

CHAPTER 2

Relevance of Diversity and Disparities to Health Programs

The health status of individuals and populations is influenced by biological processes and by lifestyle behaviors and circumstances. The intersection of biology, lifestyle, and environmental circumstances leads to disparities in health status, with some groups having lower morbidity and mortality rates than other groups. At the root of health disparities is diversity in biological characteristics, as well as in social, cultural, ethnic, linguistic, and economic characteristics of individuals and populations.

In the late 1990s, President Bill Clinton put race, racism, and ethnic diversity on the public agenda. As a consequence, federal agencies, including the National Institutes of Health (NIH) and the Department of Health and Human Services (DHHS), began explicitly to fund research into understanding and eliminating racial and ethnic disparities in health status. Private foundations and other agencies funding health programs followed suit by requiring grantees to state explicitly how each program contributes to reducing racial and ethnic health disparities. The high level of attention given to health disparities means

that program planners and evaluators must appreciate the sources of disparity—notably diversity, understand what the key aspects of diversity are and how those aspects are relevant to health programs, and know which strategies can be used to address diversity so that the health program will be successful. This chapter begins to address these issues.

A current urban legend exemplifies the influence of culture on healthcare decisions and the importance of having culturally competent staff. A woman from Africa was in labor with her first child in a U.S. hospital. Her labor was not progressing, and the physician wanted to deliver the baby by cesarean section in an effort to minimize the potential brain damage that was likely to result from a vaginal delivery. The woman and her husband refused the surgery, opting for a difficult vaginal delivery. The couple explained that they needed to make their decision based on what their life would be like when they returned to Africa. In their home village, a woman with a history of a cesarean section would be in grave danger if she were to have another baby because of the lack of surgical services for delivery in her home village. The life and health of the woman

TABLE 2-1 Examples of Cultural Tailoring Throughout the Program Planning and Evaluation Cycle

Stage in the Planning and Evaluation Cycle	Examples of Tailoring for Cultural and Ethnic Diversity
Community needs assessment	Definitions of health and illness; willingness to reveal needs or wants; self-definition in terms of culture, race, or ethnicity; health disparities; experience of disparities in access to or quality of health care
Program theory and development	Identification of contributing and determinant factors of the health disparities; role of discrimination and culturally bound health behaviors in the disparities; culturally acceptable and appropriate interventions
Process or program implementation	Culturally and ethnically adjusted program objective targets; cultural, racial, and ethnic representations and appropriateness of materials developed or chosen, such as visual representations, colors used, language or languages, location, media used, modality of distribution, and enticement used
Program intervention delivery	Type of intervention; length of time participants receive intervention (e.g., session length); amount of intervention (e.g., number of sessions)
Program effect evaluation	Language or languages of survey questionnaires; culturally appropriate enticements to participate; access to culturally and ethnically equivalent control groups

among socioeconomic, racial, and ethnic groups. *Disparities* in health care are defined as differences by race or ethnicity in access to or the quality of health care that are not due to the health or clinical needs or preferences of the person. The intuitive understanding belies the challenges in defining health disparities in a way that addresses the complexity of the problem (Braveman, 2006).

Well-documented health disparities exist. For example, blacks have nearly twice the rates of low birthweight infants and infant mortality as whites (National Center for Health Statistics [NCHS], 2016). Unintentional injury mortalities for American Indian children ages 1 to 4 years (11.7 per 100,000) is higher than for black (10.7 per 100,000) or non-Hispanic whites (7.2 per 100,000) (Hearon, 2016). Disparities also exist for

chronic illnesses: American Indians and Alaska Natives are 1.7 times more likely to have diabetes than non-Hispanic whites of a similar age, a notable improvement in narrowing that disparity since 2000 (NCHS, 2016). Black women have higher mortality rates from breast cancer than any other racial or ethnic group in the United States (National Cancer Institute, 2014). Some health status disparities might be explained by disparities in physical activity and consumption of fruits and vegetables (Gavin et al., 2011). These are a few examples of health disparities that could be addressed by individual practitioners but are perhaps more appropriately targeted by health programs across the public health pyramid.

The causes of health disparities remain the subject of research, but current theories regarding

health disparities posit that they have multiple, interactive (i.e., not mutually exclusive) causes that are biological, socioeconomic, and cultural in nature. For instance, among black mothers in particular, the biological effect of heightened levels of cortisol due to perceived discrimination has been associated with adverse birth outcomes (e.g., preterm birth, low birthweight). Among American Indians in the Southwest, the prevalence of diabetes was minimal until the 20th century, when water restrictions transformed an agricultural society into one dependent on government subsidies, largely comprised of processed commodities (Satterfield, DeBruyn, Francis, & Allen, 2014). The interactive causes of health disparities either can be primary targets for health programs or can constitute a contextual environment for the health program. In either case, at the heart of addressing health disparities in a practical manner and developing successful health programs lies the need to understand the relationship of diversity to health disparities.

Diversity and Health Disparities

Diversity, in the context of health, refers to the numerous ways in which individuals and groups differ in their beliefs, behaviors, values, backgrounds, preferences, and biology. Diversity is most often described in terms of language, culture, ethnicity, and race. Each of these aspects, along with biological diversity within the human population, has health implications.

Culture is a learned set of beliefs, values, and norms that are shared by a group of people; it is a design for how to live (Spector, 1991). As a set of behavioral norms or expectations, cultural beliefs influence a wide range of behaviors, including dietary choices, hygiene practices, sexual practices, and illness behaviors. Through such behaviors, culture has an effect on health and therefore is relevant to health programs. Cultures can be difficult to define and distinguish, particularly when subcultures rather than the dominant culture are the target of a program.

Assigning a label to a culture is less important than seeking information about unique or distinct culturally bound patterns of behavior that have health implications. For example, it is not as important to be able to identify a person as being from Hopi culture versus Navajo culture as it is to ask about daily consumption of meats and fresh vegetables and the ways in which those foods are prepared, and to understand the historical context that has influenced changes in dietary patterns. Culture, as the sharing of similar beliefs, values, and norms, contributes to a sense of unity among the members of the culture. The cultural cohesion and sense of belonging to a cultural group is a powerful force in creating conflicts as well as in creating opportunities. Both the Hopi and the Navajo have strong cultural identities that present an opportunity for health program planners to build that cultural identity into a program. The strong cultural identity can also create conflicts, however, between program planners and people from the Hopi or Navajo nations if the program is perceived as threatening their culture or being inconsistent with their cultural beliefs.

The relationship between culture and illness is recognized as having distinct manifestations, especially in mental health. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), has replaced the diagnostic category of "culture-bound syndromes" (Tseng, 2006) with "cultural concepts of distress" (Ventriglio, Ayonrinde, & Bhugra, 2016). *Cultural-concepts of distress* is a broad classification that considers the ways that cultural groups experience and frame symptoms, ways of communicating the distress, and explanations of the symptoms. The new diagnostic category stems from a growing understanding that illness is, at least in part, socially and culturally constructed. The interaction of culture and illness extends into physical illnesses: A study of pain found different levels of pain tolerance between Italians, Swedes, and Saudis (Al-Harthy, Ohrback, Michelotti, & List, 2016), suggesting the possible influence of cultural

factors. The message is that diversity in culture is related to diversity in illness manifestations and responses to illnesses (Edwards, Moric, Husfeldt, Buvanendran, & Ivankovich, 2005; Hastie, Riley, & Fillingim, 2005), even within ethnic subgroups (Tan et al., 2008). Such differences can only be identified through cross-cultural comparisons and astute observations. If program planners lack direct personal knowledge of the culture, they will need to rely on key informants and published reports of cultural influences on illness manifestations that are specific to the target audience.

