

Global Applications of Culturally Competent Health Care: Guidelines for Practice

Marilyn “Marty” Douglas
Dula Pacquiao
Larry Purnell
Editors

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 Springer

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Preface

There are three areas that heighten the need for culturally competent care: globalization and its resultant increase in population and workforce diversity, global conflicts with consequent displacement of populations, and evidence of health inequities within the same country and across different countries globally. Today, global conflicts have forcibly displaced 65.6 million persons, creating an unprecedented 22.5 million refugees in the world (UNHCR 2018). An influx of this magnitude presents a challenge to nurses worldwide to provide care to persons who may have health beliefs and practices different from their own. In addition, these new groups of refugees and displaced persons augment the local and national racial and ethnic minority populations who are increasingly vulnerable to unequal access to health care and resultant poor health outcomes. This book was compiled as an effort to reduce the effects of social inequities on the health of these populations and to provide healthcare professionals with a resource for providing culturally competent care.

Health disparities are the differential consequences on the physical and mental well-being of population groups attributable to social inequalities. These inequities create cumulative disadvantages in human life conditions exposing certain groups to a greater number and intensity of health risks. Health is tied with the social conditions of life. Thus, health promotion should be grounded on the principles of social justice and protection of basic human rights supportive of health. While individual-based care and biomedical approaches to diseases are important, population health achievement is difficult without improving the conditions in which people are born, live, and work. This book attempts to demonstrate culturally competent care as a strategy to achieve health equity.

The Guidelines for Culturally Competent Health Care were developed by a task force convened by members of the Expert Panel on Global Nursing and Health of the American Academy of Nursing and also included members of the Transcultural Nursing Society. In preparing the guidelines, the task force members reviewed documents related to culturally competent health care from more than 50 publications and sources from around the world, including healthcare, governmental and nongovernmental organizations. Several versions of the guidelines were sent to global colleagues for peer review to assess global applicability. Eventually, the final version of the Guidelines was endorsed by the International Council of Nurses and distributed to its member

national nursing organizations throughout the world. Nurses in these countries are now left to decide how to implement them.

The purpose of this book is to expand on previous work describing the Guidelines (Douglas et al. 2014) and to provide practical, clinical examples of how each of these guidelines can be integrated into practice by practitioners caring for diverse populations from around the world. This book will be useful for multidisciplinary healthcare students, clinicians, advanced practice nurses, administrators, educators, and those who provide community health or population-based care.

The first chapter provides the conceptual basis for culturally competent health care and presents a list of ten guidelines along with a few examples of implementation. Then a separate section is devoted to each guideline. Within each section is a chapter with an in-depth discussion of the guideline and its rationale, followed by three or more chapters with clinical case studies of examples of how the guideline was implemented in a particular cultural setting. All case studies follow a similar format and are written by international authors with clinical expertise and work experience in the culture being presented.

It is recognized that these guidelines must be adapted to each situation. Within each setting, there are cultural norms embedded in their respective social, economic, and political system in which they exist. Therefore, in conclusion, the guidelines and their accompanying case studies are intended to be examples of how culturally competent care can be delivered. They are not meant to be requirements for professional practice but rather to assist the practitioner, educator, administrator, or researcher in planning care for a culturally diverse population.

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Special acknowledgement must be given to Joan Uhl Pierce, PhD, RN, FAAN, who was the first chair of the task force, and whose initiative was to enlist past presidents of the Transcultural Nursing Society as members of the Academy's task force on this topic.

In addition, we would like to specifically acknowledge Dr. Marianne Hattar-Pollara for her vision of expanding these Guidelines to book form. She was also instrumental in coordinating and participating in the key planning session for this book.

Finally, we wish to acknowledge the Transcultural Nursing Society (TCNS), in particular the Transcultural Nursing Scholars, who created the forum for common interest and commitment in promoting culturally competent practices in education, research, and practice. TCNS has its mission "to enhance the quality of culturally congruent, competent, and equitable care that results in improved health and well-being for people worldwide" and a vision "to provide nurses and other healthcare professionals with the knowledge base necessary to ensure cultural competence in practice, education, research, and administration."

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Conceptual Framework for Culturally Competent Care

1

Dula Pacquiao

Of all the forms of inequality, injustice in health care is the most shocking and inhumane.
Martin Luther King, Jr. (1966)

1.1 Introduction

Social determinants have been shown to have a greater negative impact on populations who experience cumulative disadvantages in society and manifested in poorer health status. Health promotion requires a broad understanding of the mechanisms by which social disadvantages create health inequities in vulnerable populations. Vulnerable groups are more likely to experience poverty, social exclusion, and limited access to social resources and privileges. Key to improving population health is through culturally competent practice to achieve health equity by promoting a culture of health and healthy communities (Lavizzo-Mourey 2015), grounded in the principles of social justice, human rights, and beneficence. Table 1.1 presents the Global Guidelines for Culturally Competent Health Care and sample applications of each. These guidelines articulate the ethical and moral principles of culturally competent care to achieve health equity for individuals, families, and populations.

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1.2 Social Determinants of Health

Social determinants of health are the conditions in which people are born, grow, live, work, and age (WHO 2015a) as well as the systems put in place to deal with illness (CDC 2015). These social circumstances are shaped by a wider set of economic, social, and political forces influencing the distribution of money, power, and resources. Social determinants of health are mostly responsible for health inequities among populations within a society and across the globe. They determine the extent to which a person or group possesses the physical, social, and personal resources to identify and achieve personal aspirations, satisfy needs, and cope with the environment (Raphael 2004). Social determinants of health pertain to the quantity and quality of a variety of resources that a society makes available to its members, such as, income, food, housing, employment, and health and social services.

Both individual- and group-level determinants have been identified (Diez-Roux 2004; Kaufman 2008). At the individual level, factors, such as race and ethnicity, gender, employment, social class, income, and experience with discrimination, are associated with health disparity. At the group level, social factors such as strength of social capital, social cohesion, collective efficacy,

