Cultural Competence

in HEALTH EDUCATION *and* HEALTH PROMOTION

SECOND EDITION

Miguel A. Pérez | Raffy R. Luquis
Editors

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Published by Jossey-Bass
A Wiley Brand
One Montgomery Street, Suite 1200, San Francisco, CA 94104-4594—www.josseybass.com

Library of Congress Cataloging-in-Publication Data

Cultural competence in health education and health promotion / Miguel A. Pérez and Raffy R. Luquis. — Second edition.
pages cm
Includes bibliographical references and index.
ISBN 978-1-118-34749-2 (pbk.) — ISBN 978-1-118-45016-1 (epub) — ISBN 978-1-118-34749-2 (pbk.)
1. Transcultural medical care—United States. 2. Minorities—Medical care—United States. 3. Health education—United States. 4. Health promotion—United States. I. Pérez, Miguel A., 1969- editor of compilation. II. Luquis, Raffy R., 1966- editor of compilation.
RA418.5.T73C853 2014
362.1089—dc23
2013027867

Printed in the United States of America
SECOND EDITION
PB Printing 10 9 8 7 6 5 4 3 2 1

CONTENTS

We dedicate this publication to our supportive spouses and dedicated children. Helda and Susan, we could not have done this without your support and encouragement. Thanks for being part of our lives.

FOREWORD

For all health educators, regardless of their practice setting, cultural competency is essential for effective practice. With the increasing demographic changes in the US population, the importance of promoting health equity and reducing health disparities, and a greater emphasis on global health, it is important for the profession to have an informative, competency-based, practice-oriented resource for promoting the development and enhancement of skills related to cultural competency. This second edition of *Cultural Competence in Health Education and Health Promotion* meets this need. The book has been organized and written not only to provide the basics in helping prospective health educators develop knowledge and skills related to cultural competency but also to develop the deeper understanding and mastery of more nuanced skills to truly become culturally competent health educators.

Coeditors Miguel A. Pérez and Raffy R. Luquis have organized the content in a format that addresses important health education considerations related to culture, race, and ethnicity, including a clear explanation of the distinction among these three terms. Chapters 1 and 2 present a clear rationale for the importance of cultural competency among health educators, including data related to health status among different cultures, races, and ethnic groups. These chapters also present a description of health disparities among these groups in the United States.

Throughout the book, cultural understanding is promoted through content such as a framework for understanding culture, cultural factors that can affect the practice of health education, and several models for assessing the role of culture in the prevention of disease and the promotion of health. Emphasis is placed on linking cultural understanding to both health education theory and common health education approaches to program planning, implementation, and evaluation. The chapter authors have addressed a wide spectrum of important but often overlooked topics related to cultural diversity, such as the role of place as a social determinant, diversity within individual cultures, the linkage of culture to complementary and alternative medicine, and the importance of awareness and skills related to the role health education plays within the lesbian, gay, bisexual, transgender, and aging communities. It is important to note that the content throughout

this book relates directly to the National Commission for Health Education Credentialing, Inc., Areas of Responsibilities for Health Educators.

The book goes far beyond the thorough provision of information. The format of this book is presented in a manner that promotes meaningful application of the content. The objectives listed at the beginning of each chapter provide direction for both instructors and students. Following the presentation of the content, each chapter provides a conclusion, points to remember, and key terms, features that enable students to review, organize, and analyze their understanding of the content within the chapters. In addition, each chapter includes a case study that applies the chapter content to a hypothetical health education scenario. Beyond the case studies, the content of the book sets the stage for further activities within and outside the classroom that will engage students in meaningful learning activities emphasizing critical thinking and authentic application of the knowledge and skills addressed in the chapters.

From my perspective as a university faculty member and department chair, I see this book as an excellent resource for both instructors and students in undergraduate or graduate courses in which cultural competency is an important topic. I certainly see it as a primary textbook in classes that focus on cultural competence in health education and promotion. Because of the applied nature of this book to health education practice and the essential nature of cultural competency to all that we do as health educators, I also see it as a supplementary textbook in classes that address planning, implementation, and evaluation in health education and health promotion.