Diversity also exists with regard to the economic well-being of individuals, as measured through socioeconomic status (SES). The relationship between SES and a wide variety of health status indicators has a long, well-documented history (Kosa & Zola, 1975; Polednak, 1997). Research continues to unravel the relationships among education, income, and health. For example, Russell and colleagues (2016) found that mothers with less than high school education had 1.7 times increase in the likelihood of having a child with attention deficit-hyperactivity disorder and that coming from a low income family increased that risk to more 2.2 times. The correlation between SES and health status applies both across racial groups and within racial groups. For example, Bruce and colleagues (2010) found that, among African Americans, those with a higher SES had a lower risk of chronic kidney disease. Other research has found that the interaction among gender, income, and race/ethnicity has varying effects on self-rated health (Brown, Richardson, Hargrove, & Thomas, 2016). The fact that individuals in lower SES groups, regardless of other characteristics, have poorer health suggests that health programs may need to target specific SES groups, not just specific cultural, racial, or ethnic groups.

The attention given to cultural and ethnic diversity is driven, in part, by the numbers. In 2014, over one million individuals newly immigrated to the United States. Of those, 13% were from Mexico, 8% from India, 8% from China,

and 13% were refugees (Mossaad, 2016). By 2060, the population of the United States will be 43% non-Hispanic white, 29% Hispanic, 13% African American, and 9% Asian and Pacific Islander (Colby & Ortman, 2014).

Diversity and Health Programs

As this very brief introduction to health disparities suggests, the extent of diversity within a target population can have various effects on how health programs are developed and provided. Diversity has particular implications for measurement done during planning and evaluating the health program; for the design and implementation of the health program intervention; and for the healthcare organization and program itself, including cultural competency and coalition formation. Each of these is addressed in some detail in the sections that follow.

► Measurement

Measurement occurs throughout the planning and evaluation cycle. Measurement of health status and of factors contributing to the health problem occurs during the community needs assessment phase. Program delivery and participation measurement occurs during the process evaluation phase. Measurement of program effects occurs during program evaluation. At each of these points in the planning and evaluation cycle, diversity in the target audience and in program participants or recipients has ramifications regarding what is measured, which data are collected, and how data are collected.

The first consideration is always the purpose of measuring an aspect of diversity. This purpose is paramount in deciding how diversity will be measured. Imagine that in a Bowe County community assessment, an atheist born in Layetteville and a Muslim born in a neighboring town were grouped into the same ethnic category. Stated in this way, it seems strange to

assign these two individuals the same ethnicity. But grouping these individuals together makes sense if the purpose of the assessment is to have data on Mexican immigrant culture. Given that *ethnicity* denotes a set of religious, racial, national, linguistic, or cultural characteristics that define a group, the ethnicity measure in this community needs assessment was based on religion as Catholic or not and on birthplace as Bowe County or not. Thus, non-Bowe County-born Catholics were assigned a Mexican ethnicity. This example was intentionally contrived to demonstrate the importance of purpose in developing indicators of diversity and the profound effect the variables used have on the indicator and subsequent findings.

Culture is often implicit, tacit, and not expressed as a distinct factor, making it difficult to measure. In addition, because a dominant culture exists at a societal level, measures of culture are less useful in health programs than indicators of more discrete, smaller subpopulations, such as those that might be defined by ethnicity or nationality. For these reasons, ethnicity is used as a proxy for cultural identity. Typically, ethnicity is measured with a single item; however, using a valid and reliable measure of ethnicity is key to having good data for planning and evaluating health programs. The extent of language diversity and religious diversity makes constructing a comprehensive measure of ethnicity very difficult. For example, the large number of religions, religious sects, and churches listed in the U.S. military's *Ministry Team Handbook* reflects wide religious diversity, with each having specific dietary practices; clothing; health practices; religious practices; and birth, marriage, and death rituals. Health researchers are attempting to understand the relationship between health status and mainstream religious beliefs and practices (Baetz & Toews, 2009; Masters & Spielmans, 2007; Krause, Emmons, & Ironson, 2015).

Nationality, which identifies the place of birth of the individual or the parents, is a more straightforward measure. Because cultural identity and ethnicity can be difficult to measure,

nationality by birth or birthplace of the parents is sometimes used as an indicator of culture and ethnicity. Many countries have multiple ethnic groups, however, making it problematic to equate nationality with ethnicity or culture. Thus, if nationality is measured, another measure, such as primary language, may be needed to have a more accurate measure of ethnicity and culture.

The following example demonstrates the importance of carefully choosing indicators of diversity, such as measures of ethnicity or culture, for planning health programs. In one neighborhood of Chicago, a large percentage of the residents belong to a specific sect of Judaism. In this neighborhood, the food stores are kosher, the women's clothing is consistent with their religion, and friendships are built around synagogue membership. Less than half a mile away is another neighborhood with a large percentage of residents with ties to the Indian subcontinent. In this neighborhood, the food stores stock food for their cuisine, the women wear the traditional sari, and the social structure is built around the dominance of the male head of the household. The health statistics for the Jewish neighborhood are relatively good, but the health statistics for the East Indian neighborhood reveal women's health problems due to high rates of domestic violence and chronic illness related to alcoholism. Unless the data from the two neighborhoods are separated, the health statistics for the area as a whole will mask some of the women's health problems and understate the males' health problems related to alcoholism.

This description of two actual neighboring ethnic groups shows the extent to which program planners need to be familiar not only with the data but, more important, with the community characteristics. These characteristics include the cultural beliefs of the residents and the degree to which ethnic and religious diversity coexist rather than overlap. Having this level of understanding about the cultural and ethnic diversity of a community facilitates appropriate interpretation of community health status data.

Race has long been considered a physical characteristic. From a biological perspective, race

has historically been associated with specific genetic diseases, including sickle cell anemia, thalassemia, and some forms of lactose intolerance. Race has also been used as a proxy measure of culture, ethnicity, and SES. To the extent that race can be used as a risk factor for specific genetically

transmitted health conditions, it has some medical value. The categories used to measure race remain somewhat inconsistent across key national health data sources, as do indicators of ethnicity (TABLE 2-2). Use of race and ethnicity indicators deserves careful attention (Bhopal, 2006).

TABLE 2-2 Indicators Used to Measure Race in Different Surveys

Category Used	2010 U.S. Census ¹	2003 U.S. Standard Certificate of Live Birth ²	2015–2016–NHANES ³	2012 National Hospital Ambulatory Care Survey ⁴
Race				
White	X		X	X
Non-Hispanic white		X		
Non-Hispanic black		X		
Black, African American	X		X	X
American Indian or Alaska Native	X	X	X	X
Other Pacific Islander	X			
Native Hawaiian or Pacific Islander	X		X	X
Asian Indian	X			
Asian or Pacific Islander (API)		X	X	
Asian				X
Ethnicity				
Hispanic or Latino	X	X	X	X
Mexican, Mexican American, Chicano	X		X	

(continues)

TABLE 2-2 Indicators Used to Measure Race in Different Surveys (*continued*)

Category Used	2010 U.S. Census ¹	2003 U.S. Standard Certificate of Live Birth ²	2015–2016–NHANES ³	2012 National Hospital Ambulatory Care Survey ⁴
Puerto Rican	X	X	X	
Cuban	X		X	
Other Spanish, Hispanic, Latino	X			
Other Spanish or Hispanic			X	
Chinese	X			
Filipino	X			
Japanese	X			
Korean	X			
Vietnamese	X			
Other Asian	X			
Guamanian or Chamorro	X	X		
Samoan	X	X		
Other Pacific Islander	X			
Central American, South American, other Hispanic or Latino			X	
Other race	X		X	X

Sources: ¹U.S. Census. Retrieved June 30, 2016, from http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_DP_DPDP1&src=pt.

