

---

# Cultural Sensitivities and Health

---

Chuka C. Agunwa and Emmanuel I. Obi

Additional information is available at the end of the chapter

<http://dx.doi.org/10.5772/intechopen.79455>

---

## Abstract

Culture is that complex whole which includes knowledge, belief, art, morals, law, custom, and other capabilities acquired by man as a member of the society. Its components include knowledge, beliefs, norms, techniques, folkways, mores, laws, values, material culture, and universal culture. Health programs and interventions are more effective when they are “culturally appropriate” for the populations they serve. Each medical encounter provides the opportunity for the interface of several different cultures: the culture of the patient, the culture of the physician, and the culture of medicine. Peripheral, evidential, linguistic, constituent involving, and sociocultural strategies enable the health worker practice culturally sensitive healthcare delivery. Cultural targeting and cultural tailoring are applied to groups and individuals, respectively, by taking their peculiarities into account in making health care available to them. A combination of both approaches is recommended for optimal health outcomes. Cultural competency is the answer to the need for previously lacking cultural consideration in planning and delivering care. It enables the health worker overcome organizational and clinical barriers which continually impede efficient and effective healthcare delivery.

**Keywords:** culture, healthcare delivery, beliefs, targeting, cultural sensitivity

---

## 1. Introduction

What is culture? It is a complex term whose concept varies greatly, carrying different meanings depending on the social context and population in which it is applied. However, despite its more than 160 definitions, the definition by Edward Taylor in 1871 has enjoyed the most widespread global acceptability.

*“Culture is that complex whole which includes knowledge, belief, art, morals, law, custom and other capabilities acquired by man as a member of the society.” [1]*

Cultural anthropologist Kenneth Guest provided an effective and useful framework of culture when he stated “culture is a system of knowledge, beliefs, patterns of behavior, artifacts, and institutions that are created, learned, and shared by a group of people” [2].

Culture comprises generally acceptable ways of doing things common to a people which is transmitted from generation to generation. It is a people’s way of life, an embodiment of their identity.

## **2. Components of culture**

### **2.1. Knowledge**

The culture of a people includes a tremendous amount of their knowledge about their physical and social environment. This comprises a vast collection of ideas, ideologies, philosophy, science, and technology which they utilize in the attempt to understand the world they live in. These are usually of cognitive origin and basically include knowledge of how to obtain food, what to eat, how to provide shelter, recognize and treat diseases, protect the community, etc. [3].

### **2.2. Beliefs**

Beliefs are generally acceptable knowledge that can neither be substantiated nor proven to be false. In various cultures, they constitute important aspects of human living.

### **2.3. Norms**

A norm is a value or standard of behavior commonly found in a given group or society. The term is derived from the word “normal.” There are four major types of social norms.

### **2.4. Techniques**

These are norms that guide the methods of carrying out tasks when technical efficiency is of utmost concern. For example, in transportation, horses can be used.

### **2.5. Folkways**

These demonstrate the ways of life of people which place a priority on moral ethics. For example, people are expected to greet those who are older than them, in some African societies, the kola nut is shared and eaten before any important ceremony. However, an infringement of these regulations does not necessarily imply any serious threat to society and therefore does not attract severe penalties.

### **2.6. Mores**

Mores are also ethical regulations but unlike folkways they have significant effects on the survival of the group. Contraventions of mores therefore attract severe penalties. These infringements may come in form of incest, theft, murder, desecration of objects which carry spiritual significance such as items of worship.

## 2.7. Laws

These are norms which are formally coded and enforced by recognized authorities. They tend to include societal mores. Laws cut across all norms, and deviations from them threaten the corporate existence of the society. Thus, society empowers law enforcement agencies who act for common good.

## 2.8. Values

These are important elements of the culture of a society which determines what principles it considers as essential to its well-being and survival. It will usually include important ideals such as freedom, justice, the rule of law, due process, and ceremonies. These ideals form a value system which guides societal life.

## 2.9. Material life

This is the visible, tangible component of a society's way of life. Examples include buildings, dressing, art, books, etc.

## 2.10. Universal culture

There are aspects of culture which have been found to be acceptable to all human societies no matter their origin or location. These components are thus universally acceptable across the world. Some examples include the recognition of gender, age groups in form of childhood, adulthood, and old age [3].

