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Including updated case scenarios and new, innovative health programs, the third edition of *Cultural Competence in Health Education and Health Promotion* represents an unprecedented leap forward for this already celebrated series. It's perfect for any health educator who deals with an ethnically or culturally diverse population.

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CULTURAL COMPETENCE *in* HEALTH EDUCATION *and* HEALTH PROMOTION

THIRD EDITION

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Third Edition

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CONTENTS

FOREWORD FOR THIRD EDITION

Why does this book, *Cultural Competence in Health Education and Health Promotion*, matter to the health education profession? First, the demographics in the United States are continuing to change. Reflected in this book, it is predicted that racial and ethnic minorities will be the majority population within the next 20 years. The second reason why this book matters is the health disparity gap between the racial/ethnic minorities and the White/Caucasian population in the United States. African Americans/Blacks, Hispanics/Latinos, American Indians/Alaskan Natives, Asians, and Native Hawaiian and Other Pacific Islanders suffer disproportionally from disease such as cancer, diabetes, HIV infection, hypertension, and unintentional injuries. The question is "How do we address these health disparities, keeping in mind the role of culture?" Thus, the third reason for this book is the importance of health education specialists understanding the cultural issues and their impact upon health education and promotion programs. In order for health education prevention and intervention strategies to be effective, they must be culturally relevant and sensitive to the priority population.

This book is well organized into 13 chapters, with Chapter 1 providing a solid rationale for the need for health education specialists to be culturally competent in order to address the health needs of diverse cultural populations. The chapters are nicely formatted with each chapter beginning with learning objectives, next presenting the pertinent content, and ending with the conclusion, points to remember, case study, and key terms. As a university faculty preparing education specialists, I really appreciate the authors of each chapter reminding the readers of the key concepts of that chapter and allowing the readers to apply what they have learned with the case study. Lastly, in terms of organization, each chapter flows easily and coherently with each other, which is pretty amazing for an edited book. It is obvious that the co-editors spent significant time to make sure each chapter was independent and presented different information (pertinent to culture competence) while building upon each other.

It is worth noting that in Chapter 2, an expanded definition of culture is presented; thus, the authors challenge the readers to think about culture in a broader sense to include concepts such as socioeconomic status, sexual

orientation, communication styles, aging, and physical/mental abilities. These expanded definitions of culture are reflected in the book with chapters on aging, health communication, sexual minorities, and people with disabilities. These chapters help the readers understand the proposed expanded version of culture.

In conclusion, due to the shift in demographics and the diverse cultures in the United States, *Cultural Competence in Health Education and Health Promotion* is an interesting must-read for all practicing health education specialists and other health professionals. I highly recommend this book for as a required textbook for health education preparation programs. If we are serious about closing the health disparities gap between racial and ethnic minorities, we must develop, implement, and evaluate programs that are culturally relevant, appropriate, and sensitive to racial and ethnic minorities. The authors of Chapter 13 challenge us to include culture as a foundation for health education prevention and intervention programs, and they provide strategies and recommendations to start the journey of cultural competence for health education specialists.

Drs. Luquis and Pérez are uniquely qualified to co-edit the third edition of *Cultural Competence in Health Education and Health Promotion*. Along with the aforementioned experience with promoting cultural competence among health educators, they have published extensively on the topic of cultural competence in journals such as the *American Journal of Health Education*, *Journal of Cultural Diversity*, *Journal of Community Health*, and *American Journal of Health Studies*. In addition to publications, they have made presentations at health education/promotion professional meetings and conferences. Finally, Drs. Luquis and Pérez have served in the leadership positions with the former American Association for Health Education (AAHE), the National Commission for Health Education Credentialing (NCHEC), Inc., and the Society for Public Health Education (SOPHE), among others. In those positions, they have continued to promote cultural and linguistic competence.

During the past 30 years as a health educator, I have been involved with advancing the conversation pertaining to cultural diversity issues, including conducting cultural diversity training nationally for public school health teachers and university health education faculty during the 1990s in response to address the changing demographics of students in those settings. At that time, our efforts were focused on raising the awareness about cultural diversity and getting health professionals to have an appreciation for cultural differences. Much of the work was done through my membership with the former AAHE, which led me to work with the co-editors of this book. I have known and

worked with Drs. Luquis and Pérez for over 20 years. During our membership with AAHE, we worked tirelessly to promote cultural awareness, cultural appreciation, and cultural competence among the membership and health educators in general. For example, we served on AAHE's Minority Involvement Committee to increase racial and ethnic minorities in the leadership of the health education profession. Recently, we served as the editor and associate editors of the *Global Journal of Health Education and Promotion*. A major focus of the journal was to publish articles that address health issues from a cultural perspective globally. *Cultural Competence in Health Education and Health Promotion* is a great tool and resource for the enhancement of health education specialists' knowledge, attitude, and skills for developing programs from a cultural perspective. The third edition of *Cultural Competence in Health Education and Health Promotion* is also a great tool to use for the professional preparation of health education specialists to develop cultural competence skills.

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PREFACE

Welcome to the third edition of *Cultural Competence in Health Education and Health Promotion*. This textbook is designed to assist you as you explore the interaction between culture, attitudes, and behaviors and their application to health education and health promotion programs and strategies. The chapters focus on examining selected health indicators of underrepresented groups, discuss best practice models for cultural competence training, and provide strategies for reaching diverse populations while avoiding generalizations and stereotypes based on race, ethnicity, gender, and selected social issues. While no publication can guarantee the reader "cultural competence and linguistic competence," the chapters in this publication are designed to assist on the road to this lofty goal.

This textbook is unique in that it focuses on issues of cultural and linguistic competency as they influence the health education and health promotion field. Each chapter is written by and for health education academicians, students, and practitioners. Each author presents a thorough examination of the literature and research about the impact of culture, race, and ethnicity on health disparities, health equity, communication, beliefs systems, education strategies, and other factors essential to having a complete understanding of cultural and linguistic competency. For the first time, this book includes a discussion on issues related to disabilities; it also challenges the reader to become more knowledgeable about Healthy People 2030, because at the time the work was prepared the document had not been released to the public.

All chapters have been revised or expanded to reflect up-to-date information on cultural and linguistic competency health education, including a new chapter dealing with people with disabilities. Each of the chapters provides key terms and a case study (except for Chapter 13) for students and practitioners to apply the concepts discussed. This textbook contains 13 chapters that center on the common theme of learning and understanding different cultures. Chapter 1, "The Changing US Demographic Profile: Implications for Health Education," provides current information on demographics and descriptions of the profiles of major ethnic and racial populations in the United States. Chapter 2, "Diversity, Cultural Competence, and Health Promotion," focuses on concepts of diversity, race, ethnicity, and culture. Chapter 3, "Health Equity, Health Disparities, and Social Determinants

of Health: Implications for Health Education," addresses social determinants of health and their influence over health and health disparities in the United States. Chapter 4, "Complementary, Alternative, and Integrative Healing Approaches in Culturally Competent Health Promotion," provides an overview of the principles involved in the practice of complementary, alternative, and integrative healing. Chapter 5, "Religion, Spirituality, and Cultural Diversity," focuses on information about religious and spiritual trends and their influence on health, well-being, and health education. Chapter 6, "Theoretical Models, Assessment Frameworks, and Multicultural Populations," describes and provides examples of how to apply two theoretical models and two assessment frameworks that address the role of culture in the prevention of disease and promotion of health. Chapter 7, "Planning, Implementing, and Evaluating Culturally Appropriate Health Programs," has been revised to focus on culture-centered practices that can be incorporated into the planning, implementation, and evaluation of health education and promotion programs. Chapter 8, "Multicultural Health Communication," has been revised to describe the influence of culture on health communication and to identify effective communication strategies to use in multicultural contexts. Chapter 9, "Health Literacy, Health Educators, and Culturally Appropriate Health Education Programs," provides a definition of health literacy, its importance to health education, and the relationship between health literacy and cultural competence. Chapter 10, "Aging Matters: Improving the Health Status of the Older Adult Population," focuses on exploring health promotion efforts and priorities for aging populations. Chapter 11, "Culture, Sexual Minorities, and Health Education," provides information to increase awareness and increase cultural competency when working with the various sexual orientations and gender identities present in the LGBTQ (lesbian, gay, bisexual, transgender, and queer/questioning) community. New to this edition, Chapter 12, "People With Disabilities: Through a Cultural Lens," discusses the health concerns of individuals with disabilities and steps to becoming a culturally competent educator and practitioner when working with these individuals. Finally, Chapter 13, "Beyond Cultural Competency: Moving Forward in Health Education and Health Promotion," provides some final thoughts on the importance of cultural and linguistic competence and discusses how to integrate these concepts into health education and health promotion programs.

The authors and editors of *Cultural Competence in Health Education and Health Promotion* intend that this third edition will continue to fulfill the current and future needs in cultural and linguistic competency for both professional preparation and the development of health education and promotion programs by educators and practitioners. Join us in what we hope will be a lifelong journey toward cultural competence and linguistic competence.