²U.S. Standard Certificate of Live Birth. Retrieved June 30, 2016, from <http://www.cdc.gov/nchs/nvss/births.htm>.

³National Health and Nutrition Examination Survey (NHANES), Screener Module 1. Retrieved June 30, 2016, from http://www.cdc.gov/nchs/nhanes/nhanes2015-2016/questionnaires15_16.htm.

⁴Survey Content for the National Ambulatory Medical Care Survey and Hospital Ambulatory Medical Care Survey. [Revised Nov. 2012] Retrieved June 30, 2016, from http://www.cdc.gov/nchs/ahcd/ahcd_questionnaires.htm.

Researchers have made progress in identifying genetic markers for diseases that are more specific than self-reported race. As tests for genetic markers have become more widely available and affordable, race, as currently measured, has lost some medical value. It is easy to imagine a future when the current self-report measures of race will no longer be medically relevant. Until the future arrives, however, race will continue to be used as an indicator in planning health promotion and disease prevention programs.

The cultural and ethnic background of program participants affects the development or choice of questionnaires as well as the interpretation of results. In the development of scientifically sound and rigorous data collection tools, the language and culture of the intended respondents must be considered. To ensure that a questionnaire is culturally and linguistically appropriate and understood requires that the questionnaire be translated from the primary language into the second language and then translated back into the primary language. The back-translated version is then compared with the original version of the questionnaire to determine the accuracy of the translation. In addition, the translation in each direction ought to be done with input from several fully bilingual experts in the content of the questionnaire. Translation of the words is not sufficient; both the ideas embodied in the questionnaire and the wording of each item need to be translated (Epstein, Santo, & Guillemin, 2015; Willis & Zahnd, 2007). The questionnaire needs to be culturally equivalent so that the ideas and the expressions are the same, not just the words.

The following is an example of the measurement challenges that program planners and evaluators could face. A questionnaire developed in the United States in English regarding group functioning in a work unit was chosen for use with Taiwanese employees. The questionnaire was translated into Chinese by three Taiwanese researchers and then translated back into English by three other Taiwanese researchers.

The back-translated version was considerably different from the original English version.

In trying to understand what had happened, the researchers found that two factors had come into play. First, the lack of a future tense in some Chinese languages made it impossible to translate directly the English items that asked about the future actions of the respondent. Second, the questionnaire had been designed to measure the degree of individual and group functioning based on the American value of individualism. Thus, the questionnaire was difficult to translate both linguistically because of the future tenses and conceptually because of the individualist versus collectivist values of the two cultures.

This example hints at the potential complexity of using a survey questionnaire designed for one culture with a second culture. It also highlights the potential ethnocentrism involved in thinking that what is valued in the American culture—in this example, individualism—would be relevant in other cultures. This translation story helps explain why such extensive publications exist for the SF-12, a 12-item measure of overall health that is one of the most widely translated health questionnaires and now is also available with only 8 items. The various publications document the SF-12's psychometric properties when translated and used in different countries, demonstrating that even a widely used and thoroughly researched questionnaire requires a considerable amount of work to ensure that it is culturally and linguistically appropriate with each culture.

Cultural diversity also affects the interpretation of findings based on the data collected. Stakeholders involved in the health program who come from different backgrounds and cultures will often hold different values and ideas. Their culturally based interpretations may be quite different from the interpretations of health professionals, who have their own professional culture.

Culture influences how meaning is attributed to findings and how data are collected for program evaluation. For example, a violence prevention

program measured the program's effectiveness in terms of the lack of gang tags spray-painted on walls in a neighborhood that was next to a city park. When residents of the neighborhood were presented with the findings, they interpreted the findings in a skeptical manner. They explained that, for them, the lack of gang tags did not mean the lack of gangs, just that they no longer knew where the gang boundaries were and therefore where it was safe to go, including whether it was safe to go to the park for exercise. This actual example exemplifies both the powerful influences of culture on interpreting data and the value of involving stakeholders in any data interpretation.

► Interventions

Program *interventions* are the actions done intentionally to have a direct effect on program participants or recipients. The interventions used in health programs must be tailored to the intended audience if the program is to be successful in achieving the desired health effects. The choice of interventions and manner of intervention delivery ought to be based on both the sociocultural diversity of the target audience and the biological diversity within the target audience. Three approaches are evident in how culture is addressed during the development of program interventions. In addition, the diversity of the health professionals and health sectors plays a role in the effectiveness of program interventions.

Influences of Sociocultural Diversity on Interventions

Fisher, Burnet, Huang, Chin, and Cagney (2007) conducted a literature review of interventions focused on culture as means of improving health. They argue that *cultural leverage* is a strategy used to improve the “health of racial and ethnic communities by using their cultural practices,

products, philosophies, or environments as vehicles that facilitate behavior change” (p. 245) of individuals and healthcare providers. Cultural leverage, therefore, encompasses culturally tailoring interventions to specific ethnic or cultural groups as well as culturally targeting specific ethnic or cultural groups. In addition, the interventions developed for cultural leverage are culturally competent (as discussed later in this chapter). The key point is that there is increasing emphasis on, and more sophisticated approaches to, addressing culture in ways that are appropriate and beneficial to improving health and decreasing health disparities.

Understanding how to tailor the program given cultural differences begins with having or collecting information about differences across and within cultural groups. Navarro, Wilson, Berger, and Taylor (1997), in providing Native American students with a program to prevent alcohol and substance abuse, found that tribal differences and conflicting religious themes among tribes were important to individuals participating in the program. This is not surprising given that more than 500 Native American languages exist, each associated with a different tribal culture. Among low-income, urban, African American women, Beckjord and Klassen (2008) found variations in cultural values such that the women with more traditional values were less likely to seek and receive breast cancer screening. Sometimes, however, cultural tailoring may not be necessary. For example, Bond et al. (2016) found similar knowledge and perceptions about human papillomavirus (HPV) among African Americans, Caucasians, and Hispanics living in the same town in South Carolina. A health information campaign in this area intended to increase HPV vaccination thus would not need to culturally tailored with regard to race or ethnicity.

A common practice is to incorporate faith into health programs and to design programs that are church or parish based. In a review of the literature on church-based health promotion programs, Campbell and colleagues (2007) found that this approach is effective for African

Americans. The practice of collaborating with spiritual leaders and basing health programs in places of worship is likely to continue as an approach to reducing disparities. Developing faith-based programs may or may not require first understanding the health disparity in terms of religion, but it certainly does require understanding ways to collaborate effectively with church leadership and members for the delivery of a health program.

Interventions may result in immediate or permanent changes, but most health behavior interventions are intended to change behaviors that must be sustained over time. Culture can affect whether behaviors are sustained. Potentially, one type of culturally tailored intervention might be needed to initiate change and another type of culturally appropriate and tailored intervention might be needed to maintain the change or program effects. Also, program outcome objectives need to be culturally appropriate, with correspondingly appropriate target levels.

Sociocultural influences on intervention may emerge in unanticipated ways, such as through program participants themselves. For example, program participants bring their culture to the program in ways that can affect the intervention and its effectiveness. Higginson (1998) studied adolescent mothers in a high school program to examine their competitive culture, concluding that it was shaped by the mothers' social class, age, and race. Their competitive culture also pervaded the beliefs and norms of the health program in which they participated. These adolescents socialized new program participants into the competitive culture, thereby creating a "program culture."