Table 1.1 Guidelines for the practice of culturally competent nursing care

Guideline	Description
Knowledge of cultures	Nurses shall gain an understanding of the perspectives, traditions, values, practices, and family systems of culturally diverse individuals, families, communities, and populations they care for, as well as knowledge of the complex variables that affect the achievement of health and well-being
Education and training in culturally competent care	Nurses shall be educationally prepared to provide culturally congruent healthcare. Knowledge and skills necessary for assuring that nursing care is culturally congruent shall be included in global healthcare agendas that mandate formal education and clinical training, as well as required ongoing, continuing education for all practicing nurses
Critical reflection	Nurses shall engage in critical reflection of their own values, beliefs, and cultural heritage in order to have an awareness of how these qualities and issues can impact culturally congruent nursing care
Cross-cultural communication	Nurses shall use culturally competent verbal and nonverbal communication skills to identify client's values, beliefs, practices, perceptions, and unique healthcare needs
Culturally competent practice	Nurses shall utilize cross-cultural knowledge and culturally sensitive skills in implementing culturally congruent nursing care
Cultural competence in healthcare systems and organizations	Healthcare organizations should provide the structure and resources necessary to evaluate and meet the cultural and language needs of their diverse clients
Patient advocacy and empowerment	Nurses shall recognize the effect of healthcare policies, delivery systems, and resources on their patient populations and shall empower and advocate for their patients as indicated. Nurses shall advocate for the inclusion of their patient's cultural beliefs and practices in all dimensions of their healthcare
Multicultural workforce	Nurses shall actively engage in the effort to ensure a multicultural workforce in healthcare settings. One measure to achieve a multicultural workforce is through strengthening of recruitment and retention effort in the hospital and academic setting
Cross-cultural leadership	Nurses shall have the ability to influence individuals, groups, and systems to achieve outcomes of culturally competent care for diverse populations. Nurses shall have the knowledge and skills to work with public and private organizations, professional associations, and communities to establish policies and guidelines for comprehensive implementation and evaluation of culturally competent care
Evidence-based practice and research	Nurses shall base their practice on interventions that have been systematically tested and shown to be the most effective for the culturally diverse populations that they serve. In areas where there is a lack of evidence of efficacy, nurse researchers shall investigate and test interventions that may be the most effective in reducing the disparities in health outcomes

Source: Douglas, M.K., Rosenkoetter, M., Pacquiao, D.F., Callister, L.C., Hattar-Pollara, M., Lauderdale, J, Milstead, J., Nardi, D., Purnell, L. (2014), Guidelines for Implementing Culturally Competent Nursing Care. *Journal of Transcultural Nursing* 25 (2):110. Reprinted with permission from Sage Publications, Inc.

and diversity of social networks influence quality of life and health outcomes (Burriss et al. 2002). Sampson and Raudenbush (1999) observed that collective efficacy includes such informal mechanisms as behaviors, norms, and actions that residents of a given community use to achieve public order. Collective efficacy develops when members of the community have strong feelings of trust and solidarity for each other. When community members feel strongly bonded to each other, they cooperate to deter crime and share ownership of their neighborhood. Individual- and

societal-level variables are intimately linked to produce health vulnerability.

1.2.1 Socioeconomic Status

Socioeconomic position is one's relative position as compared to others in society, which is determined by individual characteristics such as income, level of education, occupation, and employment (Babones 2010). Income, education, and occupation have all been shown to predict

morbidity and mortality (Miranda et al. 2012; Seith and Kalof 2011; Williams et al. 2012). Poverty is a socioeconomic position that results from a combination of these individual characteristics, with consequent limitation to one's capacity for self-governance and subsequent dependence on society for survival. Dependence and lack of autonomy in turn foster marginalization of the affected group by mainstream society. Social marginalization excludes or limits access to institutional resources and privileges by certain individuals and groups, creating a cycle of poverty and social dependence.

Poverty is associated with a number of risk factors that affect morbidity, disability, and mortality. This association is observed globally, among the poorest and wealthiest countries alike. The poor face challenges in accessing adequate general healthcare and prenatal care. Wilkinson and Pickett (2010) found a strong correlation between the degree of income disparity within a society and health outcomes. Populations in countries with greater socioeconomic inequality experience poorer health outcomes than those living in societies with greater parity. For example, the proportion of the population reporting mental illness was much lower in Japan (9%), a country with a very small income gap as compared to 20% in countries with a greater degree of income inequality such as New Zealand, Australia, and the UK (Wilkinson and Pickett 2010).

In the USA, African Americans, American Indians and Alaskan Natives, and Hispanics are minority groups that are most greatly affected by poverty. Predominantly African American communities reside in neighborhoods with a poverty level greater than 40% (Iceland 2012). Neighborhoods with concentrated poverty and higher proportions of people of color are more likely to exhibit signs of material deprivation and economic disinvestment. Some individuals who are not poor but living in these neighborhoods are exposed to the same kind of challenges as poor residents.

According to the US Census (2016), the official poverty rate dropped slightly from 14.8% in 2014 to 13.5% in 2015; close to 43 million were living in poverty. The highest rates of poverty

were among African Americans and American Indian and Alaskan Natives. Although African Americans represented only 13.3% of the US population, they bore a disproportionate burden of poverty with the highest rate between 24% (rural residents) and 33.8% (metro residents)—more than double the national average (USDA 2017). In 2015, children (18 years and younger) comprised 33.6% of the people living in poverty with a poverty rate of 19.7%. Nearly 32% of Black children and 28.9% of Hispanic children were in deep poverty compared to 11.4% for non-Hispanic Whites. Deep poverty is defined as income less than half the threshold (Institute for Research on Poverty 2016). White neighborhoods have twice as many social services as in predominantly African American and Latino neighborhoods despite their greater need for such services (Lin and Harris 2009). Hispanics were more likely than African Americans to enter poverty between 2009 and 2011 but were more likely than African Americans to get out of poverty. African Americans also spent longer periods of time in poverty with an average of 8.5 months compared to 6.5 months among Hispanics (Edwards 2014).

1.2.2 Environment

Chronic stress is experienced by residents of neighborhoods with concentrated poverty associated with high crimes, dilapidated infrastructure, and environmental hazards from toxic pollutants. In the USA, children who are poor and of African descent have a higher prevalence of asthma (25%) as compared to poor White (16%) and Hispanic children (13%) (Seith and Kalof 2011). Neighborhoods with concentrated poverty lack resources such as safe public spaces, transportation, affordable and healthy food venues, and quality schools and healthcare services.

Wilson (1996) noted that the high rate of joblessness has concentrated poverty, particularly in inner-city neighborhoods in the USA, as jobs requiring low education and skills moved to suburban communities along with the flight of White residents from urban areas. More recently there

has been a steady shift in demand away from the less skilled toward the more skilled jobs in advanced economies, creating dramatic inequalities in wage and income between the more and the less skilled, as well as unemployment among the less skilled (Slaughter and Swagel 1997). These same changes in labor demands have caused widening income gaps in a number of developing countries as well as in advanced economies. In countries with relatively flexible wages set in decentralized labor markets, such as the USA and, increasingly, the UK, the decline in demand for less-skilled labor has translated into lower relative wages for these workers. Trade liberalization in Mexico in the mid-to-late 1980s led to increased relative wages of high-skilled workers but has not boosted the demand for unskilled labor nor raised unskilled wages. In fact, the demand for unskilled labor has declined, and their wages have fallen in some developing countries (Slaughter and Swagel 1997).

Pervasive joblessness undermines social organization and social capital of neighborhoods that could otherwise buffer the effects of poverty in these communities. According to Wilson (1996), the lack of role models from adults who are gainfully employed has contributed to the widespread degradation of work ethic in the young and the belief that education brings economic returns. African American communities in the northeast USA that were largely composed by freed slaves from the south have built strong social networks and connections that supported each other. According to Fullilove (2004), the urban gentrification movement dismantled this social network causing “root shock” especially among younger generations of African Americans who were separated from a stable network of social and emotional integration in racially divided communities.