THE EDITORS

Raffy R. Luquis is an associate professor of health education in the School of Behavioral Sciences and Education at Penn State Harrisburg. Dr. Luquis also serves as the professor-in-charge of the health education master's degree and the program coordinator for the biobehavioral health undergraduate degree. He earned his PhD in health science at the University of Arkansas, and his MS in health education and his BS in life science at the Pennsylvania State University. Dr. Luquis has a broad background in health education and health promotion. His primary research and teaching interests include cultural competency and multicultural health, health promotion and education, and human sexuality. He earned the Certified Health Education Specialist credential in 1995 and the Master Certified Health Education Specialist credential in 2011 from the National Commission for Health Education Credentialing. He was a fellow of the former American Association for Health Education and the Research Consortium of the American Alliance for Health, Physical Education, Recreation, and Dance.

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Madelyn J. Smith is a special educator with an emphasis on inclusive practices and diverse learning environments. In 2016, Madelyn earned a master of arts degree in special education from the University of Northern Colorado

and will graduate with her PhD in special education from the University of Northern Colorado in 2021. Madelyn proudly serves as a prevention specialist for an organization in the Denver metropolitan area, where she visits schools, businesses, community centers, and detention centers to teach practices to prevent sexual violence. She has presented at many conferences regarding inclusive and diverse practices in a variety of environments. As the sister of an individual with an intellectual disability, as well as an educator, Madelyn proudly serves as an advocate and ally for individuals with disabilities. She fervently champions the rights of people with disabilities and works with schools and organizations to increase equitable, inclusive practices and access for all people.

Chia Thao is a doctoral student in public health at the University of California, Merced, and a part-time lecturer at California State University, Fresno. She completed a BS in health science with a minor in gerontology, and an MPH with a concentration in community health promotion in 2007. Additionally, she earned two distinguished certificates in health policy and nonprofit management & leadership at California State University, Fresno, where she has more than 10 years of experience working with community benefit organizations (CBOs) coordinating health education and promoting programs in the Central Valley. She is the current president for a local CBO organization called Elder Abuse Services Inc. Chia's research interests center on understanding and addressing the links between pesticide exposure and poor health outcomes, particularly among Hmong small farmers in California's Central Valley. Her research experience includes diabetes, reproductive health, mental health, and environmental health in the Southeast Asian community. As a PhD student at UC Merced, she is currently exploring how environmental factors such as pesticide use affect underserved populations in the Central Valley.

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ACKNOWLEDGMENTS

First, we dedicate this publication to our supportive families. Special thanks to our families who through their support, understanding, and patience have made the third edition of this book possible. We love you!

We thank each of the contributors to this book for their dedication to the field of health education and health promotion, and for sharing their knowledge, experiences, and expertise in the chapter they developed. We extend our appreciation as well to the staff at Wiley for their careful review and assistance in the development of this book. We would also like to thank the countless individuals who have helped us along the way and have encouraged us to continue with the work presented in this publication.

Finally, we dedicate the third edition of this publication to all the health education professionals, students, and other health professionals who have read and continue to use this book as part of their academic preparation and resource in their career.

ABOUT THE COMPANION WEBSITE

This book is accompanied by a companion website.

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CHAPTER 1

THE CHANGING US DEMOGRAPHIC PROFILE

Implications for Health Education

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Introduction

The 1985 *Report of the Secretary's Task Force on Black & Minority Health* (US Department of Health and Human Services [USDHHS], 1985–1986) for the first time authoritatively documented the health disparities experienced by different population groups in the United States. This seminal report provided the basis for the science-based Healthy People initiatives, which have established ambitious health benchmarks to be achieved at the end of their respective time frames. Healthy People 2030 was released in the summer of 2020 and provides data-driven health objectives organized by health conditions, health behaviors, populations, settings and systems, and social determinants of health to be achieved by the end of the decade.

Like the previous initiatives, Healthy People 2030 envisions "a society in which all people can achieve their full potential for health and well-being across the lifespan." The framework of Healthy People 2030 establishes five overarching goals to be achieved by 2030 (see Table 1.1) (USDHHS, 2019). Achieving these goals depends on collaboration among all sectors—including but not limited to health professionals, legislators, private entities, and community-based organizations—to ensure that all Americans receive access to health care services, preventive measures, health education, and health promotion.

LEARNING OBJECTIVES

After completing this chapter, you will be able to

- **Identify the five overarching goals present in Healthy People 2030.**
- **Explain demographic changes and population trends in the United States and their implications for health education.**
- **Describe selected characteristics of the major racial and ethnic groups in the United States.**

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Companion website: www.wiley.com/go/luquis/culturalcompetence3e

Table 1.1 Healthy People 2030 Overarching Goals

• Attain healthy, thriving lives and well-being, free of preventable disease, disability, injury, and premature death.
• Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
• Create social, physical, and economic environments that promote attaining full potential for health and well-being for all.
• Promote healthy development, healthy behaviors, and well-being across all life stages.
• Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

Since Healthy People's inception, its initiatives have sought to improve the health status of all Americans by seeking to decrease morbidity rates from preventable diseases and disability, prevent mortality, and create environments that allow individuals to obtain their optimal health status. The goals established in Healthy People 2030 require an understanding of **demographic shifts**[1] and their impact on the health status of selected population segments, as there are goals that are age, gender, and race/ethnicity specific. The purpose of this chapter is to explore the impact of demographic changes on a culturally competent health education workforce. This chapter will also provide a brief description of relevant cultural characteristics for each of the major ethnic groups in the United States and will briefly illustrate the need for understanding health disparities.

Demographic Shifts

Demographic Characteristics

Data from the US Census Bureau (2017a) show that some 325,511,000 people resided in the United States in 2017, continuing an increasing population growth expected to last at least until 2060. Table 1.2 shows the expected population changes from 2020 to 2060. In addition to an increasing population, the Census Bureau also projects that as demographics change, the nation will be more diverse, and the majority of the population will be concentrated in urban areas, continuing a trend started in the late nineteenth century.

Race and Ethnicity

US Census data project a continuing diversification of the US population in terms of **race** and **ethnicity** (see Table 1.3) (US Census Bureau, 2017a). The shifts in the ethnic and racial distribution and the age distribution of the US population denote an urgent need for more culturally competent health

Table 1.2 Projected Population Size (in Thousands).

Year	Population	Numeric change	Percent change
2020	332,639	2,370	0.72
2025	344,234	2,271	0.66
2030	355,101	2,093	0.59
2035	364,862	1,859	0.51
2040	373,528	1,657	0.45
2045	381,390	1,529	0.40
2050	388,922	1,503	0.39
2055	396,557	1,548	0.39
2060	404,483	1,609	0.40

Source: US Census Bureau (2018a). 2017 National Population Projection Tables. https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html

Table 1.3 Projections of the Population by Race and Hispanic Origin for the United States: 2020–2060

Sex, Race, and Hispanic Origin	2020	2030	2040	2050	2060
One race	323,069	342,432	357,252	368,473	379,228
White	253,280	263,453	269,578	272,486	275,014
Non-Hispanic White	198,571	197,992	193,210	185,954	179,162
Black or African American	44,734	49,009	52,919	56,725	60,690
American Indian and Alaska Native	4,232	4,663	5,038	5,341	5,583
Asian	20,009	24,394	28,718	32,850	36,815
Native Hawaiian and other Pacific Islander	813	913	999	1,071	1,125
Two or more races	9,570	12,669	16,276	20,450	25,255
Hispanic or Latino	62,313	74,807	87,616	99,798	111,216

Note: Hispanic may be of any race. *Source:* US Census Bureau (2018a). 2017 National Population Projection Tables. https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html

professionals (Alonso-Palacio et al., 2017) and for health educators to develop programs that are culturally appropriate (Luquis & Pérez, 2005, 2006; Luquis, Perez, & Young, 2006; Pérez, Aunprom-me, Alonso-Palacio, & Valencia, 2016; Perez, Gonzalez, & Pinzon-Perez, 2006).

The 2000 Census marked a shift in how ethnic and racial data are collected; specifically, the Census Bureau introduced a larger pool of options, which allowed individuals, among other things, to select more than one ethnic or racial background. Although controversial at the time, this change has since been embraced because it allows for the identification of individuals of mixed descent.

Foreign Born and Immigrant

According to the US Census Bureau, 13.7% of the US population or almost 44,000,000 people residing in the United States in 2017 were foreign born (US Census Bureau, 2017a). The foreign-born population includes any resident who was not a US citizen at birth. It includes legal permanent residents (immigrants), temporary migrants (such as students), humanitarian migrants (refugees), naturalized US citizens, and persons illegally present in the United States (US Census Bureau, 2017a). Census data show an expected increase in the foreign-born population in the United States for the next three to four decades.

Diversity is also found in the foreign-born population. Table 1.4 contains data about the race and ethnicity of immigrants to the United States as reported by the Census Bureau (2017a). According to the data, Hispanic/Latinos and Asians were the largest groups of immigrants to the United States.