One way to understand the culture of a program is to analyze the ceremonies and rituals associated with it. Intentionally building ceremonies and rituals into programs can be important for high-risk groups whose members need the sense of belonging that comes with having a program culture. This can help to retain them as active program participants. These are some

examples of how diversity can affect program interventions.

Influences of Biological Diversity on Interventions

For some health conditions, physiological responses may vary by race, gender, or age, which in turn affects decisions about the type and intensity of interventions used in the health program. Generational differences in values, norms, beliefs, and health problems all contribute to diversity. From the perspective of health program planning, age distribution is an important factor in reaching the intended audiences of a program. Gender and sexual orientation are other dimensions of physical diversity that have ramifications for program development. Disability—whether physical, mental, or developmental—is another dimension of diversity but is less often mentioned. Nonetheless, it may be extremely relevant for some health programs.

The distribution of physical characteristics within a population or community influences decisions during health program planning and later during program evaluation. Take age as an example. Imagine that the Bowe County Board wants to increase the physical activity of all county residents. The age distribution across the community and within its towns will affect the nature and content of the countywide media messages. Messages that relate to the physical abilities of the elderly will need to be quite different from messages that address the physical abilities of adolescents. Similar considerations would be needed for the other types of physical diversity.

Approaches to Developing Programs

Various perspectives exist in regard to explaining patterns of health behavioral differences by culture, ethnicity, and race. Kim, McLeod, and Shantzis (1992) suggest that three approaches are used in health-related programs: cultural content

approaches, cultural integration approaches, and cultural conflict approaches.

In the cultural content approach, cultural backgrounds and norms are viewed as leading to behaviors and illnesses. For example, Kleinman (1980), a medical anthropologist, explains that illness is cultural in that sickness and symptoms are saturated with specific meaning and are given patterns of human behavior. The notion that illness is cultural, and not just biological, affects the degree to which individuals accept professional explanations of health and illness.

Cultural integration approaches to developing health programs focus on acculturation. *Acculturation*, the adoption and assimilation of another culture, affects behavior in that the less dominant group takes on behaviors of the dominant group. When planning programs, planners need to consider the degree of acculturation because it affects health beliefs and behaviors. Behavior is also affected when individuals identify with more than one culture to varying degrees so that bicultural individuals have health beliefs and behaviors that are a blend of the dominant and less dominant cultures. When targeting groups or individuals who identify with more than one culture, planners need to understand their health beliefs and behaviors as a “new” culture. This is particularly relevant for health programs targeting immigrants or first-generation U.S. citizens.

Cultural conflict approaches underscore conflict as the genesis of behaviors. Several areas of potential cultural conflict exist. One area stems from the generation gap, which leads to family conflict and unhealthy behaviors and illnesses. Differences between the role expectations of different cultures are another source of cultural conflict and unhealthy behaviors. Racism, oppression, and lack of political power lead to alienation and identity conflict, and subsequently to unhealthy behaviors and illnesses. From a psychological perspective, individuals who are experiencing these kinds of conflicts are more likely to experience stress and therefore have less attention and energy to engage in health-promoting behaviors or may be less receptive to making change. Thus an assessment

of the target population ought to assess the degree of cultural conflict. Program planners need to address the immediate, root causes of the cultural conflict if they are to develop appropriate interventions for the health program.

Profession and Provider Diversity

Health program planning and evaluation draw on the expertise of individuals from a multitude of health disciplines, including medicine, nursing, pharmacy, social work, nutrition, physical therapy, and dentistry, as well as social science disciplines, including health education, health psychology, social demography, and medical sociology. Each discipline has its own specialized knowledge, values, and professional norms. Successful planning, implementation, and evaluation of health programs require working on teams that bring together the strengths of the various professions and that respect the different educational backgrounds of team members (TABLE 2-3). Each health discipline speaks a slightly different professional language, holds different beliefs about how to identify and address health problems, and adopts a different perspective on what constitutes a health outcome. To tap into the wealth of information and experience available through professional diversity requires that the team develop a common language and shared goals for the health program.

Health professionals do not reflect the diversity profile of the population of the United States in terms of cultural, racial, and ethnic diversity. For example, African Americans accounted for 10.7% of registered nurses in 2010, yet African Americans made up 13.6% of the overall population. Similarly, 5.4% of registered nurses were Hispanic, compared to 15.5% of the total population (U.S. Department of Health and Human Services [U.S. DHHS], 2015). This same pattern of underrepresentation of minorities exists across all health professions. The ensuing lack of racial and ethnic diversity among health professionals creates a cultural gap between professionals and patients, clients, and program participants. The extent of the cultural gap between planners and

TABLE 2-3 Professional Diversity Among Health Professions

Health Discipline	Average Education	Primary Focus	Licensure/Certificate	Programmatic Contribution	Estimated Number in United States
Acupuncturist	Minimum 3 years of Asian medicine education	Restore balance between the physical, emotional and spiritual aspects of the person	Licensure based on certification	Alternative approach to understanding health and illness based on oriental medicine	27,835 in 2012 ³
Community health worker	High school or baccalaureate	Informal education, advocacy, assistance of community members	Varies by state for certification	Shares ethnic, linguistic, socioeconomic status, and life experiences with community members	48,130 in 2015 ¹
Dentistry	Dental-doctorate (3–4 years after baccalaureate)	Diagnosis and treatment of conditions of the teeth and gums	Licensure	Oral health knowledge	195,722 in 2015 ²
Dietitian, nutritionist	Baccalaureate	Dietary and nutritional elements necessary for health	Licensure and certificate	Nutritional knowledge, influence of nutrition on health	59,740 in 2015 ¹
Health administration	Master's degree	Leadership and management of healthcare organizations	Certificate	Management and administration	166,990 in 2015 ¹
Health education	Baccalaureate	Development and delivery of materials and curriculum designed to impart health knowledge and change behavior	Certificate	Social and behavioral knowledge	57,570 in 2015 ¹

Interventions

(continues)

TABLE 2-3 Professional Diversity Among Health Professions (continued)

Health Discipline	Average Education	Primary Focus	Licensure/Certificate	Programmatic Contribution	Estimated Number in United States
Massage therapist	Certificate	Massage of soft tissues and joints	Licensure varies by state, certificate		92,090 in 2015 ¹
Medicine	Medical doctorate (4 years after baccalaureate), plus residency of 3–4 years	Differential diagnosis and treatment of illnesses	Licensure and certificate	Medical, pathological, and treatment knowledge	621,066 in 2015 ¹
Nursing	Baccalaureate (associate degree minimum requirement)	Promotion of health and well-being based on scientific knowledge	Licensure and certificate	Integration of behavioral and medical knowledge	2,745,910 in 2015 ¹
Physical therapy	Baccalaureate	Restoration and maintenance of body strength and flexibility for the purpose of maximizing physical capabilities	Licensure	Focus on enhancing capability within limitations	209,690 in 2015 ¹
Social work	Master's degree	Address basic needs; help people manage environmental forces that create problems in living	Licensure	Focus on family and psychological factors	619,310 in 2015 ¹

Sources: ¹Community Health Workers National Workforce Survey. Retrieved September 11, 2012, from <http://bhpr.hrsa.gov/healthworkforce/reports/chwstudy2007.pdf>;

²Bureau of Labor Statistics (BLS). (2011). Occupational Outlook Handbook (OOH), 2010–2011 Edition. Retrieved September 11, 2012, from www.bls.gov/oco/home.htm;

³Data not available on these health disciplines.