Obesogenic environment refers to features of the living and working spaces that contribute to the development of obesity. In the USA, Drewnowski and Specter (2004) observed an association between poverty and obesity. As income decreases, the rate of obesity increases. Low-income families are more likely to consume poor-quality diets that include higher concentra-

tions of calories, sugar, refined grains, salt, and fat because these are less costly. These energy-dense foods are processed for longer shelf life and enhanced palatability but have low nutritional value and are a factor in causing obesity. Healthier foods such as fruits, vegetables, and lean sources of protein are often inaccessible, easily perishable, and beyond the means of those in poverty. Thus the poor are at risk for malnutrition, food insufficiency, and obesity with its associated health risks of diabetes, hypertension, and cardiovascular diseases. In 2011–2012, 8.4% of Americans between 2 and 5 years of age, 17.7% of those between 6 and 11 years, and 20.5% of the 12–19-year-old population were considered obese. The prevalence of obesity was highest for preschool-aged children between 2 and 4 years of age in households with incomes at or below the federal poverty threshold (CDC 2015).

In 2014, nearly 40% of the world’s adult population was overweight and 13% were obese. At least 42 million children under the age of 5 were overweight or obese. The rate at which obesity is increasing among middle- and lower-income countries is 30% higher than those of higher-income countries (WHO 2015b). Obesity is steadily becoming a health crisis among the poor worldwide, more so than starvation. Income and gender differences in the rate of overweight and obesity are more pronounced among low-income and lower-middle-income countries. For example, in low-income countries, the rate of obesity among women is more than three times higher than that of men (7.3% and 2.2%, respectively). In lower-middle-income countries, obesity among women is twice that of men (10.4% vs. 5.1%).

Overall, African Americans have a higher rate of obesity, nearly 50% compared to the rate of obesity among Whites, Hispanics, and Asians (43%, 33%, and 11%, respectively). In addition, African Americans have higher rates of high blood pressure than Whites and nearly twice that of Mexican Americans (CDC 2014a). Income and education are correlated with obesity in women in the USA. Women with higher income and more years of education, particularly with college degrees, are less likely to be obese (CDC

2014b). Heart disease and obesity are risk factors for diabetes, another chronic health condition that disproportionately affects African Americans. African Americans are 70% more likely to be diagnosed with diabetes compared to Whites and are two times more likely to die from the disease. The prevalence of visual impairment is 20 per 100 adults with diabetes among African Americans as compared to 17 per 100 adults with diabetes among Whites (United States Department of Health and Human Services-Office of Minority Health [USDHHS-OMH], 2014).

1.2.3 Social Stratification

People do not get sick randomly but in relation to their living, social, political, and environmental circumstances (Bambas and Casas 2001). Socioeconomic and political structures create conditions resulting in wealth or poverty, job stability or instability, educational advancement or exclusion, acceptance or marginalization, and community progress or deprivation. Leading causes of death have been primarily attributed to lifestyle factors. However, lifestyle factors do not rest solely on individual choice but rather on life conditions and circumstances that contribute to unhealthy behaviors (WHO 2015b). Conventional explanations of poor health, such as lack of access to medical care and unhealthy lifestyles, only partially explain differences in health status (Marmot and Bell 2009). The seminal Whitehall I and II studies of British civil servants (Marmot et al. 1978, 1991) found a social gradient in health among Caucasians who were not poor and had equal access to health services. This social gradient existed for heart disease, some cancers, chronic lung disease, gastrointestinal disease, depression, suicide, sickness absence, back pain, and general feelings of ill health. Higher social position was associated with better health.

Social gradient is conditioned by the *status syndrome* (Marmot 2006). The lower individuals are in the social hierarchy, the less likely they are able to meet their needs for autonomy, social integration, and participation (Marmot 2006).

The Whitehall studies confirmed that access to healthcare services does not guarantee equity of health outcomes, suggesting that health status is more significantly shaped by life conditions. Despite universal access to healthcare services, differential health status was observed among thousands of White British civil servants. This suggests that programs and policies providing equal access and opportunity fall short in achieving equity of outcomes because of failure to consider the fundamental differences in the needs and statuses of population groups.

1.3 Vulnerable Populations

Vulnerable populations comprise groups of people who have systematically experienced greater social or economic obstacles to health that are historically linked to discrimination or exclusion. These factors may be based on their racial or ethnic group, religion, socioeconomic status, age, gender, gender identity or sexual orientation, and migration status. Other obstacles are associated with mental health, cognitive, sensory or physical disability, and geographic location of residence (USDHHS 2010). As a consequence, vulnerable populations experience multiple cumulative adversities in life with consequent predisposition to higher and multiple health risks (Frohlich and Potvin 2008). A group's vulnerability is linked with a particular society's social, cultural, and environmental inequalities that are differentially manifested in health inequity. Vulnerable populations may include the poor with limited literacy and education; victims of war, violence, enslavement, and sex trafficking; migrant workers and those without legal status; mentally ill and individuals with cognitive and physical disabilities; females in male-dominated societies; and victims of stigma and discrimination such as LGBTQ, HIV/AIDS infected, incarcerated, prostitutes, etc.

A common thread across vulnerable populations is poverty that can stem from lack of access to quality education, resources supporting achievement, and job opportunities. Poverty not only predisposes individuals to social discrimination and exclusion but also prevents access to

basic services and opportunities that can improve their lives. The consequence of social discrimination and stigma is disempowerment and chronic underachievement, unemployment, and poverty. The poor experience the added burden of the “poverty penalty.” According to Mendoza (2011) the five penalties of poverty are poor quality, higher prices, nonaccess, non-usage, and catastrophic spending burden. Those with the least financial means end up paying more in order to participate in the market economy as compared to those with more economic means. Because poor neighborhoods have less proximity to goods and services, residents have fewer options for competitive pricing of goods and services. When priced out of the market, the poor must prioritize their necessities of daily living, often forgoing services, preventive healthcare services, and healthier food. They lack the disposable income to take advantage of lower prices offered when purchasing larger quantities of goods and services, a situation that is compounded by their lack of storage space and transportation. Because of limited access to a variety of healthcare providers and services, the poor have less autonomy and choices in healthcare decisions, which in turn impact the effectiveness of healthcare, education, compliance, and outcomes. The poverty penalty contributes to the downward spiral of vulnerable populations and their health.