The immigrant population in the United States includes almost 21 million naturalized US citizens and almost 23 million noncitizens (US Census Bureau, 2017a). Approximately 13 million noncitizens are classified as lawful permanent residents, and 1.7 million hold temporary visas (Baker, 2016; Baker & Rytina, 2014; Passel & Cohn, 2016).

It is estimated that some 10.7 million foreign-born individuals were unauthorized immigrants in 2016, compared to 8.4 million in 2007. Data from the Pew Research Center show that about 66% of unauthorized immigrants have resided in the United States for over a decade, and most of them call California, Texas, Florida, New York, New Jersey, and Illinois home (Krogstad, Passel, & Cohn, 2018).

Table 1.4 Race and Hispanic Origin of the Foreign-Born Population

	2020	2030	2040	2050	2060
One race	45,747	52,686	58,934	63,990	67,947
White	27,099	30,815	34,032	36,439	38,059
Non-Hispanic White	8,579	9,823	11,004	12,117	13,198
Black or African American	5,010	5,996	7,084	8,242	9,494
American Indian and Alaska Native	601	627	642	636	609
Asian	12,832	15,021	16,930	18,419	19,525
Native Hawaiian and other Pacific Islander	204	227	245	255	259
Two or more races	957	1,097	1,223	1,319	1,386
Hispanic or Latino	20,740	23,341	25,466	26,772	27,246

Source: US Census Bureau (2018a). 2017 National Population Projection Tables. https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html

As a group, immigrants appear to be integrating into American society rather well. In 2015, less than 15% of immigrants lived in poverty; more than 50% owned their own homes (Uh, 2016), a higher rate than the native-born population; and they are less likely to commit crimes (Landgrave & Nowrasteh, 2017).

Language

In 2015, the US Census Bureau announced that at least 350 languages are spoken in US homes. Changes were also reported for major languages spoken in 1980–2010 (see Figure 1.1). Almost 80% of the US population 5 years and older speaks only English (US Census, 2017a). Of those who speak a language other than English at home, 8.7% report speaking it "less than well."

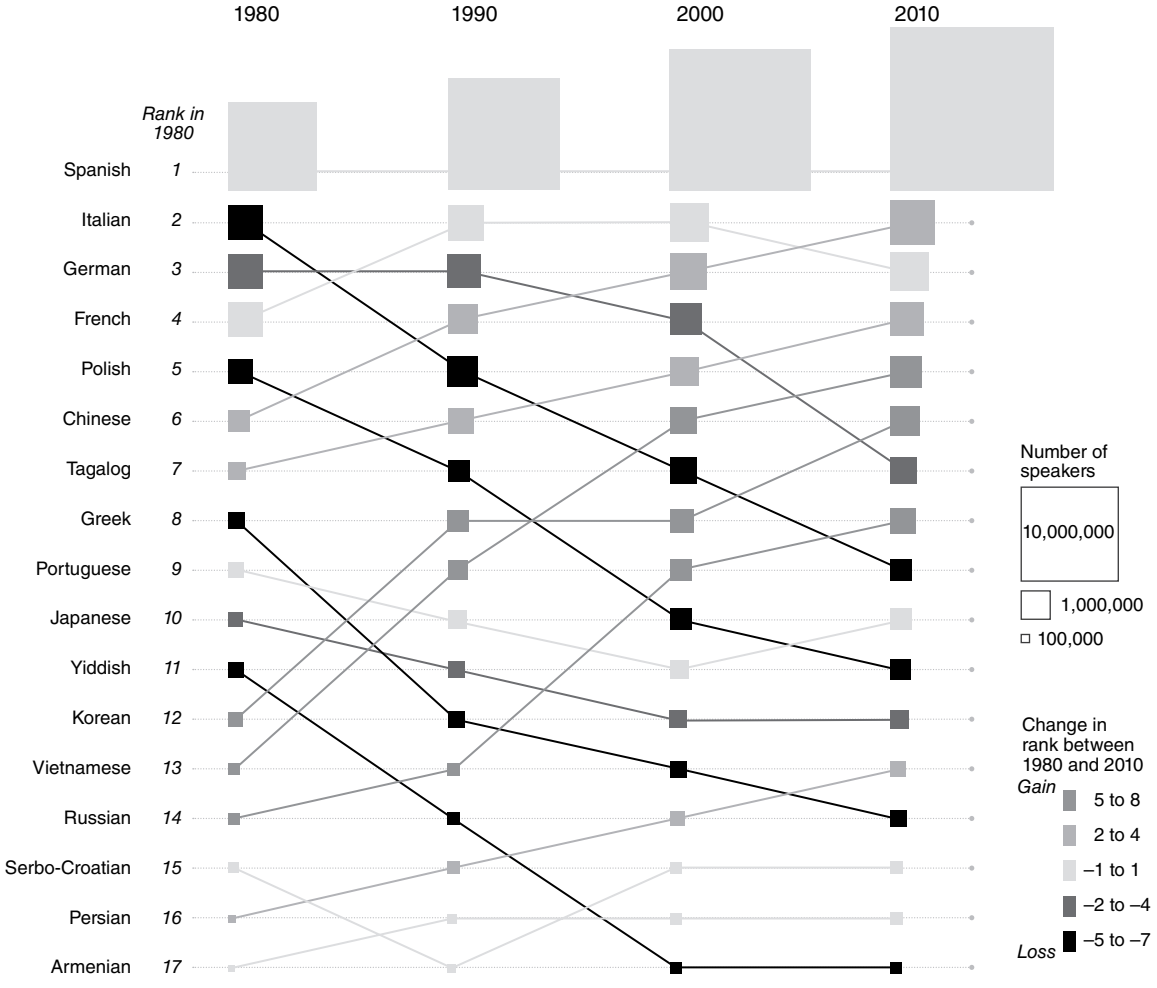

Figure 1.1 Changes in Major Language Spoken from 1980 to 2010. *Source:* US Census Bureau (2013).

Table 1.5 Projections of the Population by Selected Age Groups for the United States: 2020–2050

Sex and age	2020	2030	2040	2050
45–64 years	84,356	84,296	92,000	98,490
65 years and over	54,804	72,092	81,238	88,547
85 years and over	6,597	8,745	14,198	19,041
100 years and over	135	208	298	601

ME: *Source:* US Census Bureau (2018a). 2017 National Population Projection Tables. https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html

California has the largest percentage of residents who speak a language at home other than English (40.8%), followed by New Mexico (36.0%) and Texas (32.5%) (US Census Bureau, n.d.).

The Elderly

The US median age has increased from 35.3 years old in 2000 to 37.9 in 2016. According to the Census Bureau (2018c), "These latest estimates present changes among groups by age, sex, race and Hispanic origin at the national, state and county levels between April 1 2010, and July 1 2016. The estimates also present changes over the same period among groups by age and sex for Puerto Rico and its municipios" (p. 5).

In fact, demographers estimate that the number of individuals in the 65-and-older category will more than double by the middle of this century (US Census Bureau, 2018c). See Table 1.5 for the expected age distribution in the United States from 2020 to 2050.

The elderly population (65 years and above) is characterized by several factors, including more females than males (57% and 43%, respectively, in 2010). Not surprisingly, as the population shifts, the elderly population is also expected to become more racially and ethnically diverse in the future. The proportion of elderly in each of the four major racial and ethnic groups (White, Black, American Indian and Alaska Native, and Asian and Pacific Islander) and in the Hispanic-origin population is expected to increase substantially during the first half of the twenty-first century (Table 1.6).

Gender

According to the Henry J. Kaiser Family Foundation (HKFF, 2017a), 49% of the US population were males and 51% were females in 2017. While these percentages vary from state to state, in general there are more females than males in the US population.

Table 1.6 Projected US Population Distribution by Age 65 and Older

	2020 (%)	2030 (%)	2040 (%)	2050 (%)	2060 (%)
65–84 years					
One race	99.03	98.80	98.48	98.01	97.40
White	83.55	81.27	78.37	75.39	72.80
Non-Hispanic White	75.40	70.76	63.96	57.53	53.54
Black or African American	9.86	11.08	12.14	12.97	14.17
American Indian and Alaska Native	0.78	0.93	1.09	1.21	1.30
Asian	4.71	5.34	6.67	8.15	8.83
Native Hawaiian and other Pacific Islander	0.14	0.17	0.22	0.28	0.30
Two or more races	0.97	1.20	1.52	1.99	2.60
Hispanic or Latino	8.95	11.65	16.04	20.06	21.76
85 years and older					
One race	99.28	99.12	98.94	98.68	98.32
White	86.74	85.13	83.15	80.66	77.42
Non-Hispanic White	79.67	76.97	73.88	68.71	61.26
Black or African American	8.00	8.67	9.79	11.29	12.36
American Indian and Alaska Native	0.52	0.65	0.79	0.97	1.12
Asian	3.93	4.54	5.05	5.57	7.17
Native Hawaiian and other Pacific Islander	0.09	0.12	0.15	0.19	0.24
Two or more races	0.72	0.88	1.06	1.32	1.68
Hispanic or Latino	7.63	8.90	10.23	13.28	18.02

Source: US Census Bureau (2018b). Characteristics of Same-Sex Couple Households: 2005 to Present. https://www.census.gov/data/tables/time-series/demo/same-sex-couples/ssc-house-characteristics.html

Sexual Orientation

Gates (2011) has estimated that 3.5% of adults in the United States, or some nine million people, self-identify as gay, lesbian, or bisexual. Gates further estimates that approximately 0.3% of the population classify themselves as transgendered. These findings support several studies that have estimated that 5–10% of the US population is lesbian, gay, bisexual, or transgender (LGBT; National Coalition for LGBT Health & Boston Public Health Commission, 2002). Nonetheless, it is important to understand that the estimate that 10% of men are gay and 5% of women are lesbian is based on Kinsey Institute data, which may not accurately represent the percentage of LGBT individuals in the population (Gay and Lesbian Medical Association, 2001).

