



Achieving Cultural Competence: The Challenges for Health Educators

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ABSTRACT

The racial and ethnic diversification of the U.S. population presents a clear call for health educators to surmount the barriers they have encountered in reaching U.S. racial and ethnic groups with culturally appropriate health promotion and prevention messages. As the population becomes more culturally and ethnically diverse, the preparation of culturally competent health educators and the development of culturally appropriate health education and promotion programs become crucial. Health educators must strive to achieve cultural competency by understanding the meaning of culture and its complexity within each group; increasing cultural awareness, knowledge, skills, and desire; and applying the National Standards for Culturally and Linguistically Appropriate Services until they develop discipline-specific standards. This article discusses some of the issues surrounding cultural competence and provides some strategies by which health educators can become culturally competent.

Data from the U.S. Census Bureau show that the U.S. population has reached its most diverse composition since the nation was born (Figure 1). Census data also show that the largest population increases in the last decade were among non-White ethnic groups and foreign-born populations (U.S. Census Bureau, 2000). According to the U.S. Census 2000, 25% of the U.S. population is comprised of African Americans, Hispanics, Asian/Pacific Islanders, Native Americans and other racial and ethnic groups. Population projections indicate that the number of people represented in these racial and ethnic groups will continue to grow in the next few decades; in fact, it is esti-

ated that by 2020 the percentage of White non-Hispanic population will be reduced to 65% of the total U.S. population (U.S. Census Bureau, 2002). The racial and ethnic diversification of the U.S. population presents a clear call for health educators to surmount the barriers they have encountered in reaching U.S. racial and ethnic groups with culturally appropriate/competent programs.

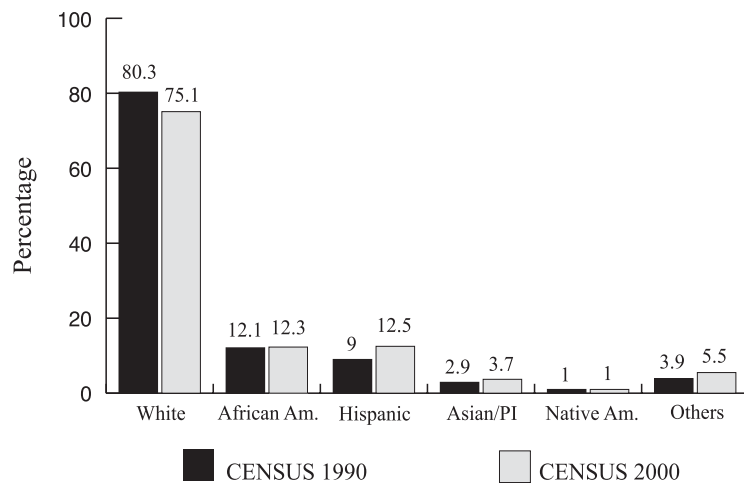
In addition, each one of these racial and ethnic groups is far from homogenous. Instead, each one represents a rich kaleidoscope of cultural diversity, encompassing people of different ancestry with unique, yet common, values and beliefs. For example,

although Hispanics, the fastest growing group, share many cultural characteristics, each of the Hispanic subgroups, such as Mexican, Cuban, and Puerto Rican, is

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Figure 1. Changes on Race and Ethnicity on U.S. Population Between 1990 and 2000



culturally and socially distinct from the others (Marin & Marin-VanOss, 1991).

The professional literature clearly establishes the need, opportunity, and methods for addressing multicultural issues in health-related fields including health education (Airhihenbuwa, 1995a, 1995b; Garcia & Bregoli, 2000; Pinzón & Pérez, 1997). In addition, numerous articles have been written about multicultural health education and the methodologies for dealing with diverse populations (Grassi, González, Tello, & He, 1999), minority participation in research (Green, Maiskai, Wang, Britt, & Ebeling, 1997; Spigner, 1994), and the development of multicultural competence (Redican, Stewart, Johnson, & Frazee, 1994; Stoy, 2000). Therefore, it is imperative that health educators become active participants in the development of discipline-specific guidelines for cultural competency.