McEwen and associates (2015) have done seminal work distinguishing the effects of chronic, unmitigated stress from acute, episodic stress and its link to health. The chronic stress experienced with poverty, subordination, and discrimination produces allostatic load or “wear-and-tear” effects. Primarily mediated by neuroendocrine responses in three regions of the brain (hippocampus, amygdala, and prefrontal cortex), allostatic load triggers a cascade of mental, emotional, and physical effects. These include insomnia, depression, post-traumatic stress disorders, impaired cognitive ability, and engagement in high-risk behaviors such as tobacco, alcohol, and drug use. These behaviors further aggravate allostatic load effects. Physical effects are mediated by the hypothalamic-pituitary axis, resulting in sustained high levels of stress hormones that

predispose one to the development of obesity, hypertension, immunosuppression, and impaired coping (McEwen et al. 2015).

Krieger (2011) has posited that individuals and groups embody their material and social world as evident in the differential patterning of disease exposure and susceptibility and ultimately mortality. Epidemiological data reflect the biological embodiment of social inequalities of individuals within the same family and population groups in communities across the globe. In other words, the cumulative impact of social adversities differentially experienced by humans across their life course shapes their health and well-being. The author emphasizes the role of social inequalities as the root cause of health inequities that condition the life chances and health trajectories of groups in society. Krieger argues that remedies should be focused on social change because of its greater impact on vulnerable individuals and groups, moving away from the individualistic paradigm that emphasizes self-responsibility for one’s health. In other words, accountability for change rests heavily on society and the government. According to Krieger, the progress in decreasing smoking in the USA was largely facilitated by public policies mandating labeling of tobacco products as carcinogenic by the Surgeon General, legislation prohibiting targeted marketing of tobacco to minorities and youth, and legal measures compelling scientific and economic accountability of tobacco companies for their product and its health effects. While smoking cessation programs focusing on individual-level change are helpful, social policies have greater impact on population health because they address sociopolitical inequity.

1.4 Health Inequity

Health inequity is the disparity due to differences in social, economic, environmental, or health-care resources. According to Whitehead (1992) health inequities are differences in health status that are unnecessary, avoidable, and considered unfair and unjust. Health inequity implies a need for collective moral obligation to correct unfair

structure and practices that places an unequal burden of risks for poorer health among socially disadvantaged groups (Braverman 2014). Although evidence of health inequity exists in all societies, the gap between the privileged and vulnerable groups is mitigated by decreasing the impact of social inequalities that create the pathways to poor health.

Using data from the World Values Survey with over 15,000 respondents from 44 countries representing developed and developing nations in several continents, Babones (2010) found that individual indicators of socioeconomic status (income, education, and occupation) affect self-reported health status worldwide, independently and collectively. People of high income have more than 50% greater odds of reporting good health than those with low income, even when education and occupational class remained the same. Those with higher levels of education have more than 60% greater odds of reporting good health than people with lower educational achievement (Babones 2010). Selected examples of health disparities in some countries are presented.

1.4.1 Africa

1.4.1.1 North Africa and Middle East

Differences in health system size, structure, and financing occur in Middle Eastern countries. Public healthcare programs in the Arab countries provide comprehensive coverage of all levels of care, including prevention, ambulatory care, and inpatient services either completely free of charge or at a nominal fee (Kronfol 2012a). There are gaps in coverage such as nonprescription drugs, dental care, cosmetic surgery, and smoking cessation. Some countries prohibit fertility treatments and abortion based on religious and bioethical grounds. Dental services are limited even in countries that adopted social health insurance such as Lebanon. Many dentists practice in the private sector and cities, limiting access to dental services by rural and poor residents. Mental health services are frequently not available in public clinics. People with mental retardation, severe mental health problems, and

low education as well as the elderly are most disadvantaged (Kronfol 2012b).

Rural residents in Middle Eastern countries and North Africa such as Sudan are more at risk of poverty and social exclusion. Geographic distance and lack of transportation pose barriers to access and utilization of preventive health services such as vaccination and antenatal services (Ibnouf et al. 2007). There is also concern about the safety, cost of transportation, and ease of boarding public buses. Most people walk or use private transportation to the clinics. The poor elderly and functionally impaired individuals are greatly disadvantaged. In many Muslim countries, a male guardian is needed to arrange for transport which further limits access because of the need to wait for this person to get off work, and many clinics are closed before he gets home from work (Kronfol 2012a).

In countries like Tunisia, Syria, and Egypt, gender significantly influences access and utilization of health services by women. In general, women prefer female physicians for reproductive health issues (Romdhane and Grenier 2009). Gender congruence and sensitivity of health providers affect service use by women (Kronfol 2012c). Although women are major healthcare users as well as providers, they are underrepresented in healthcare decision-making. Religion has an important influence on specific health practices such as male and female circumcision, the practice of medicine and litigation, the belief in fate and destiny, and other social determinants of health. There are legal, religious, medical, and social factors that serve to support or hinder women's access to safe abortion services in the 21 predominantly Muslim countries in the Middle East and North Africa, where 1 in 10 pregnancies ends in abortion (Hessini 2007; Kronfol 2012a). Gender-related issues include improving women's access to healthcare, education and literacy for girls and women, employment, and social protection for women and female genital mutilation (Kishk 2002).

Ethnic minorities in Arab countries experience discrimination in healthcare, public places, and public transport. Language barriers and differences in health beliefs and practices have

been documented among Bedouins in a Beirut Hospital (Kronfol 2012a). Barriers are also related to nationality in the Gulf countries (e.g., Kuwait and United Arab Emirates) because separate healthcare facilities are reserved for nationals of the country, non-nationals, or expatriates. Facilities for nationals receive more government support. This differentiated care setting promotes segregation and unequal treatment of individuals and groups based on nationality (Kronfol 2012a).

1.4.1.2 Sub-Saharan Africa

According to Benatar (2013), in 2008, 54% of South Africans had an income below \$3/day. While the top 10% earned 58% of annual national personal income, 70% of the population received a mere 16.9%. The Gini coefficient, a measure of income inequality, increased from 0.6 in 1995 to 0.679 in 2009. Infant mortality rates (IMR) have remained stable between 1990 and 2005 reflecting White and Black disparities—18 per 1000 live births among Whites as compared to 74 per 1000 live births among Black South Africans. IMR differed across geographical regions with 27/1000 live births in the Western Cape and 70/1000 live births in the Eastern Cape. Overall maternal mortality increased from 150/100,000 pregnancies in 1998 to 650/100,000 in 2007. Sub-Saharan Africa has endured disproportionately high prevalence of HIV/AIDs compared to other countries in the world. South Africa accounts for almost 17% of the world's population living with HIV/AIDS. The country has the largest anti-retroviral treatment program in the world, yet only 40% of eligible adults are receiving treatment. The prevalence of HIV infection among those older than 19 years ranges from 16.1% in the Western Cape to 38.7% in KwaZulu-Natal (Benatar, Sullivan and Brown 2017).