⁴Bureau of Labor Statistics (BLS). (2011). Occupational Outlook Handbook (OOH), 2010–2011 Edition. Retrieved September 7, 2011, from <http://www.bls.gov/oco/home.htm>

a health program's target audience contributes to a reduced understanding of the target audience, a greater need to become informed about the target audience, and—potentially—tensions between the planners and advocates for or from the target audience. The more comprehensive the health program and the greater the cultural diversity of the target population, the greater the need to have parallel diversity among those planning, providing, and receiving the program.

The Three Health Provider Sectors

From an anthropological perspective, the effects of health provider diversity (or lack thereof) can be understood by considering the three sectors of the health–illness system from which individuals seek help when experiencing illness (Kleinman, 1980). Each sector has direct implications for planning, implementing, and evaluating health programs.

One sector consists of allopathic, naturopathic, and other formally trained health professionals who make up the medical healthcare system. Professionals from this sector have legally sanctioned practice parameters. Traditional, Western medical professions include, among others, physicians, nurses, pharmacists, psychologists and physical therapists, whereas complementary health professionals include, for example, naturopathic physicians, chiropractors, acupuncturists, homeopathy practitioners, licensed massage therapists, and mind–body therapists. The notion of health program planning falls within this sector, as do the methods and knowledge about health program planning and evaluation. In addition, the preponderance of health programs are designed in accordance with theories and knowledge generated from this sector.

A second sector from which individuals might seek help is the folk healthcare sector, which comprises nonprofessional, secular, or sacred healers who have not received formal education but who are very likely to have received training through some type of apprenticeship. A wide variety of traditional healers makes up

this sector—curanderos, espiritistas, santeros, singers, shamans, and root-workers, among others. Evidence of the presence of folk healers can be found when visiting neighborhoods that are ethnically isolated or that maintain folkloric traditions. This would be case with enclaves of recent immigrants. Individuals may consult folk healers while also receiving modern or Western health care. The theories of illnesses and diseases that are the basis of folk health practices can conflict with allopathic theories and thus may diminish the effectiveness of interventions based on an allopathic frame of reference. The role of folk healers in community health behaviors and in addressing health problems can be central for some health programs, especially those targeting individuals who have maintained “the old ways.”

The third (and largest) sector of health providers is the popular or lay sector, consisting of family and friends. Undoubtedly, most of us talk to a family member or friend about our illness before seeking either professional or folk health care. This sector is the most relied upon, from receiving the latest news disseminated through the mass or social media to getting a mother's recipe for chicken soup. Health information is spread through the lay sector through social networks, making it a powerful factor in influencing health knowledge and behavior. Health programs that seek to change social norms or population-level behaviors are essentially seeking to change the lay healthcare sector.

► Diversity Within Healthcare Organizations and Programs

From a systems theory perspective, an organization that is internally diverse will be better able to respond to externally diverse needs and demands. This concept has been formalized into the concept of requisite variety (Weick, 1979). The concept of requisite variety suggests that

healthcare organizations with a culturally diverse and culturally competent workforce are better suited to provide services that meet culturally diverse health needs. The need for requisite variety is a fundamental reason for having a culturally and ethnically diverse health professions sector. The need for a diverse workforce was recognized in a report to the Bureau of Health Professions, within the Health Resources and Services Administration (U.S. DHHS, 2015), especially to benefit underserved and minority populations.

Organizational Culture

Many different types of organizations offer health programs, including state or local health agencies, for-profit acute care networks, nonprofit community-based agencies, and academic institutions. Each organization has a unique set of values, norms, and beliefs that are collectively held by its members and that are passed on to new employees; this constitutes the organizational culture (Deal & Kennedy, 1982; Schein, 1995). Well-known examples of organizational culture are the norms about starting meetings on time and the willingness to help other employees accomplish tasks.

Program managers need to be sensitive to the degree of fit between the organizational culture and the goals of the health program. Not all good ideas for programs are good for the organization. A good match or fit between the organization's view of its mission and philosophy—in other words, its beliefs and values—and the purpose of the health program may be important to the success of the health program in terms of financial, personnel, and other organizational support. In a similar vein, the integration and sustainability of a program within an organization are affected by organizational culture.

Another implication of organizational culture for program managers is that staff members with work experience hold some of the values and norms of their prior organizational culture. These values and norms can be shaped; in other words, new employees need to become acculturated into the new organization, a process that begins with their initial orientation. Cox (2001), an expert on multicultural organizations, defined diversity

within an organization as the variation in the social and cultural identities of people existing together. For organizations, diversity provides added value because it increases respect, improves problem solving, increases creativity and ideas, increases organizational flexibility, improves the quality of employees, and improves marketing strategies. Diversity within organizations does not just create benefits, however; it also poses challenges for managing and enhancing that diversity.

An essential element contributing to a healthcare organization's cultural competency is its ability to engage in self-assessment of its cultural competency. Understanding the cultural competency continuum puts the self-assessment into perspective.

Cultural Competency Continuum

Accompanying the emphasis on diversity and health disparities is the emphasis on *cultural competency*, the extent to which individuals are able to live or work in a culture other than their own. Cultural competency, by its very nature, has shades of less and more that extend along a continuum (Cross, Bazron, Dennis, & Issacs, 1989; Orlandi, 1992; **TABLE 2-4**), an idea that has gained wide acceptance (e.g., Knibb-Lamouche, 2012). It is possible for health professionals and program staff members to reside at different points along the continuum, depending on a variety of factors, such as the specific circumstances and the individuals' experiences with cultures other than their own. While the prevailing norm and politically correct stance is to be as culturally sensitive and as competent as possible, acceptance of different values and beliefs can be difficult, particularly those of cultures that are dramatically different from one's own.

Cultural Destructiveness

At the least tolerant end of the continuum is cultural destructiveness (Orlandi, 1992), which includes a set of attitudes and practices that explicitly promote one culture over another based on the notion of one culture being superior to the

TABLE 2-4 Cultural Continuum with Examples of the Distinguishing Features of Each Stage

	Cultural Destructiveness	Cultural Incapacity	Cultural Blindness	Cultural Openness	Cultural Competence	Cultural Proficiency
Attitude toward other cultures	Hostility	Dislike, separate but equal	Ambivalence, treat all alike	Curious, cultural awareness	Respect and tolerance, cultural sensitivity	Fully comfortable, cultural attunement
Knowledge of other cultures	Active avoidance of knowledge	None	Little or none	Some	Fair amount	Extensive
Degree of integration across cultures	None	None	None	Contemplation of potential benefits of integration	Some integration, some elements of multicultural integration	Extensive integration, fully multicultural, fusion of cultures
Implications for health program of participants at each stage	Programs address consequences of cultural destructiveness	Need to have programs provided to separate groups	If have multicultural elements, may need to justify and explain	Can provide program to participants from multiple cultures but will need to provide information and role modeling of competence	Can provide program to participants from multiple cultures with minimal adjustments	Can provide multilingual, multicultural interventions in one program

other. The attitude of superiority of one's culture over the inferior culture stems from the notion of the other being different or distasteful. Often physical (visible) characteristics, especially race, gender, sexual orientation, and age, are used as the basis for cultural destructiveness. Although staff members of a health program are not likely to be at this end of the continuum, health programs might be needed by and planned for individuals with attitudes reflective of cultural destructiveness. In fact, many of the global conflicts that lead to humanitarian crises and refugees have their roots in cultural destructiveness. International health programs are likely to deal directly with the consequences of cultural destructiveness. For programs within the United States, program planners will need to have an "insider" understanding of factors that would make the health program acceptable to culturally destructive groups.