Cultural competency among health educators is a natural evolution from the cultural sensitivity roles and training advocated by the American Association for Health Education (AAHE; formerly the Association for the Advancement of Health Education) in its *Cultural Awareness and Sensitivity: Guidelines for Health Educators* (1994). This evolution has been reinforced

by a call to health educators to become partners with federal agencies in the development and implementation of culturally competent interventions (Denboba, Bragdon, Epstein, Garthright, & McCann Goldman, 1998), as well as to become more culturally competent when dealing with diverse groups. This step is a crucial role and responsibility for health educators, because culturally competent health interventions have been described as an approach to achieve the goals of *Healthy People 2010* (Denboba et al., 1998; National Center for Cultural Competence [NCCC], 2002). Specifically, it has been stated that these types of programs can help achieve the second goal of the *Healthy People 2010*, which seeks to eliminate health disparities among segments of the population (U.S. Department of Health and Human Services [DHHS], 2000).

For health educators to be fully involved in this endeavor and become culturally competent professionals, health educators must fully understand the relationship between health and culture, the complexity of culture, cultural competence, and the challenges ahead. The purpose of this article is to discuss some of the issues surrounding cultural competence and to provide some strategies by which health educators can

become culturally competent.

COMPLEXITY OF CULTURE

Contrary to what some people believe, everyone, regardless of racial/ethnic background, has a culture to which he or she identifies. To illustrate this point, one has only to examine the countless definitions provided for culture. Spector (1996) defines it as the “sum of beliefs, practices, habits, likes, dislikes, norms, customs, rituals, and so forth that we learn from our families, during the years of socialization” (p. 68). Similarly, Airhihenbuwa (1995b) states that “culture refers to shared values, norms, and codes that collectively shape a group’s beliefs, attitudes, and behaviors through their interaction in an with their environment” (p. 317). What these definitions indicate is that culture defines a person’s self-perception in the context of a larger group and influences how he or she behaves through a lifetime.

Culture is complex and dynamic (Spector, 1996). For the most part the concept of our culture remains constant; yet our cultural identity can change through time. As individuals interact with people from different racial and ethnic groups, new environments, and new situations, their cultural identity is shaped (Bonder, Martin, & Miracle, 2001). The resulting cultural values and identity influence behavior and health choices made by the individual.

Moreover, culture shapes the way some elements such as gender, class, and sexual identity are viewed. Overall, an individual’s culture defines how each of these elements (i.e., gender, class, sexual identity) is viewed within the context of a particular racial and ethnic group. For example, among Hispanics, the male has a defined gender role and related behaviors (Marin & VanOss Marin, 1991; Nakamura, 1999), such as being the head of the household and being responsible for providing for his family, which might exert some control over issues of sexual reproduction and condom use. Similarly, the cultural belief and values of some groups have an impact on the ways sexual identity is defined and treated within the



context of the specific group.

Finally, research shows that individual ability to function and interact with other cultures, and especially a dominant culture, depends to a great extent on the person's acculturation and assimilation levels. The terms *acculturation* and *assimilation* describe the process by which a person develops a new cultural identity within the context of his or her survival in a new environment (Huff & Kline, 1999a; Spector, 1996). While *acculturation* describes the degree to which an individual adopts the main culture, *assimilation* is the process of integration of a group into mainstream society. Acculturation and assimilation generally increase with the length of time the person has resided in the United States and with subsequent generations born in this country. However, many individuals may experience several levels of acculturation and assimilation. Some individuals may have multiple cultural identities because they identify with their traditional race and ethnic group as well as with other groups they interact. Consequently, our cultural identity defines how we behave in each situation or environment.

HEALTH, DISEASE, AND CULTURE

Huff (1999) argued that "the relationship between culture and health beliefs and practices is highly complex, dynamic and interactive" (p. 23). It is not surprising that during the last decade the relationship between culture and health and disease has been explored. Culture influences the formation of people's perceptions of their health, which consequently "becomes the building blocks in constructing health beliefs and the actions resulting from those beliefs" (Airhihenbuwa, 1995b, p. 317). Moreover, culture influences individuals' diets and nutritional habits, self-care practices, communication and attitudes about health concerns, differences in symptom recognition, health care seeking behavior, and psychological stress and racism (Nakamura, 1999; NCCC, 2002).