Although the US Census Bureau (2018a) asked respondents to identify their race and ethnicity, it does not contain a question about sexual orientation. The Census, however, does ask several questions about respondents' household composition by marital status and gender of partner. As seen in Table 1.7, same-sex couples are more likely to be younger, educated, living without children, and employed, and to have a higher median household income.

The relative lack of definite data on the size of this population and the fear that many LGBT people, especially youths, have concerning revealing their sexual identity make reliable data difficult to obtain (Perrin, 2002; Rand, 2010). This lack of information makes it increasingly difficult to develop, implement, and evaluate effective health education programs for this population group.

People With Disabilities

It is estimated that approximately 61 million or almost 26% of American adults experienced at least one basic actions difficulty or complex activity limitation, with the most common form related to mobility. According to the Centers for Disease Control and Prevention (2018), middle-aged and older adults are more likely to encounter cognitive disability, individuals with higher income and education are less likely to report a disability, and women are more likely than men to report a disability. Finally, African Americans and Hispanics are more likely to report a disability. These differences may be exacerbated by cultural factors, lack of access to health care, or inability to follow medical directives.

According to Altman and Bernstein (2008), a person's disability or limitation has a direct impact on their perceived health status and their ability to enjoy life. Disabilities and other limitations also impact a person's emotional status and their self-rated health status (Altman & Bernstein, 2008). Please see Chapter 12 for more discussion on people with disabilities.

Demographics of Racial and Ethnic Groups

This section provides a brief overview of the demographic characteristics of the major ethnic and racial groups in the United States. These descriptions will not, of course, apply to every individual who identifies as a member of a particular population group. Instead, they offer overarching generalizations about the characteristics shared by members of each group. Significant differences exist within every racial and ethnic group.

Table 1.7 Household Characteristics of Opposite-Sex and Same-Sex Couple Households: 2017 American Community Survey

Household characteristics	Married opposite-sex couples		Unmarried opposite-sex couples		Total same-sex couples		Total male–male couples		Total female–female couples	
Total households (number)	57,292,082	99,763	6,985,538	28,150	935,229	7,754	451,494	5,268	483,735	6,500
Age of householder	%	Std. Error	%	Std. Error	%	Std. Error	%	Std. Error	%	Std. Error
15 to 24 years	1.1	—	11.1	0.1	4.3	0.2	3.3	0.3	5.4	0.3
25 to 34 years	12.9	—	35.0	0.2	19.5	0.3	17.8	0.5	21.1	0.6
35 to 44 years	19.7	—	21.0	0.2	20.0	0.3	19.3	0.5	20.7	0.5
45 to 54 years	21.3	—	15.5	0.2	21.2	0.3	23.0	0.5	19.6	0.4
55 to 64 years	21.4	—	10.6	0.1	19.3	0.3	20.2	0.5	18.4	0.5
65 years and over	23.6	—	6.7	0.1	15.6	0.3	16.5	0.4	14.9	0.4
Average age of householder (years)	52.4	—	39.6	0.1	48.0	0.2	48.9	0.2	47.1	0.2
Average age of spouse/partner (years)	51.7	—	38.8	0.1	46.4	0.2	46.6	0.2	46.1	0.2
Race of householder										
White	81.0	—	76.6	0.2	82.5	0.3	84.7	0.5	80.5	0.5
Black or African American	7.0	—	10.9	0.1	7.4	0.3	5.4	0.3	9.3	0.4
American Indian or Alaska Native	0.6	—	1.1	—	0.7	0.1	0.6	0.1	0.9	0.1
Asian	6.0	—	2.6	0.1	3.2	0.2	3.6	0.3	2.8	0.2
Native Hawaiian or Pacific Islander	0.1	—	0.2	—	0.2	—	0.1	—	0.2	0.1
Some other race	3.5	—	5.6	0.1	2.9	0.2	2.5	0.2	3.1	0.3
Two or more races	1.7	—	3.0	0.1	3.1	0.2	3.0	0.3	3.2	0.2
Percentage of couples interracial	7.4	—	14.3	0.2	16.0	0.3	18.3	0.6	13.9	0.5

(*Continued*)

Table 1.7 (Continued)

Household characteristics	Married opposite-sex couples		Unmarried opposite-sex couples		Total same-sex couples		Total male–male couples		Total female–female couples	
Hispanic origin of householder										
Hispanic or Latino origin (of any race)	13.1	—	18.3	0.1	12.8	0.3	12.7	0.4	12.8	0.5
White alone, not Hispanic or Latino	72.0	—	65.0	0.2	73.8	0.4	75.6	0.6	72.1	0.6
Educational attainment										
Householder has at least a bachelor's degree	40.6	0.1	27.4	0.2	49.9	0.5	54.1	0.8	46.1	0.6
Both partners with at least a bachelor's degree	25.8	0.1	14.8	0.1	32.2	0.4	34.4	0.8	30.1	0.5
Employment status[a]										
Householder employed	67.5	—	79.5	0.2	74.9	0.4	75.9	0.6	74.0	0.6
Both partners employed	48.7	0.1	62.7	0.2	60.6	0.5	62.0	0.6	59.3	0.7
Children in the household										
Children in the household[b]	38.9	—	38.2	0.2	16.4	0.4	8.5	0.4	23.8	0.6
Own children in the household	38.8	—	35.6	0.2	15.6	0.4	8.3	0.4	22.4	0.6
Household income										
Less than $35,000	12.6	—	20.9	0.2	13.0	0.3	10.4	0.4	15.4	0.5
$35,000 to $49,999	10.3	—	14.6	0.1	9.3	0.3	7.7	0.4	10.7	0.5
$50,000 to $74,999	18.0	0.1	22.2	0.2	17.1	0.4	15.1	0.4	18.9	0.5
$75,000 to $99,999	15.9	—	15.9	0.1	15.0	0.4	14.3	0.5	15.7	0.5
$100,000 or more	43.3	0.1	26.4	0.1	45.7	0.5	52.4	0.7	39.3	0.6
Median household income (dollars)[c]	88,683	109	65,594	202	92,225	783	104,130	1,290	82,063	867
Home tenure										
Own	79.8	0.1	44.3	0.2	66.2	0.5	68.2	0.8	64.3	0.7
Rent	20.2	0.1	55.7	0.2	33.8	0.5	31.8	0.8	35.7	0.7

[a] Employed or in the Armed Forces.

[b] Includes biological children, stepchildren, adopted children, and nonrelatives of the householder under 18 years.

[c] In previous years, this table displayed estimates of mean household income. *Source:* US Census Bureau (2018a).

African Americans

African Americans, or Blacks, are defined as persons whose lineage includes ancestors who originated from any of the Black racial groups in Africa. Contrary to popular belief, African Americans make up a diverse group that encompasses individuals of African descent, Caribbean descent, and South American descent. According to the total population estimates, there were 41.3 million people in the United States who identified as Black or African America alone in 2017, which represented 12.7% of the total population (US Census Bureau, 2017b). African Americans are the second-largest minority population, following the Hispanic/Latino population (HKFF, 2017b).

According to the annual US Census estimates in 2017, 58% of the Black/African American alone population resides in the South (HKFF, 2017b; US Census Bureau, 2017b). In addition, the Black population represents over 45% of the total population of the District of Columbia. Finally, in 2017, the 10 states with the largest African American population were Texas, Florida, Georgia, New York, North Carolina, California, Maryland, Illinois, Virginia, and Louisiana (HKFF, 2017b).

In comparison to the non-Hispanic White population, the African American population has a higher proportion of younger people, its members are less likely to be married, and a large proportion of its households are maintained by women (US Census Bureau, 2017b). In 2017, approximately 86% of African Americans aged 25 and older had completed high school, and 21% had attained a bachelor's degree or higher level of education (US Census Bureau, 2017b); yet these percentages are lower than the percentages obtained by their non-Hispanic White counterparts.