While I consider this book to be an outstanding textbook for undergraduate and graduate professional preparation classes, it is also an excellent addition to the professional library of health education practitioners regardless of practice setting. Chapter 12 addresses the need for cultural competence among practicing health educators. The chapter authors identify tools that can be used to assess the cultural competence of organizations involved in health education. One recommendation in the chapter is that organizations provide ongoing cultural and linguistic training to health educators. *Cultural Competence in Health Education and Health Promotion* could serve as an excellent resource for such training.

Health education and health promotion will never realize its full potential until skilled practitioners are able to consistently develop and implement programs that meet the needs and maximize the assets of individuals and communities representing all cultures. To do this, we must ensure that our professional preparation programs help prospective professionals develop the knowledge, understanding, and skills that are essential for cultural competency. In addition, health educators engaged in professional

practice must maintain their competencies as communities continue to be enriched through increasingly diverse populations. I believe that *Cultural Competence in Health Education and Health Promotion* will serve as a valuable resource as we move forward to meet this challenge.

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PREFACE

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

This textbook is unique in that it focuses on issues of cultural and linguistic competency as they influence the health education and health promotion field. Each chapter is written by and for health education academicians and practitioners. Each author presents a thorough examination of the literature and research about the impact of culture, race, and ethnicity on health disparities, health equity, communication, beliefs systems, education strategies, and other factors essential to have a complete understanding of cultural and linguistic competency. This edition has been expanded in several ways to provide both students and practitioners with a better understanding of cultural and linguistic competency within health education and health promotion. All chapters have been revised or expanded to reflect up-to-date information on cultural and linguistic competency health education—including the revised CLAS standards released in late April 2013. Each of the chapters provides key terms and a case study (except for Chapter 12) for students and practitioners to apply the concepts discussed.

This textbook contains twelve chapters that center on the common theme of learning and understanding different cultures. Chapter 1, "Implications of Changing US Demographics for Health Educators," provides current information on demographics and descriptions of the profiles of major ethnic and racial populations in the United States. New to this edition, Chapter 2, "Diversity and Health Education," focuses on concepts of diversity, race, ethnicity, and culture. Also new to this edition, Chapter 3, "Health Disparities and Social Determinants of Health: Implications

for Health Education," addresses social determinants of health and their influence over health and health disparities in the United States. Chapter 4, "Complementary and Alternative Medicine in Culturally Competent Health Education," provides an overview of the principles involved in the practice of complementary healing, alternative medicine, and holistic health. The completely revised Chapter 5, "Spirituality and Cultural Diversity," provides information on religious and spiritual trends in the United States and their influence on health and well-being. Chapter 6, "Health Education Theoretical Models and Multicultural Populations," describes and provides examples of how to apply two theoretical models and two assessment frameworks that address the role of culture in the prevention of disease and promotion of health. Chapter 7, "Planning, Implementing, and Evaluating Culturally Appropriate Programs," has been revised to focus on factors to consider when developing health education programs for culturally diverse individuals and groups. Chapter 8, "Culturally Appropriate Communication," has been revised to include the health communication model, the importance of verbal and non-verbal communication across different groups, and strategies for how to incorporate linguistic competency into health education and health promotion. New to this edition, Chapter 9, "Foundations for Health Literacy and Culturally Appropriate Health Education Programs," provides a definition of health literacy, its importance to health education, and the relationship between health literacy and cultural competence. Both Chapter 10, "The Aging US Population: An Increasing Diverse Population," and Chapter 11, "Culture and Sexual Orientation," provide an exploration of issues affecting two unique cultural groups and the role of health educators and practitioners in addressing their respective needs. Finally, Chapter 12, "Cultural Competency and Health Education: A Window of Opportunity," provides some final thoughts on the importance of cultural and linguistic competence and discusses how to integrate these concepts into health education and health promotion programs.