Cultural Incapacity

Individuals at the next step, cultural incapacity, also promote one culture over another, albeit more implicitly than individuals at the cultural destructiveness stage. Cultural incapacity is manifested in the doctrine of "separate but equal," with the accompanying segregation and discrimination. In the United States, both cultural incapacity and cultural destructiveness have been made illegal through constitutional, federal, and various state statutes.

Cultural Blindness

Cultural blindness is a perspective of being unbiased, such that people are viewed as being alike and consequently are treated alike. At this point, the definition of "alike" is based on the dominant culture, giving cultural blindness ethnocentric overtones. Historically, health programs sought and delivered universal solutions without regard to different communication patterns of different cultures (Airhihenbuwa, 1994). Treating everyone in an unbiased manner would seem to be a reasonable premise for a health program. Cultural blindness, however, does not lead to effective programs.

One explanation for this phenomenon, taken from educational psychology, centers on the role of the dominant culture. Boekaerts (1998) suggests that because culture affects self-constructs, it also affects key features of how individuals learn and process information. As a result, what may be an effective learning environment for members of the dominant culture may not be effective for members of the less-dominant culture, who are being treated like members of the dominant culture. This theory implies that health programs, especially those with education or learning components that are based on a cultural blindness perspective, are not likely to be effective for individuals who are not from the dominant culture.

Another way of thinking about the consequences of cultural blindness is by acknowledging its failure to recognize that ideas and concepts are not the same across cultures due to the differences in self-constructs and learning. From this perspective, the earlier discussion of the need to translate concepts used in questionnaires is another example of how to overcome cultural blindness and its potential consequences for health program planning and evaluation.

Cultural Openness

Cultural openness is the attitude of being receptive to a different culture and to active learning about other cultures. Although other cultures are valued and some knowledge of other cultures exists, cultural openness does not include any integration of cultures or cross-pollination of cultural ideas. In this regard, cultural openness is similar to cultural awareness. Each culture is valued and understood as separate and distinct.

An example of being culturally open is someone from a dominant white culture going to a local Native American powwow or to an inner-city black evangelical church service simply to observe what happens. Cultural openness in health programs would be evident in having minority representation on community or advisory boards for the health program, using consultants with expertise in cultural awareness, and providing

cultural sensitivity training for staff members. Such culturally open practices increase the likelihood that the health program will be culturally appropriate, but they do not ensure its appropriateness. To ensure that the health program is culturally appropriate requires actively seeking information and integrating that information into the design, delivery, and evaluation of the health program. This process requires cultural competence.

Cultural Competence

Cultural competence encompasses not only demonstrating respect for other cultures but also actively seeking advice and consultation from members of the less dominant cultural group about what is culturally appropriate from their perspective. Acting in a culturally competent manner requires various skills that one needs to acquire intentionally. These skills are more specific than listening and being respectful. Continuing with the Native American example, if a tribal healer is consulted and included as a full member in the planning team for a health program intended for members of his tribe, then the health planning team is exhibiting culturally competent behaviors, especially if the healer's approach to healing is included in the program. Generally, cultural competence is understood as an individual characteristic of providers. For example, in a study of medical clinics, Paez, Allen, Carson, and Cooper (2007) found that more culturally competent provider behavior was associated with the clinic having more nonwhite staff members and more culturally adapted patient education materials.

One challenge to understanding what constitutes cultural competence is that other terms may be used to describe it, such as "cultural sensitivity" and "cultural attunement." Both sensitivity and attunement can be viewed as elements of cultural competence. Hoskins (1999) has proposed five principles of cultural attunement: acknowledging the pain of oppression by the dominant culture, engaging in acts of humility, acting with reverence, engaging in mutuality, and coming from a place of "not

knowing." Her work has influenced thinking across health disciplines (e.g., Jackson & Samuels, 2011). Hoskins's principles are notably developed for members of the dominant culture, with the implicit expectation that the member of the dominant culture needs to become culturally competent. In other words, it is incumbent upon the member of the dominant culture to strive for cultural competence. These principles also reveal that cultural competence, as a set of behaviors, may be difficult to attain or maintain over time.

The Lewin Group (2001), writing in a report for the Health Resources and Services Administration (HRSA) on cultural competence, listed nine domains for measuring cultural competence for healthcare organizations: values and attitudes of mutual respect and regard; cultural sensitivity; communication; policies and procedures (i.e., hiring staff members who reflect the linguistic and cultural diversity of the community); training and staff development; facility characteristics; capacity and infrastructure (i.e., cultural appropriateness of the physical environment, materials, and resources; use of posters and brochures with representatives from different races and ethnicities); intervention and treatment features; and community and consumer involvement and participation in decision making, and monitoring and evaluation of research. These domains continue to be relevant and used as the basis for organizational self-assessments.

This list of domains hints at the corresponding amount of work needed to achieve and maintain a culturally competent organization and workforce. These same domains clearly apply to programs.

Cultural Proficiency

At the most culturally capable end of the cultural competency continuum is cultural proficiency, which involves proactively seeking knowledge and information about other cultures, as well as educating others about other cultures. Cultural proficiency, as with any end point on a continuum, is difficult to achieve and may not be sustained for a long period of time. Those rare individuals who can move seamlessly among

cultures, be accepted in those cultures, and act as ambassadors of multiple cultures would be considered culturally proficient.

Being *multicultural*—that is, fully accepting and integrating two or more sets of cultural values and beliefs—is a manifestation of cultural proficiency. Multiculturalism in an organization or program (Cox, 1991) is the extent to which different cultures are fully integrated. It is manifested in programs that integrate folk or professional practitioners and treatment options, have predominantly bicultural staff, celebrate holidays important to cultural groups involved in the program, and synthesize different cultural beliefs into the program plan and implementation.

Enhancing Cultural Competency

Program managers can enhance cultural sensitivity, cultural awareness, and cultural competencies

through several strategies other than hiring consultants or sending staff members for cultural competency training. Cox (2001) has stressed that to have a diverse, friendly organization, workplace, or program requires making system-wide changes, affecting everything from hiring policies to the physical structure of the workplace, that are aligned with valuing and respecting the diversity of personnel.

For example, before making plans for organizational system changes, an organizational or program self-assessment of cultural competency is warranted. A variety of assessment tools have been developed and validated for assessing health-care employees (e.g., Loftin, Hartin, Branson, & Reyes, 2013). In addition, the National Center for Cultural Competence (Cohen & Goode, 1999) has developed a simple checklist (**EXHIBIT 2-1**) for use by program planners as well as by other individuals who have roles in shaping policy

EXHIBIT 2-1 Checklist to Facilitate Development of Cultural and Linguistic Competence Within Healthcare Organizations

Does the healthcare organization, primary healthcare system, or program have:

- A mission statement that articulates its principles, rationale, and values for culturally and linguistically competent healthcare service delivery?
- Policies and procedures for staff recruitment, hiring, and retention that will achieve the goal of a diverse and culturally competent workforce?
- Position descriptions and personnel performance measures that include skill sets related to linguistic competence?
- Policies and resources to support ongoing professional development and in-service training (at all levels) related to linguistic competence?
- Policies, procedures, and fiscal planning to ensure the provision of translation and interpretation services?
- Policies and procedures regarding the translation of patient consent forms, educational materials, and other information in formats that meet the literacy needs of patients?
- Policies and procedures to evaluate the quality and appropriateness of interpretation and translation services?
- Policies and procedures to periodically evaluate consumer and personnel satisfaction with interpretation and translation services that are provided?
- Policies and resources that support community outreach initiatives to persons with limited English proficiency?
- Policies and procedures to periodically review the current and emergent demographic trends for the geographic area served in order to determine interpretation and translation services needs?

