with the responsibility of recognizing cultural misalignments in language and were weighed down by the high stakes of missing key information that could impact a family member's health. For example, Alicia shared how her grandfather described high blood pressure in his native language, but in English, his description was translated as high glucose. Such nuances were challenging to apprehend for young family members, while also deadly given the potential health consequences of incorrect interpretations. In these instances, we see how health disparities are perpetuated through linguistic injustices and the insufficiency of cultural resources in healthcare settings (Quadri et al., 2023).

6.3 Agency

Even amid trauma, participants demonstrated "agency" in how they constructed health and negotiated the inadequacies of the U.S. healthcare system. Agency refers to the active processes through which individuals and communities participate in actions that directly challenge structures; agency is the process of enacting opposition to structures that constrain access to fundamental capabilities (Dutta, 2018; Dutta, 2008). Agency can be witnessed in participants' articulations of polymorphic understandings of health moving between biomedical technologies and cultural practices. In the Global South context, Dutta-Bergman (2004) demonstrated how the Indigenous Santali people engaged in polymorphic health practices using both modern medicine and traditional ways of healing. Similar to the Santali, participants in this study valued polymorphism for its holistic healing, but also because they lacked access to biomedical care. Huesero, hilot, and acupuncture were cultural and familial traditions handed down intergenerationally, which participants used proactively as part of their regular regimens of healthcare and also reactively when they were unable to afford biomedical care. This is the paradox that Dutta (2008) refers to where on the one hand, the Eurocentric orientation of biomedicine systematically devalues culturally rooted practices, but on the other, biomedicine constituted in for-profit models of health is only accessible to elites. Expanding biomedical definitions of health, participants noted that social connectedness and mental wellness were key drivers of good health. Resonating with previous CCA findings (e.g., Dutta et al., 2017), factors such as access to fresh produce, healthcare, and work stress came up frequently. Furthermore, by moving between the U.S. and Mexico, participants revealed resilience and agency, although it is worth noting that transborder negotiations were not possible for all. Participants who identified as Latino or Mexican had a deeper comfort and understanding of how things worked in Mexico, making it easier to seek healthcare across the border; participants with Asian or Arab backgrounds did not articulate seeking care across the border perhaps due to cultural and linguistic barriers suggesting the limited nature of transborder healthcare as a solution to the inadequate U.S. healthcare system.

6.4 Reflections on the CCA and health disparities research

Using the CCA as a theoretical framework provides a powerful lens to understand health at the intersection of culture, structure, and agency for marginalized communities (Dutta and Basu, 2008). While much CCA work has been done in the South Asian context, the entanglements of culture, structure, and agency among U.S. cultural communities remains largely unexplored, with a few notable exceptions (e.g., Carter and Alexander, 2020; Dutta et al., 2017; Yehya and Dutta, 2015). Our study addressed this gap in the literature by examining the locally constructed meanings of health within underserved communities residing in a U.S. border region. Through listening to the voices of people, our study offers insights into how immigrant and border communities engage with the dominant biomedical model of health and healthcare, considering not just access to resources but also the social, political, and cultural factors that shape their health experiences. Our findings join a growing body of CCA research that underscores the urgent need to address power inequities embedded in structural and discursive contexts, which carry significant short- and long-term consequences for marginalized communities.

This study contributes to health disparities research in general by offering deeper, critically oriented insights around health disparities such as those related to trauma, hegemony, and agency. While dominant health disparities research examines social determinants of health through a positivistic paradigm, the CCA operates from a critical lens emphasizing the need for decolonizing hegemonic narratives and knowledge systems. In our analysis, the CCA sensitized us to how stressors of poverty, racial segregation in the form of food deserts, and Eurocentrism interrupted health and healing for cultural communities. While dominant health disparities research might discuss participants as lacking in "health literacy," the CCA allowed us to invoke the language of English hegemony and in so doing shift the lens from individual failings to the colonizing power of English in healthcare spaces. Through the co-creation of communicative spaces that allowed participants to share their healthcare experiences, biographies, and personal history (on their own terms), this study captured the wide-ranging geographical, intergenerational, and cultural contexts within which individuals experience health and disease. By bringing food deserts, English hegemony, and transborder healthcare into the same frame for example, this study underscores how health exists within a complex matrix of systemic factors. Isolating these variables may be useful in certain contexts, but examining these factors collectively is equally critical- because this is how individuals experience the burden of health disparities in their everyday lives- collectively. In so doing, the study offers a way to understand health disparities not as objectified discrete statistics, but as oppressive burdens that come together in the daily lives of individuals connected to history, memory, and familial tragedy. By providing cultural participants with the "right to voice," our research contributes to health disparities research by democratizing sites of articulation of health and well-being (Dutta et al., 2019).

This study contributes to praxis by illuminating the importance of racial, cultural, and linguistic justice in healthcare. Indeed, despite a presumed assumption of "care" in healthcare, in many instances, the U.S. healthcare system was no different from other powerful systems that perpetuate inequity among marginalized communities (e.g., education, criminal justice, and immigration systems). There is an urgent need for safe, accessible, and trauma-informed healthcare spaces that can dismantle intergenerational trauma experienced by communities and ameliorate health disparities. The need to foreground the rights of children in these spaces is critical to intervening in trauma. Furthermore, while healthcare continues to move in the direction of capitalistic, for-profit models of care, this study shines light on the need for restructuring healthcare grounded in relationality. Over the last few decades, research has reflected a movement away from the biomedical model and the primacy of doctors' authority with attention to how patients' needs can best be met through partnership and collaboration (e.g., Duggan, 2006; Street et al., 2009). This study reinforces the idea that caring relationships are critical for providing culturally competent care because the meaning of health itself for many cultural communities is constituted in one's relationship to a provider.

Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

Ethics statement

The studies involving humans were approved by SDSU IRB (IRB Protocol #: HS-2023-0138). The studies were conducted in accordance with the local legislation and institutional requirements. The participants provided their written informed consent to participate in this study. Written informed consent was obtained from the individual(s) for the publication of any potentially identifiable images or data included in this article.

Author contributions

RS: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Resources, Software, Supervision, Validation, Visualization, Writing – original draft, Writing – review & editing. IV-G: Writing – original draft, Writing – review & editing. BP: Writing – original draft, Writing – review & editing.

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