# 3. Culture and health

It is a proven fact that health programs and interventions are more effective when they are "culturally appropriate" for the populations they serve. To effectively and efficiently provide medical care to patients, the impact that culture has on health care must be understood and taken into consideration. In practice, however, the strategies used to achieve cultural appropriateness vary widely [4].

To provide programs and materials that are culturally appropriate, healthcare providers must be able to

- identify and describe cultures and/or subcultures within a given population;
- understand how each aspect of their culture relates to health behavior, and most importantly;
- apply this knowledge in the conceptualization, design, planning, and implementation of activities which bring health care to the people.

Each medical encounter provides the opportunity for the interface of several different cultures: the culture of the patient, the culture of the healthcare provider (e.g., the physician),

and the culture of medicine as a discipline. The success of this interaction influences adherence to medical regimens, patient satisfaction, healthcare utilization, and ultimately health outcomes [5].

The World Health Organization (WHO) global strategy on people-centered and integrated health services is a call for a fundamental paradigm shift in the way health services are funded, managed, and delivered [6]. Behind this new approach is a vision of a time when the needs, personal preferences, and safety of target populations are taken into consideration in health program planning. It is also based on the conviction that this is possible while still maintaining the timeliness, quality, effectiveness, and comprehensive content of these services.

It is sad to note that in many instances, culture is not properly evaluated. There seems to be instead a lot of assumptions made about what the culture of a group of interest is. A typical example is the mistake of assuming that all Asians have a single uniform culture or that all members of the Zulu tribe have identical belief systems. Instead that racial entity comprises several cultural subgroups and any one individual may belong to one, none, or several.

If indeed one could categorize all members of a given population into groups that had practically all aspects of their culture in common, one would have gained the advantage of carving out groups with very high levels of homogeneity. However, the process would produce so many groups, some with scanty numbers, that it would no longer be feasible to address the population any more. Which of the myriad of groups should then become the focus?

At the opposite extreme, culture would be assumed and overgeneralized based on more easily identifiable variables such as race [4]. Neither of these approaches is ideal.

Although it is true that certain cultural characteristics may cluster within a given racial or ethnic group, it is at least equally true that substantial differences exist between individuals and subgroups within these populations [7–10]. Somewhere between these two extremes, we might settle for a slightly deeper, albeit imperfect, understanding of culture that is practical enough to be easily applied yet still potent enough to enhance healthcare delivery efforts.

Many authors have previously described strategies to make health promotion programs and materials more culturally appropriate for target populations and these have been divided into five main categories: peripheral, evidential, linguistic, constituent-involving, and socio-cultural [4]. It should be emphasized that these categories are for organizational clarity only and are not necessarily mutually exclusive. Besides, it is presently common, and advisable, for practitioners to use strategies from multiple categories when a health program is to be planned and implemented. These approaches are explained below.

**Peripheral strategies** ensure that health programs are culturally appropriate by presenting them based on what the perceived interests of the target group are. This is achieved by matching materials to “surface” characteristics of a target population—as is done using peripheral approaches—the group’s receptivity to and acceptance of information and services can be enhanced [11]. For example, materials used for health education can carry national colors or be made from traditionally familiar materials such as “Kente” in Ghana or “Ankara” in Nigeria.

**Evidential strategies** enable a group to identify with a health problem by demonstrating how it affects that group. Most of the time, this is achieved using as proof, information obtained from within the population.

This is put into action, for example, when advocacy for provision of emergency obstetric care facilities within public health centers is made using the following message: “For every 100,000 Nigerian women who get pregnant, 814 will die between pregnancy and 6 weeks after delivery [12]. That is 10% of the global maternal mortality burden. Not only did the country not achieve Goal-5 of the Millennium Development Goals that sought to reduce maternal mortality ratio by 75% by 2015, but it also essentially witnessed a substantial increase in maternal deaths [13]. These women can be saved if the facilities and people who can save them are present in the health centers.”

**Linguistic strategies** take the common language of the target group into consideration when messages are being composed and disseminated. It is because of the key role language plays in engaging communities that authorities such as Rogler have referred to it as “the lowest common denominator of cultural sensitivity” [14].

**Constituent-involving strategies** refer to those which are based on the personal experiences of individuals selected from within the group. Adhering to this approach will involve ensuring a high level of participation by community members in the intended program. This enables it to leverage on their “stories” and endues the program with a lot of familiarity from its audience’s perspective. [15, 16].