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at the federal, state, or local levels. Using this checklist can help determine which areas are in need of attention (Goode, Jones, & Mason, 2002), with actions subsequently being taken to enhance the cultural competency of staff members and the program as a whole.

Enhancing the cultural competency of program staff members begins with recruiting minorities that mirror the composition of potential program participants. Staffing pattern includes having a diverse workforce as a venue for staff members to learn from each culture—that is, from other staff members. The beliefs, values, and goals of individual staff members need to be congruent with those of the organization, which results in the second factor, fit between an individual and the organization is well accepted as an appropriate criterion for hiring decisions (Cable & Judge, 1997; McCulloch & Turban, 2007) and may entail sensitive hiring decisions. Program personnel must believe in achieving cultural competency for all program staff members, not just themselves or other staff.

Cultural competency training sessions ought to be designed to overcome learner resistance and avoid creating stereotypes (Boutin-Foster, Foster, & Konopasek, 2008). One strategy to use with individual program staff members is to make it acceptable to ask questions about cultural beliefs, practices, and norms so that staff members can acquire the information necessary to become more culturally competent. Program personnel need to be able to express both their comfort and their discomfort with other cultures as a step toward receiving whatever information or counseling is needed to overcome the discomfort. Out of respect, cultural labels ought to be avoided, using instead objective descriptors or names of individuals.

Not all staff members will be equally accepting and competent with all other cultures, depending on their cultural background. Some cultures are more accepting and seeking of new experiences than others. Being alert to cultural differences within program staff members is an important step toward developing and ensuring organizational and program

cultural competency. Ignoring the difficulties inherent in having diversity can lead to further problems; therefore, the challenges inherent in moving an organization, a program, or an individual toward cultural competency need to be acknowledged and addressed in a forthright yet sensitive manner.

Another strategy for enhancing the cultural competency of program personnel is to make diversity visible. This effort might include displaying posters or cultural artifacts. It may also include making available to staff members professional journals with a health and culture focus, such as *American Indian Culture and Research Journal*, *Ethnicity and Disease*, *International Journal of Intercultural Relations*, *Journal of Black Psychology*, *Journal of Cross-Cultural Psychology*, *Journal of Health Care for the Poor and Underserved*, and *Journal of Multicultural Counseling and Development*. The high visibility of diversity in the workplace becomes a symbol that reflects the organizational culture of valuing and respecting cultural diversity.

Rea, Martin, & Wright (2002) offer realistic suggestions for addressing cultural issues in the workplace. They recommended avoiding open conflicts over cultural issues, especially given that no one “right way” exists. They also recommend working through informal communication channels when cultural issues need to be addressed or to achieve changes in organizational culture. Another realistic suggestion is for managers to focus on reinforcing those new behaviors that promote cultural competency and sensitivity. Acknowledging that individuals have personalities and thus rotating staff members to other work units or programs may be the best approach in some situations. The positive aspect of this last suggestion recognizes a hard truth: When a fit between the program and staff members does not exist, both parties may benefit from a change in the relationship. The trick to addressing this type of situation in a culturally and legally competent manner is for both parties to understand the issue as one of fit and not as a personal judgment.

► Stakeholders and Coalitions

Another key approach to achieving requisite variety is through the inclusion of diverse stakeholders in the process of planning and evaluating the health program, which is often accomplished through the development of coalitions. Several federal agencies, such as the Office of Minority Health and the Centers for Disease Control and Prevention (CDC), and private foundations, such as the W. K. Kellogg Foundation and the Robert Wood Johnson Foundation, have funding priorities related to health disparities that require programs to engage in coalition development, often in the form of community engagement. The emphasis on developing coalitions parallels the emphasis on health disparities and diversity. Coalitions, partnerships, alliances, consortia, and collaborative linkages are some of the structural forms that result when stakeholders, interested parties, members of the target audience, and professionals with expertise agree to work together toward the common goals of community and health improvements for common constituents. The term *coalition* is used as the umbrella term for such agreements.

Coalitions, in whatever form, can be viewed as potentially having power and being power brokers (Braithwaite, Taylor, & Austin, 2000). Underlying the emphasis on coalition initiatives is growing evidence that collaboration among stakeholders is key to ensuring effective community involvement and to decreasing health disparities. For example, coalitions have proved effective in reducing the number of uninsured children (Stevens, Rice, & Cousineau, 2007). Coalitions for health programs may be developed for a variety of reasons, such as creating a power base from which to gain attention for the health problem or resources to address the problem, or to achieve long-term sustainability of the health program. To achieve this purpose, of course, the coalition must be effective (i.e., successful). In a review of the literature, Zakocs and Edwards (2006) found some evidence that the following

characteristics were associated with greater coalition effectiveness: use of formal rules and procedures, an inclusive leadership style, participation by members, a diverse membership, collaboration with agencies, and group cohesion.

The process of forming a coalition follows commonsense, deceptively simple steps. At the core of a coalition is attention to group process, as the following discussion suggests. The initial step in forming a coalition is to identify potential coalition members who are either individual stakeholders or representatives of organizations with a potential stake in the healthcare program. Naturally, the potential members ought to reflect the diversity being addressed by the health program.

An early step is the task of articulating the common goal for the coalition. Coalitions are more likely to succeed if they have a defined goal with specific tasks that can be realistically accomplished with minimal expense. As coalition members, funding priorities, and leadership changes, and as time passes, the goal for which the coalition was established will need to be reiterated as a sounding board for decisions and directions. It is also worth noting that coalitions have a life cycle, which may begin with a programmatic focus but evolve to have a policy focus (Hill et al., 2007).

Also early in the formation of the coalition, program staff members must build credibility and trust both within the coalition and with stakeholders in its work. It takes time to build trusting and credible relationships, which are inevitably tested over time. Credibility and trust are extremely difficult to recover if lost. The credibility and trustworthiness of organizers are especially important considerations when working with culturally and ethnically diverse groups whose members have had negative experiences with coalitions or health programs in the past.

Rose (2000) suggested two strategies for building relationships in the coalition. One approach is to adopt issues of the coalition members as issues for the coalition. This strategy would be feasible when issues overlap—say, housing affordability and health programs for the homeless. The other strategy is to promote

honest dialogue, in which members can be frank without feeling threatened by retribution for ideas. Complementing this strategy is the adoption of a policy of “agree to disagree.” This ground rule for interactions tends to foster cooperation as well as trust. Rose reminded us that humor is a very effective tool for unifying members and for relieving tensions. It is always healthy to laugh at situations, to find the bright side, and to be amused. This need transcends cultures, despite cultural differences in what makes something humorous.

Throughout the process of forming and working with a coalition, attention to cultural competency is crucial. One aspect of being culturally competent involves conducting a self-assessment that assesses the values and principles that govern participation in coalitions. The National Center for Cultural Competence has developed a checklist that can be used to assess cultural competency in community engagement (Goode, 2001; **EXHIBIT 2-2**). The health program planners could use this tool—after substituting

“program” for “organization”—as a means of gauging the cultural competency of the health program to engage the community in health program development.

► Across the Pyramid

At the direct services level of the public health pyramid, disparities are seen as affecting individuals and their health status. As individuals from diverse cultures, ethnicities, races, and SES backgrounds interact with health professionals and the health program staff, the training in cultural sensitivity and competency is put into practice. If the professionals and staff members have not received or integrated this knowledge into their practice, the potential for continued healthcare disparities is present.