Although the allopathic medical model explains illness and disease in terms of

pathological agents (cause and effect), culture provides a culturally diagnostic model by which each individual explains his or her disease and course of treatment (Nakamura, 1999). For example, some racial and ethnic groups perceive and explain the cause of illness and disease in terms of "soul loss," "spirit possession" and "spells" (Spector, 1996). Similarly, some groups describe diseases as the consequences of their personal actions, interrelationship with family and community, and supernatural agents (Huff, 1999). Consequently, each individual would seek treatment based on his or her cultural beliefs. For example, an individual from Mexican culture may be more inclined to visit a *curandero*; an African American may use folk medicine; and a Chinese American may follow the elements of the concept of yin and yang to get relief from a similar illness (Nakamura, 1999). Thus, health educators must be aware of how culture influences personal understanding of health and illness, how this affects personal health practices, and how these views can be incorporated into health promotion interventions.

CULTURAL COMPETENCE

In 1994 AAHE became a leader in recommending that health educators become culturally sensitive. Although the recommendations released at that time were accurate and serve as the basis for culturally sensitivity training, health educators need to be culturally competent as well. Consequently, the preparation of culturally competent health educators has been addressed several times by professionals in the field (Doyle, Liu, & Ancona, 1996; Redican et al., 1994; Stoy, 2000). However, terms such as *cultural competence*, *cultural awareness*, *cultural sensitivity*, *cultural proficiency*, and *intercultural competence* have been used interchangeably to describe the process by which health educators become capable of working with different racial and ethnic groups. Thus, for health educators to become fully prepared in this area, health educators must clearly understand and define the concept of cultural competence.

The Health and Resources and Service Administration, Bureau of Health Professions stated (2002), "No single definition of cultural competence is yet universally accepted, either in practice or in health professions education" (para. 3). As an example, they compiled a list of definitions used by several initiatives and agencies, including those of the President's Initiative on Race and Health and the American Medical Association (Table 1). Recently, the Report of the 2000 Joint Committee on Health Education and Promotion Terminology defined cultural competence as follows:

The ability of an individual to understand and respect values, attitudes, beliefs, and mores that differ across cultures, and to consider and respond appropriately to these differences in planning, implementing, and evaluating health education and promotion programs and interventions (p. 5).

Although this definition focuses on the individual ability to become culturally competent, it fails to address the need for organizations to also become culturally competent. Consequently, based on all these definitions presented on cultural competence, we suggest that health education defines cultural competence as the capacity of an individual and organization to understand, behave, and respect the value, attitudes, and beliefs of different cultural groups and to incorporate these differences in the development and implementation and evaluation of policies and health education and promotion programs.

Cultural Competence and Health Education Settings

Health care organizations, community-based organizations, and schools that provide health education programs must evaluate their ability to serve multicultural populations. In an organizational context, cultural competence can be defined as a set of values, behaviors, attitudes, practices, and policies within an organization, program, or among staff that enables them to work effectively with multicultural populations (Goode & Sockalingam, 2000). Cultural

**Table 1. Selected Examples of Definitions of Cultural Competence**

Organization/Author	Definition	Key Terms
President's Initiative on Race and Health	Cultural competence is the ability to deliver effective medical care to people from different cultures. By understanding, valuing, and incorporating the cultural differences of America's diverse population and examining one's own health-related values and beliefs, health providers deliver more effective and cost-efficient care.	Understanding, valuing, incorporating, and examining cultural differences, values and beliefs
U.S. Department of Health and Human Services	Cultural competence comprises behaviors, attitudes, and policies that can come together on a continuum that will ensure that a system, agency, program, or individual can function effectively and appropriately in diverse cultural interaction and settings.	Behaviors, attitudes, and policies
American Medical Association	The knowledge and interpersonal skills that allow providers to understand, appreciate, and work with individuals from cultures other than their own.	Knowledge and interpersonal skills
Health Resources and Services Administration, Bureau of Primary Health Care, Office of Women and Minority Health	Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. "Competence" implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.	Behaviors, attitudes, and policies
Substance Abuse and Mental Health Services Administration Center for Mental Health Services	Cultural competence includes attaining the knowledge, skills, and attitudes to enable administrators and practitioners within a system of care to provide effective care for diverse populations, i.e., to work within the person's values and reality conditions.	Knowledge, skills, and attitudes

Source: Definitions taken from Health Resources and Service Administration, Bureau of Health Professions, 2002. *Definitions of cultural competence*. Retrieved from 7/12/2002 bhpr.hrsa.gov/diversity//cultcomp.htm.

competence can also be defined as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among, professionals that enables this system, agency, or those professionals to work effectively in cross-cultural situations" (Cross, Bazron, Dennis, & Isaacs,

1989, p. 4).