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

THE EDITORS

Miguel A. Pérez is a health educator who specializes in international health and applied research, adolescent health issues, and cultural competence. In 2001, he received a Fulbright Award to teach at the Universidad El Bosque in Bogota, Colombia. In 2005, he was a Fulbright senior specialist scholar in public/global health at the Nelson Mandela Metropolitan University, South Africa. In 2006, he was a Fulbright senior specialist scholar in public/global health at the Universidad del Norte in Barranquilla, Colombia. Most recently he has worked in developing health promotion training programs in the Dominican Republic and Thailand. He has been the chairperson of the Department of Public Health at Fresno State since 2008. Pérez received his doctorate from Penn State University and is a fellow with the former American Association for Health Education and with the Research Consortium of the American Alliance for Health, Physical Education, Recreation, and Dance.

Raffy R. Luquis is an associate professor and the program coordinator of the health education master's degree in the School of Behavioral Sciences and Education at Penn State Harrisburg. He earned his PhD in health science at the University of Arkansas and his MS in health education and his BS in science at the Pennsylvania State University. His primary teaching and research interests are multicultural health, cultural competency in health promotion, community health, program evaluation, and human sexuality. He has numerous refereed publications and more than fifty national, regional, and state presentations. He is a fellow of the former American Association for Health Education and the Research Consortium of the American Alliance for Health, Physical Education, Recreation, and Dance. He earned the master certified health education specialist credential from the National Commission for Health Education Credentialing in 2011.

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William H. Dailey Jr. is a gerontology lecturer in the Department of Public Health and the Department of Social Work/Gerontology at Fresno State and also teaches at Fresno City College as a faculty member in the Social Sciences Department. He also works with Farley, his guide dog. William earned his doctorate of education focusing on the area of educational leadership and change in dealing with disabilities related to aging issues at Fielding Graduate University. His doctoral dissertation focuses on the collaborative limitations, perceptions, and interactions among practitioners to meet the needs of an increasing elder population. Dailey was appointed as a delegate to the White House Conference on Aging held in December 2005 in Washington, DC. He continues to collaborate with the California delegation on key aging issues. His research interests include the role of grandparents in raising their grandchildren, aging and disability issues facing elders, alternative housing and transportation issues, and LGBT elders.

Alba Lucia Diaz-Cuellar is assistant professor of health promotion in the School of Health and Human Services—Department of Community Health at National University. She has more than twenty-five years of experience in public health and education fields, working with diverse communities of all ages and ethnic backgrounds. She is an active member of the United Nations Children's Fund, which she served as director of health and education programs in Africa (Guinea Bissau, Nigeria, South Africa), Southeast Asia (Thailand, Myanmar), and Latin America (Bolivia, Peru, Ecuador, Colombia,

and Venezuela). In addition to teaching and research, she conducts short-term consultancies with the United Nations on worldwide projects on peace processes, the reduction of education and health disparities, and the elimination of extreme levels of poverty. Her research interests include the interconnections of politics, power, and poverty, with special emphasis on social justice, indigenous health, international migration, community organizing, and community empowerment. Her most recent research has focused on the area of health promotion and disease prevention, particularly health education and health advocacy. The core of her community-based research lies in the investigation of the impact of grassroots interventions, the use of community-based health educators (indigenous *promotoras)* for the dissemination of the concept of the Ulysses syndrome at national and international levels.

Suzanne F. Evans serves as core faculty and the School of Education online coordinator at Pacific Oaks College in Pasadena, California. Prior to joining Pacific Oaks, she served as an associate professor in the School of Health and Human Services at National University. As a member of the full-time graduate faculty, she taught in the community health, public health, and health education programs. She previously taught in the School of Education in teacher education, special education, reading, and curriculum development. Because of her belief that scholarship is an integral aspect of the role of professional educators, her research agenda and scholarship activities have focused on culture-centered education, culturally proficient practices, the value and utilization of multicultural literature, professional development with teachers in the use of transformative and culturally responsive pedagogy, and stress and resilience.