UNESCO's EFA Global Monitoring Report (2015) noted that not a single country in sub-Saharan Africa has achieved gender parity in either primary or secondary education, with the poorest girls as most disadvantaged. In 2012, at least 19 countries around the world had fewer than 90 girls for every 100 boys in school; 15 of these countries were in sub-Saharan Africa. In the Central African Republic and Chad in 2012, the number of girls in secondary was half that of

boys. In Angola, the situation has actually worsened, from 76 girls per 100 boys in 1999 to 65 in 2012. The country with the greatest inequity in primary and lower secondary is Chad. In Guinea and Niger, approximately 70% of the poorest girls had never attended school compared with less than 20% of the richest boys. Gender disparities in secondary education have barely changed in sub-Saharan Africa since 1999, with approximately eight girls for every ten boys enrolled. In a few poor countries, such as Rwanda, new gender gaps at the expense of boys have emerged. In Lesotho, only 71 boys were enrolled for every 100 girls in 2012, a ratio unchanged since 1999 (UNESCO 2015).

Although gender gaps in youth literacy are narrowing, the report had predicted that fewer than seven out of every ten young women in sub-Saharan Africa were literate in 2015. Two-thirds of adults who lack basic literacy skills are women, a proportion unchanged since 2000. Half of adult women in sub-Saharan Africa cannot read or write. Gender-based school disparities that have been attributed to gender-based violence, child marriages, and secondary school dropout by pregnant girls remain a persistent barrier to girls' education. If existing laws mandating older age for females at marriage were enforced, this would result in an overall 39% increase in years of schooling in sub-Saharan Africa. Pregnancy has been identified as a key driver of dropout and exclusion among female secondary school students in sub-Saharan African countries, including Cameroon and South Africa. The prevalence of premarital sex before age 18 years, increased in 19 out of 27 countries in the region between 1994 and 2004 (UNESCO 2015).

1.4.2 Asia

1.4.2.1 China

As the most populous nation in the world, China's population as of January 1, 2017 was approximately 1.38 billion people, representing an increase of 0.53% (7.3 billion people) from 2016. China has a population density of 148 people per square kilometer. In 2016, the number of births

exceeded the number of deaths by 7,315,733, but because of external migration, the population increased by only 41,254. The sex ratio of the total population was 1.051 (1051 males per 1000 females), which is higher than the global sex ratio (Countrymeters 2017a). Since the 1950s, the process of industrialization in China has shifted its economy from agriculture to manufacturing, which has significantly increased its energy consumption and created mass rural to urban migration. In 2011, the proportion of the population living in urban areas surpassed those living in rural areas for the first time, and an additional 200 million rural-to-urban migrants are anticipated during the next 10 years (Gong et al. 2012). Industrialization has led to serious environmental and ecological problems, both in urban and surrounding areas, including increased air and water pollution, local climate alteration, and a major reduction in natural vegetation and production (Fang et al. 2003). A major threat is the absence of continuous healthcare coverage for rural-to-urban migrants who are at risk of dual infectious disease burden from exposure to pathogens associated with rural poverty like parasitic worms in the soil and pathogens such as tuberculosis in crowded urban environments. Urbanization has led to changes in patterns of human activity, diet, and social structures with profound implications for noncommunicable diseases, e.g., diabetes, cardiovascular disease, cancer, and neuropsychiatric disorders. Urban residents have experienced an increase in the levels of cholesterol-related diseases (Lee 2004) and an overall decline in quality of life.

According to statistics from China's Ministry of Environmental Protection, cities in the Yangtze River Delta, Pearl River Delta, and Beijing-Tianjin-Hebei region suffer over 100 haze days every year, with particulate matter/PM2.5 concentration of two to four times above the World Health Organization guidelines, which can lead to systemic damage to human health (Pan et al. 2012). PM2.5 are small-sized particles in the air that can reach a large surface area of the respiratory system that carry a variety of toxic heavy metals, acid oxides, organic pollutants, and other chemicals, as well as microorganisms such as bacteria

and viruses. Heavy metals and polycyclic aromatic hydrocarbons carried by PM2.5 can enter and deposit in human alveoli, causing inflammation and lung diseases, as well as enter the circulation and affect the normal functioning of the cardiovascular system. Exposure to PM2.5 can lead to significantly increased mortality from cardiovascular, cerebrovascular, and respiratory diseases, as well as greater cancer risks (Pan et al. 2012).

Air pollution in China is mainly caused by burning coal in factories and power plants and oil combustion by vehicles. During winter, homes are heated through a central heating system powered by coal burning; hence "smog" days are more frequent in winter seasons. Rohde and Muller (2015) have analyzed national reports on hourly air pollution from 1500 sites in China over 4 months including airborne particulate matter, sulfur dioxide, nitrogen dioxide, and ozone. Significant widespread air pollution is observed across Northern and Central China, not limited to major cities and geologic basins. Sources of pollution are widespread but are particularly intense in the northeast corridor from near Shanghai to north of Beijing. Rohde and Muller found that 92% of the Chinese population experienced more than 120 h of unhealthy air (based on US-EPA standard) and 38% experienced average concentrations that were unhealthy. The authors concluded that this level of exposure contributes to 1.6 million deaths/year (0.7–2.2 million deaths/year at 95% CI), roughly 17% of all deaths in China.

Wheat is the third largest crop and an essential contributor to food security in China and the world. Higher levels of air pollution in the North China Plain region during winter and spring, which correspond to the early growing phase of winter wheat, significantly reduce sun radiation and increase relative humidity, resulting in decreased photosynthetic rate, higher risks of fungal infection, and negative effects on wheat yields (Liu et al. 2016). Particulate matter such as cement dust, magnesium-lime dust, and carbon soot deposited on vegetation can inhibit plants' respiration and photosynthesis and cause chlorosis and death of leaf tissues because of the thick crust formation and alkaline toxicity from

wet weather. The dust coating may also affect the normal action of pesticides and other agricultural chemicals. Accumulation of alkaline dusts in the soil can increase soil pH to levels adverse to crop growth (Last et al. 1985).

1.4.2.2 India

Being the second most populous country in the world, India's population as of January 1, 2017 was estimated at 1.33 billion representing an increase of 1.26% (16.6 million) from 2016. In 2016, the number of births exceeded the number of deaths by 17,154,513, but due to external migration, the population declined by 541,027. The sex ratio of the total population was 1.068 (1068 males per 1000 females) which is higher than the global sex ratio (Countrymeters 2017b). Forty-one percent of India's population is predicted to live in urban areas by 2030 (United Nations 2004). India's rapid urbanization comes with opportunities to make cities more livable and transform their economy, but this also comes with negative consequences by weakening an already inadequate social service infrastructure creating lack of basic services and pressure on resources. Cities have a transport crisis, road congestion, and pollution from noise, air, and waste. Public health concerns are associated with lack of quality housing, clean water, and sanitation.