Nevertheless, health educators working in different settings need to realize that the process by which an organization becomes culturally competent does not happen overnight. Goode and Sockalingam (2000) state that at the organizational level the process

for cultural competence requires a comprehensive and coordinated plan. This plan includes interventions at different levels of policymaking, infrastructure building, program administration and evaluation, the delivery of services and enabling support, and the individual. They also add that at the



individual level within the organization the person must examine his or her own attitudes and values and the knowledge and skills needed to become cultural competent (Goode & Sockalingam, 2000). Cultural competence includes awareness and acceptance of others' and one's own cultural values, and a commitment to honor and respect the beliefs and values of others. Cultural competence becomes a complex process rather than an endpoint. Thus, organizations must create an environment that supports an ongoing process of cultural competence.

Cultural Competence Models

Dean (2001) argued that cultural competence is a myth and questioned the notion that one person could become competent in the culture of another. She states that it is impossible to become competent in something (e.g., culture) that is constantly changing. Hence, she "proposes a model in which maintaining an awareness of one's lack of competence is the goal rather than the establishment of competence" (Dean, p. 624). Based on this notion, health practitioners must engage in an ongoing process in which they seek to understand and learn from clients, because they are the experts on their culture. We argue, however, that within their role as resource persons, health educators need to be culturally competent. This competency may be expressed in the form of conversational language skills, experiences abroad, sensitivity to historical events (e.g., Tuskegee Study), and low literacy populations. For example, a health educator would utilize radio messages to reach a migrant population rather than printed flyers or postcards.

Campinha-Bacote (1999, 2001) suggests that cultural competence is a process and proposes a model composed of these five levels as essential constructs of cultural competence: cultural awareness, cultural knowledge, cultural encounters, cultural skills, and cultural desire. Each of these constructs requires health professionals to become involved in a process. Through cultural awareness individuals become sensitive to values, beliefs, and practices.

Through cultural knowledge they understand the client's world view. Cultural encounters provide the health practitioner with an opportunity to interact with several members of a particular group to refine understanding of that particular group. Cultural skill refers to the ability to collect culturally relevant data and to use culturally specific assessment. Finally, cultural desire is the genuine motivation to work with people from diverse cultures (Campinha-Bacote, 2001, 1999). Health educators can learn from this model, because it provides another framework to define and understand the complexity of cultural competence. Whether health educators follow this model or another model, we must recognize that cultural competence is an ongoing complex process.

ACHIEVING CULTURAL COMPETENCE

Given the multicultural nature of contemporary U.S. society, health educators must strive to achieve cultural competence and incorporate this concept into their planning, implementing, and evaluating process of health education and promotion programs. Health educators can achieve this by understanding the meaning of culture and its complexity within each racial and ethnic group; increasing cultural awareness, knowledge, skills, and desire; using sensitivity in communication; and applying the National Standards for Culturally and Linguistically Appropriate Services. It is important to clarify that health educators must not confuse this notion with the idea that health educators must become "experts" about every ethnic and racial group residing in the United States. However, the process of cultural competency does require that health educators be cognizant of differences, which may affect their ability to reach target populations, and be proficient in utilizing techniques to bridge cultural divisions. In addition, health educators must acknowledge their lack of knowledge of these issues to understand the need for preparation in this area. In the following sections the authors suggest strategies by which health educators can become

culturally competent.

Understanding and Questioning Culture

As previously stated, culture can be defined in many different ways; however, out of all these definitions emerges the notion that culture is dynamic, complex, and constantly changing. Culture defines individuals, family, and community, and influences how these groups of people operate in our society. Consequently, expanding on Freire's theories, Airhihenbuwa (1995b) encouraged health educators to engage in raising critical consciousness as a process to understand the issues surrounding culture and health education.