Moreover, African Americans are more likely to be employed in service, sales, natural resources, production, and related occupations (US Census, 2017b). Consequently, in 2017, the African American median family income was less than the non-Hispanic White median family income ($49,549 vs. $82,851), the unemployment rate was twice that of non-Hispanic Whites (9.5 and 4.2%, respectively), and 19% of all families were living below the poverty level.

In 2017, 55% of African Americans in comparison to 75% of non-Hispanic Whites had private health insurance, while almost 44% compared to 34% relied on public health insurance. Finally, a slightly higher percentage of African Americans had no health insurance coverage compared to the non-Hispanic White population (10% and 5.9%, respectively) (US Census, 2017b). According to the Office of Minority Health (OMH, 2019), African Americans generally had a higher death rate than non-Hispanic Whites for heart diseases, stroke, cancer, asthma, influenza and pneumonia, diabetes, HIV/AIDS, and homicide.

Hispanics

In 2017, Hispanics accounted for 18% of the US population (HKFF, 2017b) and are considered the largest minority group in the United States. It is estimated that by 2065, they will account for 24% of the total population (Flores, 2017). Hispanics include all those of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

In 2016, among Hispanic subgroups, Mexicans ranked as the largest, at 63% of the Hispanic population, followed by Puerto Ricans, Central Americans, Other Hispanics, South Americans, and Cubans (US Census Bureau, 2018b). The following states reported a population of 1 million or more Hispanic residents in 2016: Arizona, California, Colorado, Florida, Georgia, Illinois, New Jersey, New Mexico, New York, and Texas (US Census Bureau, 2018b).

In general, Hispanics are younger on average than non-Hispanic Whites, with approximately one in three Hispanics being under the age of 18 and with a median age of 28 years. The average age for the non-Hispanic White population was 43 years in 2015 (Flores, Lopez, & Radford, 2017). In 2017, 78% of Hispanics were US citizens, with 66% of Hispanics having been born in the United States (US Census, 2017b).

English language proficiency is increasing among Hispanics. Data from the Pew Research Center indicates that 69% of Hispanics said they speak only English at home (Flores, 2017). Although approximately three-quarters of Hispanics spoke a language other than English (that is, Spanish) at home, less than one-third spoke English less than very well (US Census Bureau, 2017b).

In 2017, Hispanic households were more likely to be family households (76%) than were non-Hispanic White households (64%). While a husband–wife family comprised 48% of the households, approximately one in five households was maintained by a woman with no husband present (US Census Bureau, 2017b). In 2017, 71% of Hispanics completed 4 years of high school or more, a significant increase from the 55% completion rate in 1997 (US Census Bureau, 2018b).

Hispanics were much more likely than non-Hispanic Whites to work in service, sales, construction, production, and related jobs. Hispanics were also more likely to have a lower median family income and to live in poverty than non-Hispanic Whites (US Census Bureau, 2017b). In 2017, about 17% of Hispanic families, in comparison to 6% of non-Hispanic White families, were living under the poverty level. Moreover, 49% and 38% of Hispanics relied on private and public health insurance, respectively (US Census, 2017b). Still, health insurance coverage varies by subgroups, with Puerto Ricans and

Cubans having a higher rate of private insurance than Mexicans or Central Americans (OMH, 2019).

Hispanic health continues to be influenced by factors such as language and cultural barriers, lack of access to preventive care, and lack of health insurance. The leading causes of illness and death among Hispanics are heart disease, cancer, unintentional injuries (accidents), stroke, and diabetes. In addition, Hispanics are significantly affected by asthma, chronic obstructive pulmonary disease, HIV/AIDS, obesity, suicide, and liver disease (OMH, 2019).

Asians

The Asian population in the United States is not homogeneous, as it includes many groups that differ in language and culture (US Census Bureau, 2017b). Asian refers to people who have their origins in the Far East, in Southeast Asia, or on the Indian subcontinent, including people from Cambodia, China, the Philippines, India, Japan, Korea, Malaysia, Pakistan, and Vietnam. In 2017, Asian alone or in combination accounted for 22 million of the US population, with 18.2 million classified as Asian alone (US Census Bureau, 2017b, 2019). In addition, the estimated Chinese population was the largest (22%), followed by Asian Indians (20%), Filipinos (18%), Vietnamese (9%), Korean (8%), and Japanese (6.8%).

The Asian population is younger on average than the non-Hispanic White population. In 2017, Asians had a median age of 36.1, about 6 years younger than non-Hispanic Whites (US Census Bureau, 2017b). Moreover, Asians were more likely than non-Hispanic Whites to be married (58%) and to live in family households (74%), with a higher percentage of households maintained by married couples (61%). Although almost three-quarters of Asians were US citizens, through either birth or naturalization, approximately 66% of Asians were foreign born (US Census Bureau, 2017b). Most importantly, about 51% of foreign-born Asians arrived in the United States after 2000, and about 74% spoke a language other than English at home (US Census Bureau, 2017b).

When it comes to education, approximately 87% of Asians 25 years and older had at least a high school diploma, and 53% had attained a bachelor's degree or higher level of education (US Census Bureau, 2017b, 2019). However, the educational level varied among Asians; for example, 77% of Taiwanese have attained a bachelor's degree. Moreover, Asians were more likely to be employed in management, professional, and related occupations than were non-Hispanic Whites: 51% versus 42%, respectively (OMH, 2019). In 2017, the median family income for Asians was over $13,000 higher than the median family income for White non-Hispanic households ($96,495 vs. $82,851). Still,

about 11% of Asians lived below the poverty level, compared to 9.6% of non-Hispanic Whites (US Census Bureau, 2017b).

In 2017, a high percentage of Asians (74%) had private health insurance coverage, and 26% had public health insurance (US Census Bureau, 2017b). Health insurance coverage varies among Asian subgroups, with Filipinos and Chinese (78% and 72%, respectively) reporting a higher percentage of having private health insurance, and Hmong and Vietnamese (43% and 32%, respectively) reporting the highest percentage of public insurance (OMH, 2019).

Also, it is significant to note that Asian women had the highest life expectancy of any racial and ethnic group in the United States, and Chinese women had the longest life expectancy among all the Asian subgroups. Still, Asians contend with several factors affecting their health, including infrequent medical visits, language and cultural barriers, and lack of health insurance. Finally, Asians are at higher risk than others for cancer, heart disease, stroke, unintentional injuries, diabetes, chronic pulmonary disease, hepatitis B, HIV/AIDS, smoking, tuberculosis, and liver diseases (OMH, 2019).

Native Hawaiian and Other Pacific Islanders

Native Hawaiian and other Pacific Islander (NHPI) refers to people who are natives of Hawaii and other Pacific islands, including people of Polynesian, Micronesian, and Melanesian backgrounds (OMH, 2019; US Census Bureau, 2019). NHPI differ in language and culture across many subgroups. According to US Census Bureau (2017b, 2019) estimates, close to 1.6 million Native Hawaiians and Pacific Islanders alone or in combination were residing in the United States. The Native Hawaiian population was the largest NHPI group, followed by Samoan and Guamanian or Chamorro. States with significant numbers of Native Hawaiians and Pacific Islanders include Hawaii, California, Washington, Texas, Nevada, and Utah (OMH, 2019).

In 2017, the median age for this group was almost 15 years less than the median age of non-Hispanic Whites (28.7 vs. 43.5). In addition, approximately 42% of NHPI aged 15 years and older were married, compared to 52% of the non-Hispanic White population. The majority of NHPI households were family households (71%), with 47% maintained by married couples (US Census Bureau, 2017b). Almost 92% of the NHPI were US citizens by birth or by naturalization, and 72% of them spoke only English at home (US Census Bureau, 2017b).

When it came to education, a high percentage of NHPI had graduated from high school (89%), and 23% had attained a bachelor's degree or higher level of education (US Census Bureau, 2017b). In 2017, almost 70% of NHPI were employed in service, sales, natural resources, and production-related

occupations. The median family income for NHPI of $71,783 was lower than that for non-Hispanic Whites ($82,851). Still, 13% of all NHPI families were living under the poverty level, compared to 6% of non-Hispanic Whites (US Census Bureau, 2017b).

In 2017, almost 67% of NHPI had private insurance, and 34% relied on public insurance (US Census Bureau, 2017b). Data on the health status of this population showed that NHPI have higher rates of smoking, alcohol consumption, and obesity than other racial and ethnic groups do. Some leading causes of morbidity and mortality among this group are cancer, heart disease, unintentional injuries (accidents), stroke, and diabetes (OMH, 2019).

American Indians and Alaska Natives

In 2017, the US Census Bureau (2017b) reported 5.6 million people to be American Indians or Alaska Natives (AIAN), entirely or in combination, representing slightly more than 1.7% of the US population. This group is made up of people who have their origins in any of the original peoples of North, Central, and South America and who maintain tribal affiliation or community attachment. The majority of the AIAN alone-or-in-combination population (78%) lived outside of AIAN reservations or other trust land (OMH, 2019).