**Sociocultural strategies** discuss health-related issues in the context of broader social and/or cultural values and characteristics of the intended target group. It is imperative that this kind of program should be based on a deep understanding of the culture of the people. One should appreciate not just what their cultural practices are but why they behave the way they do. This knowledge makes proper prioritization of activities possible. If, for example, economic wealth is highly regarded in a particular community, it becomes important to study wealth creation opportunities which exist and use them as vehicles of engagement with the target population. Alternatively, the same planners might seek to develop a new program that builds on the population’s religious values in a way that is meaningful to that group [4].

## 4. Cultural targeting and cultural tailoring

### 4.1. Cultural targeting

Cultural targeting is a term that has been given multiple definitions by various authorities. It has been defined as “the use of a **single intervention approach** for a defined population subgroup that takes into account **characteristics shared by the subgroup’s members** [17].” Others have defined it as part of a larger process of audience segmentation in which **appropriate channels for reaching a given group** are identified [18], while another school of thought defines it as “a **single intervention approach** for a defined population subgroup that takes

into account characteristics shared by the subgroup's members" [19]. The concept is based on the assumption that the group has enough characteristics in common to make a single approach effective. In reality, this is not always the case.

#### 4.2. Cultural tailoring

Cultural tailoring, on the other hand, is any combination of information or change strategies intended to reach **specific individuals** based on characteristics that are unique to them related to the outcome of interest, and have been **derived from an individual assessment**.

Historically, only a few health promotion programs made serious attempts to develop culturally appropriate strategies to meet the needs of target populations. But with increasing evidence that health promotion programs and materials will be more effective when cultural factors are taken into consideration health service managers seem to be gradually changing their approach. Recently, most interventions have been based on assumptions of culture. While this may be an improvement of the past, much more precision in culture interpretation and description is required for better outcomes [20].

### 5. Cultural targeting vs. cultural tailoring: striking a balance

Questions have been raised as to whether it is logical to expect a consideration of what is common to a group while still laying emphasis on individual peculiarities. In fact, some authorities have referred to the idea as a paradox [4]. In practice, it is probably unnecessary to expect that one will have to choose between cultural tailoring and cultural targeting when designing and delivering a health service. Instead, it is more important to carefully decide to what extent both approaches need to be combined in order to get the most benefit each offers. There will be situations when the health needs within a target population are so similar that identifying subgroups becomes difficult. In such situations, health tailoring loses its necessity, while targeting becomes the more important approach.

A basic understanding that must be borne in mind is that while a group may have certain characteristics in common (beliefs, values, attitudes, etc.), individuals within the group have imbibed these ideas to different extents, a few not at all. A typical example is the widespread belief in God in African societies.

Therefore, strategies for achieving cultural appropriateness should match the nature of the problem being addressed. The World Health Organization's Sustainable Development Goal Number 10 which seeks to eliminate health disparities can only be achieved by programs which have been adapted based on cultural considerations. This way they will succeed where other programs have failed.

Previous research abounds to prove that minority groups within populations are at a much higher risk of suffering from adverse health conditions such as cardiovascular disease, cancer, etc. While the epidemiology of these conditions indicates that several factors are at play, sociocultural factors have been found to exert a very strong influence on the occurrence of

these diseases. Many indices of poor health situations such as socioeconomic strata, level of education, job-related hazards, and environmental pollution have been found to be more prevalent among minority groups [21, 22]. These poorly represented groups have also been found in greater numbers among the uninsured than among people with insurance. They have higher rates of emergency department use and avoidable hospitalizations, later-stage diagnosis of cancer, and the inability to obtain prescription medications [23, 24].

“Unequal treatment: confronting racial/ethnic disparities in health care,” a report by the Institute of Medicine in 2002 identified more than 175 studies which demonstrated the link between minority groups and several disease conditions. These associations were observed even after the effect of possible confounders such as age, disease stage, socioeconomic status, and treatment facility was eliminated [25].

Furthermore, this groundbreaking research exposed factors which had been initially overlooked as playing important roles in the observed disparities between minority groups and the rest of the population. These included health beliefs, values, personal preferences, ability to identify clinical features of disease, ability to communicate effectively with health workers, level of adherence to preventive measures, and health outcome expectations among others. It is believed that all these factors influence health outcomes via their effect on the way the patient interacts with the health system, whether it be the way services are designed or the people who deliver them [26–28].