Bertha Felix-Mata completed a bachelor's degree in psychology at California State University, Fresno. She earned a master's degree in public health with emphasis in behavioral sciences and health education at the University of California Los Angeles and a doctorate in education from Fielding Graduate University, School of Educational Leadership and Change. She has assumed key leadership roles in seeking and obtaining program funds to provide access to health care and educational programs specifically addressing disadvantaged populations. She volunteers as a speaker and volunteer board member for various organizations. Felix-Mata has served as adjunct professor for Fresno State University, where she taught in the department of Chicano Latino studies, women's studies, and the Health Science Department. Her lifelong community service has been recognized by the California State Legislature with the 2000

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ACKNOWLEDGMENTS

We thank each of the contributors to this book for their dedication to the field of health education and for sharing their knowledge, experiences, and expertise in the chapter they developed. We extend our appreciation as well to the staff at Jossey-Bass for their careful review and assistance in the development of this book. Proposal reviewers Kathleen G. Allison, Denise Britigan, Bonnie Chakravorty, Quynh Dang, Heather Diaz, Amy Hammock, Cynthia Hatcher, Nishele Lenards, Kimberly Parker, Lori Pelletier, Augusta Villanueva, Ashley Walker, Charles M. Ware, Karen Winkler, and Kathleen J. Young provided valuable feedback on the original book proposal. Denise Britigan, Bonnie Chakravorty, and Kimberly Parker also provided thoughtful and constructive comments on the complete manuscript.

We dedicate this work to the countless individuals who have helped us along the way and have encouraged us to pursue our dreams. Special thanks to our families who through their support, understanding, and patience have made this dream a reality. We love you!

M.A.P.
R.R.L.

CHAPTER 1

IMPLICATIONS OF CHANGING US DEMOGRAPHICS FOR HEALTH EDUCATORS

Miguel A. Pérez
Raffy R. Luquis

The 1985 *Secretary's Report on Black and Minority Health* for the first time authoritatively documented the health disparities that different population groups in the United States experience (US Department of Health and Human Services, 1998). This seminal report provided the basis for the Healthy People initiative, which has established ambitious health benchmarks to be achieved at the end of their respective time frames (US Department of Health and Human Services, 2011).

Healthy People 2020 establishes the current national health targets, with four overarching goals to be achieved by the end of the decade (see box 1.1). Achieving these goals depends on collaboration among sundry segments of society to ensure that Americans not only have access to superior health care services but also incorporate preventive measures, including health education, into their daily lives.

The goals established by Healthy People 2020 require an understanding of *demographic shifts* and their impact on the health status of selected population segments. This chapter explores the impact of demographic changes on preparing a culturally competent health education workforce. It also provides a brief description of relevant cultural characteristics of each of the major ethnic groups in the United States.

LEARNING OBJECTIVES

After completing this chapter, you will be able to

- **Identify the four overarching goals in Healthy People 2020.**
- **Explain the demographic changes and population trends in the United States.**
- **Describe selected characteristics of the major racial and ethnic groups in the United States.**
- **Discuss challenges and opportunities for health educators.**

demographic shifts
Statistical changes in the socioeconomic characteristics of a population or consumer group.

BOX 1.1 HEALTHY PEOPLE 2020 OVERARCHING GOALS

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development, and healthy behaviors across all life stages.

Demographic Shifts

Demographic Characteristics

Data from the 2010 decennial census show that 308,745,538 resided in the United States in 2010 (US Census Bureau, 2011a) with steady population increases expected until 2050 (see table 1.1). Moreover, the Census Bureau projects that the nation will become more diverse and the majority of the population will be concentrated in urban areas, continuing a trend that started in the late nineteenth century.

Table 1.1 Projections of the Population and Components of Change for the United States, 2015–2050

Year	Population	Numeric Change	Percent Change
2015	325,540	3,117	0.97
2020	341,387	3,196	0.95
2025	357,452	3,217	0.91
2030	373,504	3,206	0.87
2035	389,531	3,209	0.83
2040	405,655	3,240	0.81
2045	422,059	3,315	0.79
2050	439,010	3,450	0.79

Source: US Census Bureau (2008a).