In 2017, American Indians and Alaska Natives were younger than non-Hispanic Whites, with a median age of 32.3 years. American Indians and Alaska Natives aged 15 and older were less likely to be married than non-Hispanic Whites (36% and 52%, respectively). Approximately 64% of American Indian and Alaska Native households were family households, with 38% maintained by married couples (US Census Bureau, 2017b). Finally, approximately 80% of American Indians and Alaska Natives aged 5 and older spoke only English at home (US Census Bureau, 2017b).

Information on educational attainment showed that approximately 84% of American Indians and Alaska Natives aged 25 and over had at least a high school diploma, and 20% had attained a bachelor's degree or higher level of education (US Census Bureau, 2017b). American Indians and Alaska Natives aged 16 and older were employed in a variety of occupations, including 31% in management, 23% in service occupations, 23% in sales and office occupations, and 23% in natural resources, production, and related occupations (US Census Bureau, 2017b). Still, the median family income of $55,589 for these two groups was approximately $27,000 less than the median family income for non-Hispanic Whites. Almost 22% of American Indians and Alaska Natives lived below the poverty level, and 15% had no health insurance coverage (US Census Bureau, 2017b).

There are currently 573 federally recognized AIAN tribes and more than 100 state-recognized tribes. Federally recognized tribes receive health and educational assistance from the Indian Health Service (IHS), a federal government agency that is part of the USDHHS (OMH, 2019). This agency operates a comprehensive health service delivery system for two million American Indians and Alaska Natives who reside mainly in reservations and rural communities. However, this population has low accessibility to hospitals, health clinics, or contract health services imbedded by the IHS; consequently, studies have documented a frequency of poor health and limited health care options for this group (OMH, 2019).

Nonetheless, American Indians and Alaska Natives frequently are faced with issues such as cultural barriers, geographical isolation, inadequate sewage disposal, and low incomes that prevent them from receiving quality medical care. American Indians and Alaska Natives are disproportionately affected by heart disease, cancer, unintentional injuries (accidents), diabetes, stroke, mental health issues, suicide, obesity, substance abuse, sudden infant death syndrome (SIDS), teenage pregnancy, liver disease, and hepatitis (OMH, 2019).

Whites

According to the Census Bureau, White "refers to a person having origins in any of the original peoples of Europe, the Middle East, or North Africa" (US Census Bureau, 2011, p. 2). As such, the White category includes individuals who self-identify as Caucasian, Irish, German, Polish, Arab, Lebanese, Algerian, and Moroccan, among others. The White alone population is the largest racial group in the United States, with approximately 197.2 million or 61% of the total population in 2017 (HKFF, 2017b; US Census Bureau, 2017b). Given the racial and ethnic diversification of the population, the White alone population has continued to decrease over the last decade.

The White population is older than the other racial and ethnic groups, with a median age of 43.5 years. In 2017, 64% of the White households were family households, with most of those (51%) being in married-couple families (US Census Bureau, 2017b). In 2017, 94% of the White population aged 25 and older had graduated from high school (US Census Bureau, 2018c), and 30% had attained a bachelor's degree or higher level of education.

In 2017, the majority of the White population (51%) was employed in management, sales, and related occupations. As a result, the median family income of $82,851 was higher than the median family income of African Americans, Hispanics, and American Indian/Alaskan Natives (US Census Bureau, 2017b). Seventy-five percent of the White population had private health insurance, and the overall poverty rate was less than 10%. Finally, the

top five causes of death for the White population are diseases of the heart, cancer, chronic lower respiratory disease, unintentional injuries, and cerebrovascular disease (National Center for Health Statistics, 2018).

Ethnic and Racial Groups Stereotypes and Health Education

While the previous section presented an overall description of the major racial and ethnic groups, health educators should not use these characteristics to make simplistic generalizations or create stereotypes of individuals from those groups. In addition, health educators must determine if an individual fits the cultural characteristics of the group rather than use a stereotype (Purnell, 2014). Stereotypes create myths that can influence how health educators view and think about certain racial and ethnic groups based on their religion, gender, occupation, or nationality (Temple, 2001). For example, a health educator could make the generalization that all Hispanic individuals practice the Catholic faith; hence, there is no need to educate them about contraception, as this would go against their religious beliefs. If the health educator assumes the previous statement to be true, then he or she is stereotyping the individuals based on one Hispanic cultural characteristic and would fail to address these individuals' needs.

Thus, health educators could avoid stereotyping by

- Learning the characteristics of the different racial and ethnic groups and acknowledging the diversity within each group.
- Being aware of how they ask questions to the individual when addressing his or her needs.
- Educating others on how stereotypes affect the process of health education.
- Creating a safe environment in which individuals feel free to discuss any health issue or concern without being judged due to their racial and ethnic background.

Conclusion

The US population continues to become more diverse, and members of underrepresented non-majority groups still face a number of barriers to obtaining optimal health. Health education specialists must work in conjunction with health care professionals not only to improve the health status of these groups but also to attempt to decrease the adverse health consequences

for this population given the kinds of socioeconomic factors discussed in this chapter. Health education specialists must be cognizant of the differences existing between and among ethnic and racial groups in the United States. The following chapters discuss many ways of reaching out to these diverse populations.

Points to Remember

Demographic shifts in the US population involving race, ethnicity, age, and sexual orientation make it imperative for health education specialists to learn how to deliver quality and culturally and linguistically appropriate health education and prevention programs. An accurate understanding of the needs of different ethnic and cultural groups will go a long way toward achieving the goal of reaching diverse groups with prevention programs.

Case Study

Almost all health promotion planning models require the collection of demographic data for the populations to be served. Using US Census Bureau data, create a demographic profile for the county in which you currently reside. Be sure to collect the following information:

1. Total population
2. Age distribution
3. Sex distribution
4. Ethnic and racial composition
5. Educational level
6. Socioeconomic characteristics
   - **a.** Family incomes
   - **b.** Occupational categories
   - **c.** Estimated level of unemployment
   - **d.** Poverty ratios
7. Health characteristics
   - **a.** Vital statistics (numbers and rates of births and deaths)
   - **b.** Incidence and prevalence of diseases (morbidity)
   - **c.** Leading causes of death (mortality)
8. Any other data you consider important for understanding the population in your county

KEY TERMS

Demographic shift

Race

Ethnicity

Note

1. More than one term may be used to refer to a particular population group. For instance, although some people prefer the term *African American*, others prefer the term *Black*. Similarly, although some prefer the terms *Latino* and *Latina*, others prefer the term *Hispanic*, and yet others prefer to list the name of their country first (for example, *Salvadoran American*). This chapter uses the terms used by the US Census Bureau, including *Hispanic*, both *African American* and *Black*, and *White*, *Alaska Native*, *American Indian*, *Asian*, *Native Hawaiian*, and *Pacific Islander*.

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CHAPTER 2

DIVERSITY, CULTURAL COMPETENCE, AND HEALTH PROMOTION

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Introduction

The demographical changes in the United States (see Chapter 1) have a direct impact on health education, health promotion, and public health. Estimated data of the US population show that non-Whites accounted for 38% of the population in 2017, which has continued to grow since 2010 (US Census Bureau, 2019). While the United States has been known for its diversity, the continued influx of individuals from all over the world has created a more culturally diverse society, which at times has resulted in conflict. As a nation of immigrants, culturally diverse, we do not speak the same language, have the same customs, or eat the same food. However, we all acknowledge the existence of cultural differences around us.

Moreover, the cultural diversity in American society has made it necessary to understand the health care and health promotion needs of various racial and ethics groups in an effort to provide optimal services and to understand health-seeking behaviors and attitudes, cultural nuances, and perceptions about health. Health education specialists must be aware of cultural nuances, cultural beliefs and values, and treatment-seeking behaviors to make sure that the optimal services are provided to

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LEARNING OBJECTIVES

After completing this chapter, you will be able to

- **Compare and contrast the concepts of diversity, race, ethnicity, and culture.**
- **Describe key racial and ethnic groups in the United States, including African Americans/Blacks, Asians/Pacific Islanders, Native Americans and Alaska Natives, Whites, and Hispanics/Latinos.**
- **Identify cultural practices among various groups.**
- **Define principles and practices of cultural competence.**
- **Discuss cultural nuances and relevance to particular groups.**
- **Recognize the significance of cultural competency and its importance to health care organizations and public health education.**

a diverse population. Addressing these factors will lead to overcoming barriers to care among racial and ethnic minorities and succeeding in offering quality services leading to the elimination of racial and ethnic disparities.

Given the growth in racial and culturally diverse communities, health education specialists and other public health practitioners need to embrace and value diversity to minimize any form of racial or ethnic oppression and discrimination. Taking a positive stance on issues of diversity requires that health education specialists understand concepts related to diversity, race, ethnicity, and culture as they continue to commit to engage in culturally and linguistically appropriate practices.