Health programs designed for the direct services level of the pyramid will need to verify that the interventions included in the program match the culture, language, and norms of the

EXHIBIT 2-2 Checklist to Facilitate Cultural Competence in Community Engagement

Does the healthcare organization, primary healthcare system, or program have:

- A mission that values communities as essential allies in achieving its overall goals?
- A policy and structures that delineate community and consumer participation in planning, implementing, and evaluating the delivery of services and supports?
- A policy that facilitates employment and the exchange of goods and services from local communities?
- A policy and structures that provide a mechanism for the provision of fiscal resources and in-kind contributions to community partners, agencies, or organizations?
- Position descriptions and personnel performance measures that include areas of knowledge and skill sets related to community engagement?
- A policy, structures, and resources for in-service training, continuing education, and professional development that increase capacity for collaboration and partnerships within culturally and linguistically diverse communities?
- A policy that supports the use of diverse communication modalities and technologies for sharing information with communities?
- A policy and structures to periodically review current and emergent demographic trends?
- Community partners who are representative of the diverse population in the geographic or service area?
- Ways to identify new collaborators and potential opportunities for community engagement?
- A policy, structures, and resources to support community engagement in languages other than English?

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program recipients. It may also be necessary for the health program to be designed so that the intervention can be culturally, ethnically, and linguistically tailored to those participating in the program at the moment. In terms of measurement considerations at this level of the pyramid, the direct interaction with program participants allows for needs assessment, program process, and program effect data to be collected from individuals, through either quantitative questionnaires or qualitative interviews.

At the enabling services level of the pyramid, disparities are seen as they affect aggregates and families. Diversity is manifested in subcultures or enclave ethnicity, as well as in the larger cultural context. The interpersonal interaction between the program staff members and the program recipients remains an essential element of services at this level. As a consequence, the cultural competency of individual program staff members continues to be important as they implement the program interventions.

The interventions provided as enabling services will need to be tailored to the specific sociocultural characteristics and preferences of the target aggregate. For example, an existing enabling service may be planned for a new target audience. This endeavor would result in fairly specific changes, modifications, or additions to the existing program in an effort to make it culturally and linguistically acceptable to the new target audience. In terms of measurement, data are likely to be collected from individuals, allowing for tailoring the data collection to the characteristics of the aggregate.

At the population-based services level of the public health pyramid, disparities within a population are revealed through the collection of data related to that population, such as vital statistics and healthcare utilization. For all practical purposes, disparities are most easily identified by examining differences within a population, although they can also be identified within large aggregates, such as schools. Because health programs designed for the population level of the pyramid are delivered or provided to the population, interpersonal interaction between program staff members and program recipients

will vary from minimal (e.g., in an immunization campaign) to none (e.g., in a media campaign). Thus, issues of cultural competency for program staff members are lessened.

The need for the intervention itself to reflect cultural competency remains at the population-based service level. Health programs targeted at populations face the challenge of deciding whether to make the program generically acceptable for most members of the population or whether to develop different versions of the intervention tailored to known, culturally distinct subpopulations or aggregates. This challenge, while similar to the need for flexibility in direct services programs, is complicated by the inability to tailor the intervention during a program encounter.

With regard to measurement, most data collected at the population-based services level of the public health pyramid will be on such a scale that simple, generic data collection methods will be needed. This will result in having data that offer less detail but cover more program recipients. Unlike programs at the direct services or enabling services levels, a population-based program may not be able to gather data on actual program recipients. This fact creates a situation in which program planners may need to work more closely with the organizations and agencies responsible for collecting population-level data to ensure that the measures employed are as relevant to the program as possible.

At the infrastructure level, personnel diversity, organizational culture, and program culture all play roles in program planning and delivery. Overall, diversity and disparities are visible through their effects on existing and new health policy and priorities and on organizational processes and culture. Interpersonal interactions among program planners, staff members, stakeholders, and policy makers are the focus of efforts to address health disparities and cultural issues. Programs at the infrastructure level aim to change the cultural competency of the workforce and the capacity of the workforce to address health disparities and cultural diversity.

As with programs for the other levels of the pyramid, interventions implemented at the

infrastructure level need to be tailored to the sociocultural characteristics of the target audience within the infrastructure. In addition, they need to address the professional diversity that exists within the infrastructure, within specific healthcare organizations or agencies, and within the healthcare system as a whole.

With regard to measurement at the infrastructure level, the availability of individual data versus aggregate data will depend on the nature of the health program. Health programs provided to groups of workers, such as cultural competency training, make it possible to measure specific attributes of program participants. Health program interventions designed to change health policy are not amenable to direct data collection but would rely on population-level data, especially for program effects.

One other infrastructure issue that warrants mentioning is the legal implications of diversity. For example, the Americans with Disabilities Act (ADA) of 1990 requires that planning for programs take into account issues of accessibility for disabled persons. Another legal issue relates to antidiscrimination laws, which affect both the management of program personnel and the process by which program participants are recruited and accepted into the health program. State laws and local ordinances regarding same-sex marriage and civil unions may also affect reimbursement for programs, responses to survey questions about marriage, and recruitment of family members into programs. All these factors influence the planning and evaluation of the health program and therefore fall within the purview of the infrastructure level of the public health pyramid.

► Discussion Questions

1. Discuss the ways in which the linguistic diversity of a target audience affects programs being planned at each level of the public health pyramid.
2. Think of a specific health program provided by a specific healthcare organization with which you are familiar. Complete

either of the cultural competency self-assessments included in this chapter (Exhibits 2-1 and 2-2). What surprised you about taking the self-assessment? Which recommendations would you make based on the results of the self-assessment?

3. Identify one health-related questionnaire that has been used with more than one cultural or linguistic group. Discuss the adequacy of the linguistic and conceptual translations of the questionnaire.
4. List four health programs in your community. Are they supported by coalitions? What is the composition of each coalition? Does there appear to be a relationship between coalition diversity and health program success?

► Internet Resources

Centers for Disease Control and Prevention

The Centers for Disease Control and Prevention's National Center for Health Statistics is a good resource for health statistics. It allows users to manipulate data on a specific health indicator by variables such as race or income. Find it at www.cdc.gov/nchs/hdi.htm.

National Center on Cultural Competence

Georgetown University's National Center on Cultural Competence (NCCC) website (<http://nccc.georgetown.edu/>) has a wealth of resources related to cultural competency. The mission of the NCCC is to increase the capacity of health and mental health programs to design, implement, and evaluate culturally and linguistically competent service delivery systems.

Bureau of Primary Health Care

The Bureau of Primary Health Care, which is part of the Health Resources and Services Administration (HRSA), has a website devoted

to creating centers of excellence. The relevant document is entitled *Transforming the Face of Health Professions Through Cultural and Linguistic Competence Education: The Role of the HRSA Centers of Excellence*; it can be found at www.hrsa.gov/culturalcompetence/cultcompedu.pdf.

Public Health Services, Office of Minority Health

The 2013 document entitled *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, by the Office of Minority Health, sets out the standards for linguistically appropriate health care. It and related resources can be found at <https://www.thinkculturalhealth.hhs.gov/Content/clas.asp>.

Medical Anthropology

This medical anthropology website includes a page of culture-specific syndromes, with some explanation and maps. Visit it at http://anthro.palomar.edu/medical/med_4.htm.

The Joint Commission

The Joint Commission. (2010). *Advancing effective communication, cultural competence, and patient and family-centered care: A roadmap for hospitals*. Oakbrook Terrace, IL: Author. Although this workbook is written for hospitals, the content provides a comprehensive overview of the considerations involved in effectively communicating. It can be found at https://www.jointcommission.org/roadmap_for_hospitals/.

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