## 6. Cultural competence

As the abovementioned evidence accumulated over the years, solutions in the form of “cultural competence” in health care have been prescribed. This refers to a situation where the importance of culture and cultural disparities is taken into consideration and where the design of health programs and services addresses the peculiar cultural needs of a target population. As a result, understanding and addressing the “social context” has emerged as a critical component of cultural competence [26].

A culturally competent healthcare agency, program, or individual provider can function effectively and appropriately in healthcare delivery to culturally diverse individuals. It also involves understanding, appreciation, and respect for cultural differences and similarities within, among, and between culturally diverse populations. To be culturally competent in healthcare delivery, the health professional needs to be sensitive to the differences between groups, to the differences in outward behavior, and also to the attitudes and meanings attached to emotionally related health issues like depression, pain, and disability [29].

The extent to which a society perceives health information or medication as being relevant to them has a profound effect on their reception to and willingness to use them. Even at individual levels, culture-specific values greatly influence perception of sickness and disease, patient roles, expectations, how much information the patient desires, what treatment modalities are acceptable, gender and family roles, and processes of taking decisions concerning health care [26].

It is important to note that no two patients will interpret what good health care is in exactly the same way. This interpretation will be based on personal backgrounds and experiences which have been found to be influenced to a large extent by factors like age, gender, ethnicity, race, religion, and economic status. These factors influence the perception of the individual who receives a health service or product [30]. Therefore, it is important to note that a culturally sensitive healthcare delivery system limits barriers as regards culture and language thus bringing about desirable health outcomes and positive behavioral adjustments.

Cultural competency is one of the main ingredients in closing existing disparities in access to health care. It is one-way healthcare providers, and their target audiences can always find a common ground as they address health issues. Patients and doctors, population groups, and healthcare organizations can work together to achieve positive health outcomes in such a way that cultural differences become an advantage instead of a weakness. This is possible when the beliefs, practices, and cultural needs of communities are given high priority [31].

Agreement on what terms to use is not universal as words like “cultural responsiveness,” “cultural humility,” and cultural effectiveness” have been used, each of which has a unique definition. However, a sense of agreement exists based on the fact that each proponent of the above terms has recognized certain aspects of health delivery, especially the patient-provider relationship, as critical part of the concept. What seems to be lacking, however, is the development of a more comprehensive approach to thinking about and implementing cultural competence in health care at multiple levels and from multiple perspectives in order to overcome barriers which exist at organizational and individual levels.

## **7. Barriers to cultural competence**

### **7.1. Organizational level**

Cultural competence of health interventions is largely determined by leadership within organizations as well as discharge of a myriad of functions carried out by individual members of the healthcare team. The degree to which the makeup of major establishments reflect the different groups that make up the target population will influence how culturally adequate the policies, procedures, and decisions made will be. Available evidence suggests that inequalities of representation at strategic, management, and operational levels within the health organization result in poor acceptability and access to health services.

Inadequate minority representation in governance, administrative, and clinical leadership roles causes healthcare systems to be disconnected from the minority communities they serve.

### **7.2. Case study 1 (a transgression of the principle)**

Mr. Audu Bako had just discovered he was HIV positive. It came to him as a shock; despite the fact that he had four wives and several other “mistresses” and never practiced safe sex, he had never thought that this dreaded disease would catch up with him. After all, none of his friends had it. He would never divulge his condition to anyone, not even his wives. If his

neighbors or coworkers discovered his secret, he would become a laughing stock of the community. He would lose his respect, people would keep their distance from him, even avoid him completely.

He had been referred to an HIV clinic at the big hospital at the center of town. He was not comfortable going there. He would have preferred a place at the outskirts of town or even another town where he was unknown. He cautiously approached the entrance to the clinic which he identified with the large signboard outside it. As he made to enter, he saw his landlord Chief Alfred Nwosu stepping out of the clinic with a polythene bag in his hand, glancing cautiously in either direction as he made to exit the clinic. Audu swiftly changed his direction and hurried away before he was spotted. He walked back to the car park and drove his car away hurriedly. He never came back.

What went wrong? The clinic was located separately from other clinics in the hospital making it easy to identify its clients. In African countries like Nigeria, HIV is still associated with a lot of prejudice against the victim as most people associate it with sexual promiscuity, even blaming patients for their condition. Audu would rather take his chances elsewhere than be seen at the clinic, than to be labeled one of "them."