Note: Resident population as of July 1 for each year. Numbers in thousands.

race
The categorization of parts of a population based on physical appearance due to particular historical social and political forces

ethnicity
Pertaining to or characteristic of a people, especially a group (ethnic group) sharing a common and distinctive culture, religion, language, or the like

Race and Ethnicity

Census data project a continuing diversification of the US population in terms of *race* and *ethnicity* (see table 1.2). In fact, the Agency for Healthcare Research and Quality projects that members of underrepresented groups

Table 1.2 Projections of the Population by Sex, Race, and Hispanic Origin for the United States, 2015–2050 (in thousands)

Sex, Race, and Hispanic Origin	2015	2020	2030	2040	2050
One race	319,105	333,913	363,621	392,875	422,828
White	256,306	266,275	286,109	305,247	324,800
Black	42,137	44,389	48,728	52,868	56,944
AIAN	3,472	3,759	4,313	4,875	5,462
Asian	16,527	18,756	23,586	28,836	34,399
NHPI	662	734	885	1,048	1,222
Two or more races	6,435	7,474	9,883	12,781	16,183
Race alone or in combination:					
White	261,922	272,835	294,881	316,707	339,441
Black	44,906	47,748	53,519	59,454	65,703
AIAN	5,463	5,907	6,770	7,654	8,592
Asian	18,952	21,586	27,352	33,722	40,586
NHPI	1,325	1,480	1,814	2,181	2,577
Not Hispanic	267,828	275,022	287,573	297,432	306,218
One race	262,309	268,648	279,243	286,782	292,876
White	203,208	205,255	207,217	206,065	203,347
Black	39,916	41,847	45,461	48,780	51,949
AIAN	2,548	2,697	2,946	3,157	3,358
Asian	16,141	18,308	22,991	28,064	33,418
NHPI	497	541	628	716	803
Two or more races	5,519	6,374	8,329	10,650	13,342
Race alone or in combination:					
White	208,014	210,838	214,599	215,604	215,411
Black	42,267	44,697	49,518	54,339	59,318
AIAN	4,194	4,445	4,874	5,256	5,633
Asian	18,289	20,801	26,266	32,252	38,644
NHPI	1,051	1,158	1,375	1,600	1,827
Hispanic	**57,711**	**66,365**	**85,931**	**108,223**	**132,792**
One race	56,795	65,265	84,377	106,092	129,951
White	53,098	61,020	78,892	99,183	121,453
Black	2,221	2,543	3,267	4,088	4,995
AIAN	924	1,062	1,367	1,717	2,104
Asian	387	448	595	772	981
NHPI	165	193	257	332	419
Two or more races	916	1,100	1,553	2,131	2,841
Race alone or in combination:					
White	53,908	61,997	80,282	101,103	124,030
Black	2,639	3,051	4,002	5,115	6,385
AIAN	1,269	1,462	1,896	2,399	2,959
Asian	664	785	1,086	1,470	1,942
NHPI	274	322	439	581	750

Source: US Census Bureau (2008b).

Note: Hispanic may be of any race. AIAN: American Indians or Alaska Natives. NHPI: Native Hawaiian and other Pacific Islander.

are expected to make up more than 40 percent of the US population by 2035 and 47 percent by 2050 (Brach & Fraser, 2000). The shifts in the ethnic and racial distribution and the age distribution of the US population denote an urgent need for health educators to develop culturally appropriate programs (Luquis & Pérez, 2005, 2006; Luquis, Pérez, & Young, 2006; Pérez, Gonzalez, & Pinzon-Pérez, 2006).

The 2000 Census marked a shift in how ethnic and racial data are collected. The Census Bureau introduced a larger pool of options, which allowed individuals to select more than one ethnic or racial background. Although controversial, this measure allows the identification of individuals of mixed descent.