In addition to urbanization, gender inequity is a significant social determinant of health of Indians. Being female is associated with lack of education, employment, health access, and autonomy. Studies indicate that Indians in urban areas and women in particular have poorer health outcomes than rural Indians and men, respectively. India has the largest number of people with diabetes than any other country, and the prevalence of diabetes among urban Indians rose from 2.1 to 12.1% from 1970 to 2003 (Ramachandran et al. 2003). The study by Mohan et al. (2016) using a cross-sectional sample of 6853 rural, poor urban, and middle-class urban women between 35 and 70 years old revealed that urban middle-class women have the highest levels of anthropometry, body mass index, cholesterol, waist-to-hip ratio, hypertension, and diabetes as compared to poor urban and rural Indian women. The study

also noted high occurrence of cardiovascular disease, stroke, and diabetes in middle-aged urban women. The higher rates of greater body mass index, waist-to-hip ratio, and cholesterol in urban middle-aged women may be attributed to greater caloric and fat intake and decrease in comparative physical activity. While some Hindus are vegetarian, saturated fat is derived from use of ghee (clarified butter), coconut milk, and cream in the food preparation. Middle-class urban women have the highest cardio-metabolic risks compared to poor urban and rural women (Mohan et al. 2016).

The rate of cardiovascular disease rates among individuals 30–60 years of age is 405 per 100,000 in India as compared to in Great Britain (180/100,000) and China (280/100,000) (Chauhan and Aeri 2013). Higher prevalence of cardiovascular disease is noted in urban than rural India. There has been a tenfold increase in the prevalence of coronary artery disease in urban India during the last 40 years, and rates have ranged between 1.6 and 7.4% in rural populations and 1 and 13.2% in urban populations (Gupta 2012).

The American College of Cardiology's Pinnacle India Quality Improvement Program (PIQIP) found that women had fewer patient medical encounters than men, including visiting a physician, hospital, or clinic for evaluation, testing, or treatment. Although women had a higher rate of noncommunicable diseases, they received less medication prescriptions than men (Kalra et al. 2016). Women are more at risk for hypertension, diabetes, and hyperlipidemia but receive less medical care than men. Sengupta and Jena (2009) found rural and urban women suffer from goiter, 1.93 and 3.62 times more than men, respectively. Urban women were observed to suffer more from asthma than their male counterparts.

In 2011, the Indian population over 65 years comprised 90 million and is predicted to exceed 227 million by 2050. Women are considered a disadvantaged group among the aging population. Although Indian women live longer than men, they consistently report poorer health, higher disabilities, lower cognitive function, and lower utilization of health services (Rao 2014).

Kakoli and Chaudhuri (2008) found wide health disparities between elderly men and women even after controlling for demographics, medical conditions, and known risk factors. However controlling for economic independence reduced the gaps significantly, suggesting that financial empowerment may be the key to improving health outcomes of elderly women.

The Longitudinal Aging Study conducted in the southern states of Karnataka and Kerala and two northern states of Rajasthan and Punjab found that elderly women have lower cognitive function than elderly men and the disparity was linked with gender discrimination evident in women having poorer education and less social engagements, both of which impact their health. Higher level of discrimination against women was observed in the two northern states (Population Reference Bureau 2012).

In India, gender bias is evident in all life stages of a woman—female infanticide, poor education facilities, dowry practices, stereotypical roles of women as homemakers, and discrimination against widows. Although dowry practices have been declared illegal, some families continue to expect payment by the bride's family to the groom's family before marriage. The burden of dowry payments has created a strong preference for sons and marginalization of females as a burden to their families. It is exceptionally hard for elderly women to have good health and quality of life. Although there are existing government initiatives for female children, they do not address the current generation of elderly women who continue to face discrimination, poverty, poor education, and poor health.

1.4.3 North America

1.4.3.1 United States

The USA is the only one among the most economically developed member countries of the Organization for Economic Co-operation and Development (OECD) that does not provide universal healthcare access to its citizens. Yet, it outspends all other members on healthcare. In 2012, the USA spent 16.9% of its GDP on

healthcare, representing 7.5% points above the OECD average of 9.3%. Forty-eight percent of US healthcare is publicly financed, well below the average of 72% in OECD countries (OECD 2014a). The USA lags behind other developed countries and some less developed countries in many health outcomes (OECD 2014b). Health coverage for able adults below 65 years of age is generally acquired through employer-sponsored health insurance. An employer-sponsored system of access to care fosters inequity by favoring high wage earners with good benefits over low-income groups whose employers may not have the ability to provide optimal or any coverage for their employees.

At the end of 2014, more than seven of every ten uninsured individuals in the USA have at least one full-time worker in their family, and an additional 12% have a part-time worker in the family. Yet, for these families, employment does not translate to enough income to be able to purchase health insurance. While access to healthcare does not guarantee equity in health outcomes, lack of universal access perpetuates social and health inequity. Many gaps in coverage remain. While Medicare is available for adults 65 years and older, procurement of supplemental benefits depends on the financial capacity of the individual or his/her family. Medicaid and the State Children Health Insurance provide healthcare access to eligible indigent families and their children. However, because these costs are shared by each state with the federal government, funding is not the same across different regions. In addition, some healthcare practitioners do not accept patients with Medicaid, leaving these patients with even fewer options.

The Patient Protection and Affordable Care Act or the Affordable Care Act (ACA) was signed into law by President Obama on March 23, 2010, with a goal to provide access to health coverage to more than 40 million Americans. ACA aims to expand healthcare coverage to most US citizens and permanent residents by requiring most people to obtain or purchase health insurance (USDHHS 2015). To date, ACA has failed to reach its goal of expanding access to affordable health insurance for many Americans because of

lack of political will to establish a universal system of healthcare that offers equity of access to quality healthcare for all.

Racial and ethnic minorities in the USA receive lower quality and intensity of healthcare compared with Whites across a wide range of preventive, diagnostic, and therapeutic services and disease states (Washington et al. 2008). The adjusted rate of preventable hospitalizations is higher among African Americans and Hispanics compared with the rate for non-Hispanic Whites (Moy et al. 2011). Among adults aged 65 years or more, racial and ethnic differences in influenza vaccination rates persist, with African Americans consistently having the lowest each year (Setse et al. 2011).

The Agency for Healthcare Research and Quality/AHRQ (2014) reported continuing evidence of suboptimal quality of care and access to health services among minority and low-income groups despite the ACA. Health disparities and access to care have shown no improvement for disadvantaged groups. The Centers for Disease Control and Prevention (CDC 2011) reported that despite progress over the past 20 years, racial/ethnic, economic, and other social disparities in health persist. Racial and ethnic minorities experience greater rates of poverty, unemployment, lack of health insurance, shorter life expectancy, and higher morbidity and mortality rates than White Americans, as shown in Table 1.2 (AHRQ 2014; CDC 2011).