### **7.3. Case study 2 (a transgression of the principle)**

Dr. Sanjay Patel sat down in his consulting room at the large hospital in Calgary, Alberta, where he worked as an Obs/Gyn consultant providing family planning services. His last client for the day was a middle-aged woman of Asian descent. Her file indicated she was 42 years old and that her name was Mrs. Fei hung Zhao. It also indicated a bad obstetric history and the fact that she already had five children. Three minutes into the interaction, it dawned on Dr. Patel that his client's understanding of English was quite poor. Further enquiry revealed that there was no member of staff who could speak any Chinese. He tried to get across to her with some basic words and a lot of sign language. She refused the hormonal contraception (as an injection or IUCD) which was ideal for women of her age but preferred oral pills. He tried his best to instruct her on how to take them and asked her to return in a month with a family member. Fei hung returned 5 months later; she was 3 months pregnant.

What went wrong? The Mandarin community comprises about 3% of the Canadian population. It is a conservative society and as such Fei hung was not comfortable discussing birth control with a man, especially one of a different race. Not one member of the Chinese community worked in the hospital. The language barrier ensured that she did not understand most of Dr. Patel's attempt to educate her and her rejection of hormonal contraception was because she felt it would make her fat. She misunderstood the directions on how to take her pills and when to return. By the time she got pregnant, she was shocked and disappointed; she really felt she had done all the right things.

### **7.4. Clinical level**

When there is a failure to properly appreciate, understand, and even explore cultural differences during the patient-provider interaction, clinical barriers to healthcare delivery arise.

These differences manifest during interactions with different patients and within diverse settings and situations. A reasonable level of flexibility, perception, and judgment is therefore required.

When cultural and linguistic barriers in the clinical encounter negatively affect communication and trust, it leads to patient dissatisfaction, poor adherence (to both medications and health promotion/disease prevention interventions), and poorer health outcomes.

According to Kreuter et al. [4], “Cultural competence” in healthcare delivery demands three basic skills when quality healthcare delivery to varied patient populations is the focus:

- The ability to understand how sociocultural factors affect personal beliefs and behavior.
- An appreciation of how these factors influence decision-making at all levels of the health-care system.
- Capacity to design, plan, and implement interventions that take these issues into account.

### **7.5. Case study 3 (an observance of the cultural competence principle)**

Dr. Teta Greene stood in front of a gathering of 120 members of the Freetown branch of the Sande society, a fraternity of Liberian women. Her mission in that community was to start a campaign against the dehumanizing practice of female genital mutilation which had caused untold hardship for many years. When it was time for her address them, Dr. Greene introduced herself and two men who had accompanied her. After a brief introduction, both men proceeded to address the women for the next 30 minutes. By the end of the talk, many women were in tears. Dr. Greene asked women who were willing to help stop the practice among their children, families, and community to raise their hands. More than half of the group raised their hands and gave their names as a sign of commitment. How did she get that kind of response?

Dr. Greene knew that genital mutilation is a ritual for admission into the Sande fraternity so the entire audience had experienced it and were suffering from its various complications. The first speaker was an elderly public school headmaster who was well respected in the community and whose mother had been mutilated as a child. The second speaker was a Catholic priest who was well respected in the predominantly Catholic community. Both men spoke about the dangers of the practice and how the same women subjected to it were its strongest promoters. The message was right, the messengers were ideal, and therefore the required change was achieved.

### **7.6. Case 4 (an observance of the principle)**

The acceptance of family planning in Egypt had been very low for centuries, and as a result, contraceptive prevalence rates were poor and maternal mortality high. However, in the late 1930s, the Grand Mufti, considered the highest authority as far as the interpretation of the Quran was concerned, issued a document endorsing contraception. He stated that contraception was in no way against the tenets of Islam. This led to the establishment of family

planning clinics across the country and positive changes in fertility indices [32]. What brought about this change? In many countries, especially in Africa and the Middle East, the most influential voices are those of religious leaders. Where a health service goes against religious beliefs, wide acceptance is almost impossible even when other cultural factors are taken into consideration. Ensuring that the health “product” is supported by religious institutions is fundamentally strategic in these societies.

Based on the illustrations above, it needs to be clearly stated that cultural competence is required at several critical points within the healthcare delivery process. For ease of understanding, these have been divided into three; organizational, structural, and clinical interventions:

**Cultural competence at organizational levels:** interventions deployed at this point must ensure a reasonable level of diversity in the composition of leadership and personnel of a healthcare organization to ensure that it is representative of its target population.