Foreign Born and Immigrant

According to the American Community Survey Five-Year Estimates (2006–2010), 12.7 percent of the US population, or some 38,675,012 people, were foreign born; that is, they were residents who were not US citizens at birth (US Census Bureau, n.d.). This category includes legal permanent residents (immigrants), temporary migrants (such as students), humanitarian migrants (refugees), naturalized US citizens, and persons illegally present in the United States (US Census Bureau, 2006). The remainder of the US population was born in one of the fifty states (85.9 percent) or Puerto Rico (1.3 percent).

The American Community Survey Five-Year Estimates (2006–2010) show that the majority of the foreign-born population, excluding those born at sea, came from Latin America (see table 1.3).

Approximately 72 percent of foreign-born individuals are legal immigrants, with over a third (37 percent) being naturalized citizens. It is estimated that some 8 million foreign-born individuals were unauthorized

Table 1.3 World Region of Birth of Foreign-Born Population in the United States, 2010

	Estimate	Percent
Europe	4,847,078	12.5%
Asia	10,747,229	27.8
Africa	1,466,454	3.8
Oceania	214,809	0.6
Latin America	20,565,108	53.2
North America	834,095	2.2

Source: US Census Bureau (n.d.).

immigrants in 2010, marking a decrease from a peak of 8.4 million in 2007 (Hoefer, Rytina, & Baker, 2011; Passel & Cohn, 2011).

Language

Almost 80 percent of the US population 5 years and older speaks only English (US Census, n.d.). Of those who speak a language other than English at home, 8.7 percent report speaking it "less than well." (See table 1.4 for a list of the major languages spoken in the United States.)

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

Table 1.4 Languages Spoken in the United States, 2010

Language	Percent
English	79.9%
Spanish	12.5
Other Indo-European	3.7
Asian and Pacific Islander	3.1
Other	0.8

Source: US Census Bureau (n.d.).

The Elderly

The median age in the United States in 2010 was 37 years of age; however, the fastest-growing age group is those age 65 and older (table 1.5). In fact, demographers estimate that the number of individuals in this age category will more than double by the middle of this century (US Census Bureau, 1995, 2010b). (See table 1.5 for age distribution in the United States in 2010.)

Table 1.5 Projections of the Population by Selected Age Groups for the United States, 2015–2050

Sex and Age	2015	2020	2030	2040	2050
45 to 64 years	83,911	84,356	84,296	92,000	98,490
65 years and over	46,837	54,804	72,092	81,238	88,547
85 years and over	6,292	6,597	8,745	14,198	19,041
100 years and over	105	135	208	298	601

Source: US Census Bureau (2010b).

The elderly population is characterized by several factors, including more females than males (57 percent and 43 percent, respectively, in 2010). Not surprisingly, as the population shifts, the elderly population is also expected to become more racially and ethnically diverse. The proportion of elderly in each of the four major racial and ethnic groups—white, black, American Indian and Alaska Native, and Asian and Pacific Islander and in the Hispanic-origin population—is expected to increase substantially during the first half of this century.

Gender

In 2010, 50.8 percent of the US population were females and 49.2 percent were males. Similarly, in 2010, 85.9 percent of females and 84.6 percent of males had obtained a high school diploma, and 27.5 percent of females and 28.5 percent of males had obtained a baccalaureate degree (US Census, 2010b).

Sexual Orientation

Gates (2011) has estimated that 3.5 percent of adults in the United States, or some 9 million people, self-identify as gay, lesbian, or bisexual. Moreover, approximately 0.3 percent of the population classify themselves as transgendered. These findings support several studies that have estimated that 5 to 10 percent of the US population is lesbian, gay, bisexual, or transgender (National Coalition for LGBT Health and Boston Public Health Commission, 2002). Nonetheless, it is important to understand that the estimate that 10 percent of men are gay and 5 percent of women are lesbian is based on Kinsey Institute data, which may not accurately represent the percentage of LGBT individuals in the population (Gay and Lesbian Medical Association and LGBT health experts, 2001).