In 2014, individuals below poverty level were at the highest risk of being uninsured. Over eight in ten of uninsured individuals were in low- or moderate-income families, with incomes below 400% of the poverty line, a requirement to receive subsidies for health insurance. While 45% of the uninsured were non-Hispanic Whites, people of color are at higher risk of being uninsured than non-Hispanic Whites. People of color make up 40% of the overall population but account for over half of the total uninsured population. The disparity in insurance coverage is especially high for Hispanics, who account for 19% of the total population but more than a third (34%) of the uninsured population. Hispanics and African

Table 1.2 Racial and ethnic health disparities in the USA

Health disparity	Most vulnerable/disadvantaged groups
Life expectancy from birth	African Americans
<i>Mortality</i>	
Cancer	African Americans
Complications of diabetes	African Americans
Coronary artery disease and stroke	African Americans
Homicide	African Americans
Motor vehicular deaths	American Indian and Alaskan Natives (AIANs)
Suicide	AIANs
<i>Morbidity</i>	
Childhood asthma	Puerto Ricans and African Americans
Diabetes	African Americans, AIANs
Human immunodeficiency virus (HIV)	African Americans, AIANs, males who have sex with men (MSM)
Hypertension and its complications	African Americans
Obesity	African Americans, Mexican-Americans
Infant mortality	African Americans
Low birth weight	African Americans
Extremely preterm birth	African Americans
Preterm birth	African Americans
<i>Health behaviors</i>	
Smoking	AIANs

Sources: Agency for Healthcare Research and Quality Advancing Excellence in Health Care (2014). *2014 National healthcare quality and disparities report*. Rockville, MD: USDHHS

Centers for Disease Control and Prevention. (2011). *Health disparities and inequalities report*. Atlanta, GA: Author

Americans have significantly higher uninsured rates (20.9% and 12.7%, respectively) than Whites (9.1%) (Kaiser Family Foundation 2015).

Health inequities occur along racial and ethnic lines. Differences in life expectancy between African and White American populations remain although the gap has narrowed. African Americans, on average, have a life expectancy of 4 years shorter than Whites (CDC 2014a).

African Americans comprise only 25% of the population living in poverty (Iceland 2012), but the effect of poverty is worsened by discrimination and marginalization. The mortality rate of infants born to Black women is 2.3 times higher than infants born to White women, and the maternal mortality rate for Black women is 3 times higher than that of White women (USDHHS, HRSA-MCHB 2013). Almost half of African American women (46%) are hypertensive compared to 30% of White women (CDC 2014c). African American women are victims of interpersonal violence at a rate of 7.8 per 1000 females aged 12 years and older as compared to White women and Latinas (6.2 and 4.0, respectively) (National Coalition on Black Civic Participation 2014).

1.4.3.2 Canada

Despite a universal healthcare system in Canada, low-income Canadians are less likely to see a specialist when needed, have more difficulty getting care on weekends or evenings, and are more likely to wait 5 days or more for an appointment with a physician. Canadians with below-average incomes are three times less likely to fill a prescription and 60% less able to get a needed test or treatment due to cost than above-average income earners (Mikkonen and Raphael 2010).

Men living in the wealthiest neighborhoods on average live more than 4 years longer than men in the poorest neighborhoods. In comparison, women in wealthiest neighborhoods live almost 2 years longer than women in the poorest neighborhoods. Those living in the most deprived neighborhoods had higher suicide and death rates. Adult-onset diabetes and heart attacks are far more common among low-income Canadians. Food insecurity is common in households led by lone mothers and aboriginal households. Food-insufficient households are more likely to report having diabetes, high blood pressure, and food allergies than households with sufficient food. Children in food-insecure households are more likely to experience a wide range of behavioral, emotional, and academic problems than children

living in food-secure households (Mikkonen and Raphael 2010).

Social exclusion is evident among recent immigrants and aboriginal populations in Canada. Recent immigrants have higher unemployment rates and lower labor force participation than Canadian-born workers. Compared to non-Aboriginal Canadians, First Nation Aboriginal people earn much less income, have twice the rate of unemployment, are more likely to live in crowded conditions, and are much less likely to graduate from high school. Aboriginal Canadians live the shortest lives and have higher rates of infant mortality, suicide, major depression, alcohol, and childhood sexual abuse than non-Aboriginal Canadians (Mikkonen and Raphael 2010).

1.4.3.3 Mexico

Mexico is considered most advanced of all the developing countries in the world. Since 2004, Mexico has extended healthcare coverage to 52 million previously unenrolled Mexicans through the *Seguro Popular*. Although some areas like Mexico City has an impressive number of tier one hospitals with top-notch medical advancements, many public hospitals are underfunded, lack medical technology, and offer limited services. Access to quality care is reserved for those who can pay for private hospital care (Izek 2016).

According to Guthrie and Fleck (2017), type 2 diabetes is the leading cause of death and disability in Mexico and has been declared a national health emergency. In 2013, the country has launched the National Strategy for the Prevention and Control of Overweight, Obesity and Diabetes through public health, medical care, and fiscal and regulatory policies. Mexico accounts for the most hospitalizations (many of them preventable) related to diabetes, among the 35 OECD countries. Many Mexicans are diagnosed with diabetes at a relatively early age with 3.25% of cases detected between 20 and 39 years, compared to the OECD average of 1.7% (Guthrie and Fleck 2017).

The rapid increase in obesity, diabetes, hypertension, and hypercholesterolemia in Mexico puts women of reproductive age at higher risk for pre-

existing hypertensive disorders and diabetes mellitus (WHO 2016). Socioeconomic disparities are evident in maternal mortality rates (MMR) from direct causes. MMR from direct maternal deaths has been declining between 2006 and 2013; the rate among women residing in the poorest municipalities decreased from 119.1 to 72.7 deaths per 100,000 live births as compared to the decline from 35.2 to 26.9 deaths per 100,000 live births among women in the wealthiest municipalities. Between 2008 and 2010 the poorest quintile had a statistically significant higher MMR from indirect causes than the wealthiest quintile (WHO 2016). Between 2000 and 2013, the number of stillbirths decreased from 9.2 to 7.2 per 1000 as compared to the 2015 worldwide average of 18.4 per 1000 births. Approximately 51% of stillbirths occurred intrapartum, with 40% occurring at 28 weeks' gestation or later, comparable to the global estimate of 33–46% for third-trimester stillbirths (Murguia-Peniche et al. 2016).

1.4.4 European Countries

Bask (2011) examined the accumulation of problems among welfare recipients by using two waves of data from annual surveys of living conditions in Sweden in 1994–1995 and 2002–2003. The analysis focused on such factors as chronic unemployment, economic problems, health problems, experiences of threat or violence, crowded housing, lack of a close friend, and sleeping problems. Being single (with or without children) and immigrant was associated with the most clusters of problems. Interestingly, education and economic factors were not significant, which was attributed by the author to the fact that Sweden is a welfare state with an ambitious universal social policy agenda involving redistributive activities and extensive spending on public welfare.