**Cultural competence at structural levels:** this requires efforts to ensure that healthcare delivery processes and activities are designed in such a way that they guarantee reasonable levels of access to quality care for all subgroups within the population that system serves [26].

**Cultural competence at clinical levels:** interventions required here are steps taken to improve the capacity of a healthcare practitioner to recognize, understand, and harness cultural peculiarities of individual patients in the provision of health-related information and care.

## 8. Conclusion

In conclusion, the face of health care is changing. The concepts of cultural awareness, cultural competence, and cultural sensitivity are gradually becoming standard terminologies in quality healthcare delivery. It has therefore become more imperative that they are understood and practiced.

With constant changes in the composition of global populations, it becomes more likely that disconnections may exist at points where services are rendered, including healthcare services. It also becomes more important that these differences are managed in such a way that the management of each patient is devoid of bias. Regardless of whether the healthcare provider is a nurse, physician, therapist, admissions clerk, or other professional, there are opportunities each and every day to interact with patients and their families and to succeed or fail in the application of the concepts of cultural sensitivity.

There is compelling evidence that proves the connection between patients’ satisfaction with their healthcare providers and various healthcare provider behaviors. This implies that ability to deliver quality health care in its true sense will depend more and more on how much the information and skill the health worker has is “colored” by cultural sensitivity.

Finally, there is a growing need for healthcare workers to be aware of the predominant cultural factors that influence how their clients think and behave. These individuals must be

empowered with skills which enable them to attend to the various collections of people they serve. Several interventions have been recommended and include in-house training, case study reviews, live interactions with patients, role-playing, and the use of continuing education healthcare videos. Regular periodic assessments based on established standardized procedures are also important for objective measurements of progress made.

## Author details

Chuka C. Agunwa\* and Emmanuel I. Obi

\*Address all correspondence to: [chukaagunwa@gmail.com](mailto:chukaagunwa@gmail.com)

Department of Community Medicine, College of Medicine, University of Nigeria, Enugu, Nigeria

## References

- [1] Edward T. Primitive Culture: Researches into the Development of Mythology. Physiology, Religion, Art and Custom. Vol. 1. London: John Murray Publishers; 1871
- [2] Guest KJ. Cultural Anthropology: A Toolkit for a Global Age. WW Norton & Company; 2017. <http://books.wwnorton.com/books/webad.aspx?id=4294994619>. [Accessed: May 7, 2018]
- [3] Aniebue PN. Introduction to Medical Sociology. Vol. 1. Institute of Developmental Studies, University of Nigeria, Enugu; 2008. p. 19
- [4] Kreuter MW, Lukwago SN, Clark EM, Sanders-Thompson V. Achieving cultural appropriateness in health promotion programs: Targeted and tailored approaches. *Health Education & Behaviour*. 2002;**30**(2):133-146
- [5] Bussey-Jones J, Genao I. Impact of Culture on Health Care. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2594562/pdf/jnma00312-0094.pdf>. [Accessed: May 7, 2018]
- [6] WHO Global Strategy on People-Centred and Integrated Health Services. [http://apps.who.int/iris/bitstream/handle/10665/155002/WHO\\_HIS\\_SDS\\_2015.6\\_eng.pdf;jsessionid=1C3C231332898AC3207C424B1562B9E3?sequence=1](http://apps.who.int/iris/bitstream/handle/10665/155002/WHO_HIS_SDS_2015.6_eng.pdf;jsessionid=1C3C231332898AC3207C424B1562B9E3?sequence=1). [Accessed: May 8, 2018]
- [7] Pasick RJ, D'Onofrio CN, Otero-Sabogal R. Similarities and differences across cultures: Questions to inform a third generation for health promotion research. *Health Education Quarterly*. 1996;**23**(suppl):S142-S161
- [8] Gurak D, Rogler L. New York's newimmigrants: Who and where they are. *The Hispanics*. New York University Education Quarterly. 1980;**11**:20-24
- [9] Zimmerman R, Vega W, Gil A, Warheit G, Apospori E, Biafora F. Whois Hispanic? Definitions and their consequences. *Am J Pub Health*. 1994;**84**:1985-1987