Although the US Census Bureau asks respondents to identify their race and ethnicity, it does not ask about sexual orientation. The census, however, does ask several questions about respondents' household composition by marital status and gender of partner (table 1.6).

A review of 2010 census data by demographers at the Williams Institute of the University of California, Los Angeles School of Law (Gates & Cooke, 2011) indicates that there are 646,464 same-sex couples in the United States, or 5.5 per 1,000 households. The same analysis shows that 51 percent of females in same-sex couples and 49 percent of males in similar relationships classify themselves as spouses.

The relative lack of definite data on the size of this population and the fear that many LGBT people, especially youths, have concerning revealing their sexual identity make reliable data difficult to obtain (Perrin, 2002; RAND, 2010). This lack of information makes it increasingly difficult to

develop, implement, and evaluate effective health education programs for this population group.

Table 1.6 Households and Household Type by Sex of Partner, 2010

	Estimate	Percent
Total households	116,716,292	100
Family households	77,538,296	66.4
Male householder	52,964,517	45.4
Female householder	24,573,779	21.1
Nonfamily households	39,177,996	33.6
Male householder	18,459,253	15.8
Male householder living alone	13,906,294	11.9
Female householder	20,718,743	17.8
Female householder living alone	17,298,61	14.8

Source: US Census (2010a).

People with Disabilities

According to the US Centers for Disease Control and Prevention (2011) some 71.4 million adults have experienced difficulty with at least one basic action (e.g., hearing) or a limitation on complex activity (e.g., difficulty with physical functioning). Table 1.7 shows some of the most common forms of disability experienced by Americans.

Table 1.7 Disabilities Experienced by US Adults, 2009

Disability	Number (Percent)
Hearing difficulty	37.1 million (16.2%)
Vision difficulty	21.5 million (9.4%)
Difficulty walking a quarter mile or unable to do so o	16.7 million (7.3%)
Difficulty with any physical functioning	35.8 million (15.6%)

Source: Centers for Disease Control (2011).

The data show disparities in disabilities by age and race/ethnicity (table 1.8). These differences may be exacerbated by cultural factors, lack of access to health care, or inability to follow medical directives.

According to Altman and Bernstein (2008), a person's disability or limitation has a direct impact on his or her perceived health status and ability to enjoy life. They note as well that disabilities and other limitations have an impact on a person's emotional status and self-rated health status (Altman & Bernstein, 2008).

Table 1.8 Percentage of Adults with Disabilities by Age and Ethnicity, 2009

	18 to 64 Years	65 Years and Older
Whites	24.4%	58.9%
African Americans	27.5	57.7
American Indian/Alaska Natives	31.1	61.7
Asians	12.9	43.2
Native Hawaiians/Pacific Islander	[a]	[a]
Two or more races	37.2	56.2
Hispanics/Latinos	19.8	56.2

Source: US Department of Health and Human Services (2011).

[a] Data are unavailable.

Demographics of Racial and Ethnic Groups

The following section provides a brief overview of the demographic characteristics of the major ethnic and racial groups in the United States. These descriptions do not, of course, apply to every individual who identifies as a member of a particular population group; significant differences exist within every racial and ethnic group. Rather, they offer overarching generalizations about the characteristics that members of each group share.

African Americans

African Americans, or blacks, are defined as persons whose lineage includes ancestors who originated from any of the black racial groups in Africa. Contrary to popular belief, African Americans make up a diverse group that encompasses individuals of African descent, Caribbean descent, and South American descent. African Americans are the second largest racial group in the United States, with approximately 42.0 million people, or 14 percent of the population. The majority of this population (38.9 million) identified as black alone, and the rest reported black in combination with one or more other races (US Census Bureau, 2011b). In addition, the black alone or in-combination population experienced a higher growth (15 percent) than the total population (10 percent) from 2000. The majority of people who reported they were black and one or more other races identified themselves as black and white (59 percent). This combination constituted the largest increase in the multiple-race black population.

According to the 2010 Census, 55 percent of the African Americans/black alone or in combination population reside in the South (US Census