A study comparing all-White British civil servants with Whites and Blacks in the USA found that socioeconomic status was related to health (Adler et al. 2008). Subjective social status (SSS), that is, the perception of one's socioeconomic position, was also associated with health

status. Occupation was a more important determinant of SSS among British civil servants compared to education and income among the US subjects. SSS was significantly related to overall health and depression in all groups and to hypertension in all groups except African American males. Socioeconomic factors did not predict SSS scores for Black Americans as well as they did for the British subjects and White Americans. Overall, relationships between SSS and health were stronger for the British and White US subjects than for African Americans, suggesting other factors, such as racial characteristics, influence their health.

Studies done in a number of countries showed that health disparities affect racial and ethnic minorities more than dominant groups in the same society. A longitudinal study of inpatient psychiatric admissions of adolescents in London found that young Blacks are nearly six times more likely than those in the White group to be admitted with psychosis, followed by "Other" (other ethnic groups and those with mixed ethnic background) and Asians. Young people with psychosis in the Black and Other groups were around three times more likely to experience formal detention on admission (Corrigall and Bhugra 2013). In Spain, Romanies (Gypsies), a marginalized group, were found to have greater prevalence of migraines compared to the general population. Romanies suffering from migraines had the worse self-reported health status and greater incidence of depression (Jimenez-Sanchez et al. 2013).

1.4.5 Latin America and Caribbean

In Latin and Caribbean countries, the poor tend to use fewer public resources than middle- and upper-income groups. Large patterns of health inequalities between socioeconomic groups, as well as between gender and ethnic groups, suggest a link between health outcomes and material and social living conditions. There is a growing impact of social determinants reflected by inequalities in health and overall well-being of the poor populations (Bambas and Casas 2001).



Fig. 1.1 Framework for culturally competent healthcare

1.5 Framework for Culturally Competent Healthcare

This section explains the key concepts undergirding the framework for culturally competent healthcare (see Fig. 1.1). The goal of culturally competent care is the achievement of health equity, particularly for vulnerable populations who are most affected by the social determinants that lead to health inequity. In order to achieve health equity, culturally competent care must be grounded in the principles of social justice and human rights.

1.5.1 Social Justice and Human Rights

Human rights are founded on the principle that all human beings have dignity and equal value. Article 25 of the Universal Declaration of Human Rights promulgated by the UN Assembly in 1948 emphasized the right of everyone to a standard of living adequate for the health and well-being for oneself and one's family, including food, clothing, housing, medical care, and necessary social services. UDHR also emphasized the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond his control (ICHRP 2012). These human rights are indivisible and must coexist as a collective in order to assure protection of an individual's dignity and well-being. The right to health is not possible without assuring economic, social, and cultural rights (UN 1948).

Assurance of health and well-being must take steps to address social determinants of health, which are multiple, complex, and interrelated. Human rights protection is critical particularly for individuals and groups who are vulnerable because of social exclusion, poverty, and other structural factors hindering their social mobility and autonomy. Health is intimately linked with such life realities as poverty, unemployment, educational opportunities, and living environments. Although human beings have universal rights, there is ample evidence that the privileged groups enjoy unfair advantages over the disempowered groups.

Social justice places the responsibility on society and its institutions to safeguard the health and well-being of the vulnerable while ensuring protection of the basic human rights of everyone. Achieving health equity, however, requires a moral obligation to redistribute resources to uplift those who do not have enough to live a decent life. Rawls (1971) first proposed a theory of justice with a set of principles governing the distribution of primary social goods, such as liberties, opportunities, income, and wealth. A just society according to Rawls is one that renders the most vulnerable less vulnerable.

Powers and Faden (2008) argue that injustice does not arise solely from the distribution of material goods and services but also in the allocation of non-distributive aspects of well-being. Victims of social subordination, discrimination, and stigma experience lack of respect, attachment, and autonomy that impact their well-being. The authors recommend that social justice needs to integrate the distributive and non-distributive aspects of justice. Indeed, improvement of health and well-being of

vulnerable groups should address inequity in the allocation of material goods and services as well as prevent maldistribution of goodwill such as love, respect, compassion, and advocacy. Both are essential to becoming a fully participating member of society. These nonmaterial variables can make individuals either flourish or diminish their life chances in society (Powers and Faden 2008).

1.5.2 Cultural Competence

Several definitions and alternate terms exist in the literature on cultural competence. The definition by Cross et al. (1989) was adopted by the Office of Minority Health in developing the National Standards for Culturally and Linguistically Appropriate Services (CLAS) (USDHHS 2001). Cultural competence is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enable them to work effectively in cross-cultural situations. Cross et al. used competence to indicate different levels of capacity at the individual, organizational, and system levels. At the system level, the needs of the community and society are addressed. Cultural competence initiatives have achieved some success at the individual care level, particularly in using linguistically congruent services, accommodation of different values and practices in healthcare, and education of health professionals. However, the evidence of lingering and widening health disparities among diverse groups demonstrate that culturally competent initiatives have not eliminated population health disparities.

1.5.2.1 Individual Level

Cultural competence is based on the requisite knowledge, attitudes, skills/behaviors, and practices that value and respect differences. At the individual level, knowledge pertains to a level of understanding of different cultural values, beliefs, and practices of individuals and families seeking care. Attitudes include respect, openness, sensitivity, self-awareness, and critical reflection. Skills include cross-cultural communication, cultural assessment, cultural conflict management, and accommodation of cultural differences.

1.5.2.2 Organizational Level

Organizational practices constitute development of infrastructure, leadership and management, and care delivery systems that promote culturally competent care. Healthcare organization initiatives may include (a) programs for training and development of multidisciplinary employees in culturally competent care; (b) offering services during hours and in locations convenient to patients who are unable to take time off work, have no private transportation, and need someone to look after their children when they go for their medical appointments; (c) providing trained interpreters and translators with expertise in common languages or dialects presented by patients; (d) offering menus and pastoral services that accommodate ethnic and religious differences of patients; and (e) providing adequate social services to address needs of patients and families.

1.5.2.3 Community Level

Community-level cultural competence is an area that needs development. This is a critical approach to address social determinants of health in vulnerable populations who have limited social capital. Bourdieu (1977) first defined social capital as the aggregate of actual or potential resources that are linked to a durable network of institutionalized memberships in a group and that provides and maintains material and symbolic gains for its members. While poor ethnic enclaves may offer emotional support and acceptance for their members, lack of economic and symbolic capital poses many constraints on their ability to be financially secure and influence the conditions in which they live. By contrast, individuals and communities with higher socioeconomic status and who are accepted as part of the dominant group have access to a social network that can enhance their socioeconomic position and power. Social and economic stratification in society is culturally reproduced, perpetuating vulnerability of some groups and privileged positions of others.

Culturally competent professionals and organizations are actively engaged with vulnerable communities. By forging multisectoral and multidisciplinary social networks in partnerships with the community, they promote broad aware-