- [10] Huerta E, Macario E. Communicating health risk to ethnic groups: Reaching Hispanics as a case study. *Journal of the National Cancer Institute. Monographs.* 1999;(25):23-26
- [11] Resnicow K, Baranowski T, Ahluwalia J, Braithwaite R. Cultural sensitivity in public health: Defined and demystified. *Ethnicity and Disease.* 1999;9:10-21
- [12] World Health Organization. Trends in Maternal Mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, World Bank and the United Nations Population Division. Geneva, Switzerland: World Health Organization; 2015. [Accessed: July 29, 2017]. Available from: <http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/>
- [13] Alkema L, Zhang S, Chou D, et al. A Bayesian approach to the global estimation of maternal mortality. *ArXiv151103330 Stat.* 2015. [Accessed: August 15, 2017]. webpage on the Internet. [cited August 15, 2016]. Available from: <http://arxiv.org/abs/1511.03330>
- [14] Rogler LH, Malgady RG, Costantino G, Blumenthal R. What do culturally sensitive mental health services mean? *The American Psychologist.* 1987;42:565-570
- [15] Eng E, Parker EA, Harlan C, editors. Lay health advisors: A critical link to community capacity building (special issue). *Health Education & Behavior.* 1997;24:407-510
- [16] Thomas J, Eng E, Clark M, Robinson J, Blumenthal C. Lay health advisors: Sexually transmitted disease prevention through community involvement. *AmJ Pub Health.* 1998;88:1252-1253
- [17] Pasick RJ, D'Onofrio CN, Otero-Sabogal R. Similarities and differences across cultures: Questions to inform a third generation for health promotion research. *Health Education Quarterly.* 1996;23(suppl):S142-S161
- [18] Rimal R, Adkins D: Using Computers to Narrowcast Health Messages: The Role of Audience Segmentation, Targeting, and Tailoring in Health Promotion. Paper presented at the American Public Health Association annual meeting, Atlanta, GA; 2001. p. 100
- [19] Kreuter M, Skinner C. What's in a name? *Health Education Research.* 2000;15:1-4
- [20] Kreuter M, Strecher V, Glassman B. One size does not fit all: The case for tailoring print materials. *Annals of Behavioral Medicine.* 1999;21:1-9
- [21] Williams DR. Socioeconomic differentials in health: A review and redirection. *Soc Psych.* 1990;53:81-89
- [22] Pincus T, Esther R, DeWalt DA, Callahan LF. Social conditions and self management are more powerful determinants of health than access to care. *Annals of Internal Medicine.* 1998;129:406-401
- [23] Andrulis DP. Access to care is the centerpiece in the elimination of socioeconomic disparities in health. *Annals of Internal Medicine.* 1998;129:412-416
- [24] Department of Health and Human Services (US) and Health Resources and Services Administration (US). Health care Rx: access for all: barriers to health care for racial and

ethnic minorities: access, workforce diversity and cultural competence. A report prepared by the Department of Health and Human Services and the Health Resources and Services Administration for the Town Hall Meeting on the Physician's Initiative on Race; 1998 Jul; Boston, MA

- [25] Institute of Medicine. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington: National Academies Press; 2002
- [26] Betancourt JR, Green AR, Carillo AE, Ananeh-Frimpong O. Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*. 2003;**118**:293
- [27] Eisenberg JM. Sociologic influences on medical decision making by clinicians. *Ann Int Med*. 1979;**90**:957-964
- [28] Carrillo JE, Green AR, Betancourt JR. Cross-cultural primary care: A patient-based approach. *Ann Int Med*. 1999;**130**:829-834
- [29] Seibert PS, Stridh-Igo P, Zimmerman CG. A checklist to facilitate cultural awareness and sensitivity. *Journal of Medical Ethics*. 2002;**28**(3):143-146. DOI: 10.1136/JME.28.3.143
- [30] Culturally Sensitive Care is Quality Patient Care | Envision Inc's Healthcare Blog. <https://envisioninc.wordpress.com/2010/05/24/culturally-sensitive-care-is-quality-patient-care/>. [Accessed: May 7, 2018]
- [31] US Department of Health and Human Services, The Office of Minority Health -What Is Cultural Competency? Available at [https://www.cdc.gov/nchhstp/socialdeterminants/docs/what\\_is\\_cultural\\_competency.pdf](https://www.cdc.gov/nchhstp/socialdeterminants/docs/what_is_cultural_competency.pdf). [Accessed: May 9, 2018]
- [32] Shaikh BT, Azmat SK, Mazhar A. Family Planning and Contraception in Islamic Countries: An Annotated Bibliography. Saarbrücken: Lambert Publishing; 2012. p. 1