Defining Diversity, Race, Culture, and Ethnicity: Implications for Health Education

Diversity

Diversity entails the understanding that each individual is unique and different. As such, we health education specialists must understand that the definition of diversity has evolved beyond race and ethnicity, as diversity includes socioeconomic status, age, Limited English Proficiency (LEP), worldviews, social class, learning style, sexual or gender identity, disability, religion, and college readiness (Saunders Russell, Augustin, & Jones, 2017). Moreover, diversity is a dynamic philosophy of inclusion based upon respect for cultures, beliefs, values, and individual differences of all kinds. Diversity respects and affirms value in differences in ethnicity and race, gender, age, sexual orientation, socioeconomic status, linguistics, religion, politics, and special needs (Betancourt, Green, & Carillo, 2002). Thus, paying attention to diversity is necessary in order to prepare all members of our society to seek common goals of a democratic society (Betancourt et al., 2002).

Race

Historically, **race** refers to the grouping of humans based on shared physical or social qualities into categories viewed as different by society. Race has been used to differentiate people based on language, national affiliations, physical traits, and social construct to create some cultural meaning. However, race is not an inherent physical or biological quality (Barnshaw, 2008). Racial features are genetic and inherited and include elements such as skin, hair, eye color, and susceptibility to specific diseases. Society tends to assign people to racial categories not because of science or fact, but because of opinion and social experience. "Race is an unscientific, societally constructed taxonomy that is based on an ideology that views some human population groups as inherently superior

to others on the basis of external physical characteristics or geographic origin" (Williams, Lavizzo-Mourney, & Warren, 1994, p. 26). In reality, then, race is primarily, though not exclusively, a socially constructed category (Anderson & Taylor, 2009). It is not the biological characteristics alone that define racial groups, but how groups have been treated historically and socially.

According to the US Census Bureau (2018), the racial categories include racial and national origin or sociocultural groups, and do not attempt to define race biologically, anthropologically, or genetically. As such, an individual may choose to report more than one race to indicate his or her racial mixture. For the purpose of data collection, the US Census Bureau classifies race into five categories:

- White—A person having origins in any of the original peoples of Europe, the Middle East, or North Africa
- Black or African American—A person having origins in any of the Black racial groups of Africa
- American Indian or Alaska Native—A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment
- Asian—A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam
- Native Hawaiian or Other Pacific Islander—A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands

Ethnicity

Ethnicity is conceptually different from race, as it is culturally based and refers to persons and their religion, languages, traditions, and heritage (Hammond, Cheney, & Pearsey, 2015). According to Baumann (2004), although ethnicity has been defined in several ways, a definition of an ethnic group consists of six main characteristics: (a) a common proper name to identify the essence of community, (b) a common ancestry, (c) a shared historical past, (d) one or more elements of common culture, (e) a link to a homeland or symbolic attachment to the ancestral land, and (f) a sense of solidarity on the part of at least some members of the group. As such, ethnicity refers to "a group or individual's concept of cultural identity which includes a wide variety of learned behaviors that a human being uses in his or her natural and social environment to survive, which may result in cultural demarcation between and within societies" (University of Wisconsin–Fox Valley, 2006, p. 1). People generally begin with identifying their

membership with an ethnic group and then explaining their ethnicity as the relationship to a particular ethnic group. Finally, Crossman (2019) defined ethnicity as a concept that refers to a shared culture and a way of life, which can be reflected in language, religion, clothing, cuisine, music, and art. There are thousands of different ethnic groups in the world, from the Han Chinese, the largest ethnic group, to the smallest indigenous groups, which may include only a few dozen people. It is also important to note that ethnic groups do not use the same criteria to define their membership but rather what is important to the group. For example, French Canadians use language (i.e., French) to distinguish themselves from the other Canadian groups, while religion is an important part of the ethnic identity of Jews (Crossman, 2019).

An ethnic group consists of people who share a common orientation toward the world; whose members identify with each other, based on a real or presumed common genealogy or ancestry; and who are perceived by others as having a distinctive culture (Hammond, Cheney, & Pearsey, 2015). Ethnic groups distinguish themselves differently from one time period to another. Ethnic groups have a consciousness of their common cultural bond and typically seek to define themselves, but also are defined by the stereotypes of dominant groups. An ethnic group does not exist simply because of the common national or cultural origins of the group, however. They develop because of their unique historical and social experiences, which become the basis for the group's ethnic identity. As a land of immigrants, the United States is home to many different ethnic groups, perhaps more than are in any other nation (see Chapter 1 for a discussion on the different racial and ethnic groups). Immigrants bring with them the special features of their cultures of origin and strive to maintain cultural ties to their places of origin while at the same time becoming American. We speak of Italian American, Irish American, and Jewish American cultures, for example. These ethnic groups form subcultures within the (larger) American culture.

Per data collected by the US Census Bureau (2018), race and ethnicity are distinctive categories, with Hispanic origin as the only identified ethnic group. As such, Hispanic origin is viewed as the heritage, nationality, lineage, or country of birth of the person or the person's parents or ancestors before arriving in the United States. A person who identifies as Hispanic, Latino, or Spanish can be of any race.

Culture

Culture is a concept that has many different meanings. Hammond et al. (2015) defined culture as the shared values, norms, symbols, language, objects, and way of life that are passed on from one generation to the next.

Culture is what we learn from our parents, family, friends, peers, and schools. Through culture, people interact with others in the society. Culture includes thoughts, styles of communicating, ways of interacting, views on roles and relationships, values, practices, and customs (Donini-Lehnoff & Hedrick, 2000; Robins, Fantone, Hermann, Alexander, & Zweifer, 1998). Culture also includes a number of additional influences and factors, such as socioeconomic status, physical mental ability, sexual orientation, and occupation (Betancourt et al., 2002). According to Cross, Bazron, Dennis, and Isaacs (1989), culture impacts our lives as it determines on the most fundamental level the way in which we perceive our world, how we assign meaning to what we see, and how we respond to it. People of one culture share a specific language, traditions, behavior, perceptions, and beliefs respective of their culture. Culture gives them an identity, which makes them unique and different from people of other cultures.

Culture is therefore an organic concept, evolving constantly. A definition for culture comes from the National Center for Cultural Competence (2006), which defines culture as:

> An integrated pattern of human behavior which includes but it is not limited to thoughts, communications, languages, practices, beliefs, values, customs, courtesies, rituals, manners of interacting, roles, relationships and expected behaviors of a racial, ethnic, religious or social group; and the ability to transmit the above to succeeding generations.

The US Department of Health and Human Services (2003) refers to culture as the shared attributes of a group of people, or broadly defined as a common heritage or learned set of beliefs. Thus, culture is applicable to groups of Whites, like Italian Americans, and to any other racial and ethnic group. A culture can also be defined by characteristics such as national origin; customs and traditions; length of residency in the United States; language; age; generation; gender; religious beliefs; political beliefs; sexual orientation; perceptions of family and community; perceptions of health, well-being, and disability; physical ability or limitations; socioeconomic status; education level; geographic location; and family and household composition.

Banks and Banks (2001) have identified culture as having two distinct sections: macroculture and microculture. Macroculture is our common values and beliefs from living in the same country. Microculture is the culture shared by specific group members. The goal is to function successfully within both the macro- and microcultures (Banks & Banks, 2001). Within this context, culture affects every aspect of our lives. However, most people are so entrenched in their culture that they do not recognize that other people live according to the norms of a different culture (Brislin, 2000).

Our understanding of our own culture and of cultures other than our own will impact how we interact with people not of our culture. Limited understanding can lead us to making mistaken assumptions and judgments and placing unclear expectations on others. Much of what causes conflict or confusion occurs when people of different cultures interact with no awareness of the difference between their cultures. Cultural misunderstandings and conflicts arise mostly out of culturally shaped perceptions and interpretations of each other's cultural norms, values, and beliefs. Ethnocentrism is a negative result of culture and occurs when one comes to believe that their culture is superior to all other cultures.

Cultural Practices and Their Impact on Health Education Strategies and Outcomes

Cultural Universals

Although every society has a specific culture, there are certain elements of culture that are universal. They are known as cultural universals, in which there are certain behavioral traits and patterns that are shared by all cultures around the world. For instance, classifying relations based on blood relations and marriage, differentiating between good and bad, having some form of art, use of jewelry, classifying people according to gender and age, and so on are common in all cultures of the world (Kartha, 2011).

Dominant Culture

Although many dimensions of culture are universal, there are many dimensions along which cultures differ. This variance in basic values results in cross-cultural miscommunication and strife. The culture of the dominant culture or group in power often dictates the paradigm of accepted values. According to Samovar, Porter, and McDaniel (2013), dominant cultures use a variety of methods to consolidate their power, including fear, money, and force. White men, Samovar et al. (2013) argued, create the dominant culture in the United States. Even though White men do not represent a majority of US society, they are in enough powerful positions to establish the mainstream culture.

Some of the values contained within the dominant culture of the United States include the importance of individualism and privacy; informality in interaction with others; an emphasis on the future, time, and punctuality; and a high regard for achievement, work, and material acquisition and competition (Stratishealth, 2019). These values often conflict with other cultural groups who may value tradition, cooperation, tranquility, enjoyment of life, family obligation, and a present worldview.

Culture and Health

Health is defined as a group's view of the physical, mental, emotional, and social components required in a healthy person (Cushner, 2002; Giger & Davidhizar, 1991). Health is culturally defined; as such, certain health behaviors exist among cultures that should be explored (Rose, 2011). Various groups often share specific views of health and illnesses (Giger & Davidhizar, 1991). Accordingly, different cultural groups tend to have different health treatment options.

For example, although European Americans (i.e., Whites) cannot be viewed as one culture and people, but a loosely associated series of subcultures, generalized beliefs can be attributed to them (Smedley, Stith, & Nelson, 2002). European Americans tend to value individualism and independence; are future-oriented; value practicality, efficiency, and promptness; respect the intrinsic value of work; and support competition (Stratishealth, 2019). Traditional Western medicine is favored by most European Americans. They tend to practice preventive medicine, yet also suffer from a rise in rates of chronic diseases and diseases related to obesity. There is a small trend by European Americans to begin to integrate a more holistic mind–body–spirit approach of care.

For Asians/Pacific Islanders, the extended family has significant influence, particularly the oldest male in the family, who is often the decision maker and spokesperson. Maintaining harmony is an important value for Asian families, resulting in an avoidance of conflicts and direct confrontations. Because of these traits, Asian/Pacific Islanders tend not to disagree with the recommendations of health care professionals but may still not follow treatment recommendations (McLaughlin & Braun, 1998).

Hispanics as an ethnic group vary greatly in terms of race, religion, and national origins, which results in distinct cultural beliefs and customs. Nevertheless, some common characteristics include respect for older family members, who are often consulted on important matters involving health and illness. There is a tendency to believe that illness is God's will or the result of divine intervention for previous or current sinful behaviors. Due to ties to indigenous cultures, some Hispanic patients may also prefer the use of home remedies or folk healers (McLaughlin & Braun, 1998).

Similar to Hispanics, many African Americans place a great deal of importance on the family and church. The wide use of extended kinship bonds, which includes grandparents, aunts, uncles, and cousins, often determines the relationship with health care providers. In many cases, a key family member is consulted for important health-related decisions, and the church plays an important support system (McLaughlin & Braun, 1998).

Like other ethnic groups, Native Americans also place great value on family and spiritual beliefs. Generally, Native American groups believe in being oriented in the present and valuing cooperation. However, the most relevant belief in terms of health care is their belief that a state of health exists when a person lives in total harmony with nature. As a result, illness is viewed as an imbalance between the ill person and natural or supernatural forces. Many contemporary Native Americans still use a medicine man or woman, known as a shaman (McLaughlin & Braun, 1998).

These examples of beliefs highlight the need to understand the effects of culture on health and health care. If health education specialists are not aware of these cultural differences, it can negatively impact the health of those they serve. Diaz-Cuellar and Evans (2014) provided a framework for examining generally accepted values and health beliefs of specific groups; it is provided in Table 2.1. Describing this general cultural framework of commonly held values within which some cultural groups operate provides a starting place for cultural competency. However, health education specialists and other health professionals must understand that within each group and subgroup, there are variations in cultural norms; hence, they must be cautious when viewing these guidelines to avoid any stereotypes.

Cultural Groups

In order to develop cultural and linguistic competence, health education specialists and other public health professionals must be cognizant of the different cultural groups living in their communities. It is also important that health education specialists and others do not make assumptions about certain groups based on previous experiences with individuals from a similar cultural background, as there are diverse practices and cultural patterns within each group and subgroup.

As previously stated, the 2010 US Census listed five major racial categories: White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander (US Census Bureau, 2018). Individuals have the option to identify as one or more (i.e., multiracial) of these racial categories. In addition, Hispanic is classified as an ethnic group; thus, individuals must identify whether they are Hispanic or not. It is pivotal to also understand that some of these racial and ethnic categories can be ambiguous as they try to categorize people from different countries, nationalities, and languages under one label. For example, Asian includes anyone who has an origin in places such as the Far East, Southeast Asia, or the Indian subcontinent (e.g., Cambodia, China, India, Japan, Korea, Malaysia, etc.). Similarly, Hispanic includes individuals from Mexico, Central and South

Table 2.1 Framework for Understanding Culture

	African American	Native American	Hispanic/Latino	Asian	Pacific Islander	European American	Middle Eastern
Health perspective	Harmony Illness = sin	Harmony with nature Illness = disharmony	Health = gift from God	Harmony Balance	Harmony Traditional medicine	Biomedical	Based on good & evil
Psychobehavioral activity	Action oriented	Being	Being	Action oriented	Being	Action oriented	Becoming
Axiology	Cooperation Direct communication Help orientation	Cooperation Indirect communication Save face	Cooperation Indirect communication Help orientation	Cooperation Indirect communication Save face	Cooperation Indirect communication Help orientation	Competition Direct communication Help orientation	Cooperation Direct communication Save face
Ethos	Independent Respect elders Strong kinship bonds Equalitarian family	Interdependent Respect elders Noninterference Extended family	Interdependent Respect elders Authority based Extended family Patriarchal	Interdependent Respect Goal oriented Authority based Extended family Patriarchal	Interdependent Collectivist Respect elders Extended family Patriarchal	Individuality Self-motivated Goal oriented Nuclear family	Interdependent Respect elders Authority based Patriarchal
Epistemology	Cognitive Kinesthetic	Affective Spatial	Cognitive Irrational	Cognitive Traditional	Affective	Cognitive and affective Easy to change	Cognitive Traditional
Logic	Linear	Circular	Circular	Circular	Circular	Linear	Linear
Ontology	Religious focus	Spiritual	Religion Fatalism	Spiritual	Spiritual	Religious	Religious
Concept of time	Present	Cyclical present	Past & present	Present	Past & present	Linear Future focus punctuality	Past & present
Concepts of self	Collectivist Extended family	Collectivist Extended family	Collectivist Extended family	Collectivist Extended family	Collectivist Extended family	Individual Nuclear family	Collectivist Extended family
Nature and environment	Connected with	Connected to & with nature harmony	Connected to nature	Harmony with nature—ying/yang	Connected	Separate from nature & attempt to control	Connected
Human nature	Good & bad	Good	Good	Good	Good	Good & bad	Good & bad
Proximity	Close proximity	Close proximity	Close proximity	Close proximity	Close proximity	Close proximity	Close proximity
Silence vs. talk	Active talk High-volume	Silence	Silence	Silence	Talk	Talk	Silence

Source: Diaz-Cuellar, A.L. & Evans, S.F. (2014). Diversity and health education. In Pérez, M. & Luquis R. (Eds.) Cultural Competence in Health Education and Health Promotion. (2nd ed.) San Francisco: Jossey Bass.

America, Caribbean (e.g., Puerto Rico and Cuba), and even Spain. Thus, we cannot assume a homogeneity among people from such diverse groups as Asian or Hispanic ancestries. Finally, another group that is not captured individually, but within one of the other categories, is the Arabs, which may include people who are Arab, Egyptian, Iraqi, Jordanian, Lebanese, Middle Eastern, Moroccan, North African, Palestinian, and Syrian.

Immigrants, Migrants, and Refugees

Diversity is affected by a people who were born outside the country and have settled in a new country, in this case the United States. A person's designation as either an immigrant, migrant, or refugee has been found to influence their health status and access to the health care system in this country, and many times it is related to their assimilation and acculturation levels.

By definition, an immigrant is someone who chooses to leave their country of origin and settle into another country (International Organization for Migration [IOM], 2011). The Immigration and Nationality Act (INA) defines immigrants as any alien residing in the United States, further classifying them as illegal aliens or lawfully permanent residents (Department of Homeland Security [DHS], 2018). Globally, immigrants are classified into two categories depending on their type of movement. They can be internal immigrants if their movement takes place within the borders of their country of origin, or external immigrants if they move to a different country or continent.

The United States continues to be a very popular place for immigrants to reside, with about one-fifth of immigrants moving here. It is estimated that 13.5% of the US population are immigrants, and that number jumps to 27% if we take into account their descendants (Zong, Batalova, & Hallock, 2018). In the United States, data from the Department of Homeland Security (DHS) show there were 1,127,167 new lawful residents in the United States (DHS, 2017), and an additional 11.4 million people reside in the country without legal status.

As indicated in this chapter, the legal status of individuals affects their health status as well as their insurance coverage. It is estimated that only 56% of the civilian non-institutionalized immigrant population had insurance coverage in the United States in 2016 compared to 70% of those born in the United States (Zong et al., 2018). Insurance coverage is a proxy for access to health care services in this country because the Affordable Care Act specifically bars undocumented immigrants from receiving access to federally covered programs.

Migrants are persons who cross an international border so that the country of destination becomes their new country of usual residence, regardless of