Individuals are products of their culture, which provides the filter by which they interpret their reality. Along these lines, health educators must become aware of their own cultural "baggage" (i.e., bias and beliefs about individuals' culture) and question how this internal cultural perception influence the work they do every day. In other words, if health educators have preconceived notions of people's behaviors based on these individuals' cultural background and let these ideas affect their work, they could not effectively serve the multicultural population. Thus, health educators must continuously question and challenge the issues related to culture and how culture influences individuals' behaviors, as they strive to become better professionals.

Increasing Cultural Awareness, Knowledge, Skills, and Desire

The development of basic cultural awareness and knowledge is essential in the professional preparation of health educators. Today, there is a growing literature on cultural issues (Airhihenbuwa, 1995a; Huff & Kline, 1999a; Nakamura, 1999; Spector, 1996) and there are professional organizations whose mission is to promote culture competence (e.g., NCCC). In addition, there are many opportunities to participate in workshops and conferences dealing with culture and health, and most universities offer courses that deal specifically with cultural issues (i.e., culture and education, minority health).



One of the challenges that many health educators face is that they do not have easy access to many of these resources and are so overwhelmed by their job responsibilities that it is difficult to engage in a learning process without compromising their job performance. For example, in a recent conversation between the first author and a school health teacher during a discussion at a local workshop, the teacher shared with him her frustration in trying to work with children from diverse cultural backgrounds without the proper training or resources to manage her daily tasks (R. Luquis, personal communication, June 18, 2002). Although health educators at school settings represent just a portion of all health educators, one may wonder whether health educators at other settings are lacking the preparation they need in this area and are experiencing a similar situation.

Almost a decade ago, Redican et al. (1994) found that the state departments of education do not actively promote or design culturally sensitive material for teachers. Thus, the questions become, has this situation changed in the last few years? Are health teachers getting the resources and support they need from the school administration to become culturally competent educators? In addition, Redican et al. found that many of the states expect teachers to receive preparation in cultural training from professional preparation programs. To exacerbate this problem, most professional preparation programs do not provide adequate training in this area. Redican et al. (1994) reported that institutions of higher education preparing health educators were not active in offering cultural sensitivity training as part of the professional preparation.

Doyle et al. (1996) found that although some professional preparation programs have taken some actions toward the development of cultural sensitivity courses, few programs address the cultural competencies needed for health educators to effectively serve the diverse population. Beatty and Doyle (2000) also found that although multicultural content was included in the

courses evaluated from a health education preparation program, not all the courses dealt appropriately with or focused on cultural issues. Therefore, health education preparation programs must include multicultural courses that address sensitivity, competencies, and required field experiences as part of their core requirement for the program (Beatty & Doyle, 2000). In addition, a national assessment of professional preparation programs in cultural sensitivity and competence in health education is well overdue to ensure that every health educator is receiving the knowledge and skills needed to effectively serve a diverse population.

Moreover, a multicultural education course should go beyond the concepts of cultural competence and discuss the areas of race, gender, class, and sexual orientation (Abrums & Leppa, 2001), as issues of oppression, racism, and discrimination based on gender and sexual orientation still exist in our nation. Finally, national organizations such as AAHE should continue advocating for the implementation of policies that require every state to provide support and training in the area of multicultural education for school teachers and health educators working in other health service organizations. For example, many schools can easily accomplish this task by offering in-service training in multicultural education, with similar content as college courses, as part of their yearly workshops. In addition, books and guidelines such as the Cultural Awareness and Sensitivity: Guidelines for health educators (AAHE, 1994) must be updated to reflect the current demographics, cultural issues, and the need for cultural competence in the field of health education.

Health educators must also develop cultural skills and culturally appropriate interventions when dealing with people from diverse groups. This process requires that health educators learn how to conduct a comprehensive cultural assessment to determine the explicit needs and appropriate interventions for the people being targeted (Campinha-Bacote, 2001, 1999). Marin (1993) recommended that culturally appro-

priate intervention strategies reflect the cultural values, subjective cultural characteristics, and behavioral preferences and expectations of members of the target group. Consequently, there is a need to include a cultural assessment as part of any needs assessment conducted with a multicultural population during the development of health promotion and disease prevention programs. Huff and Kline (1999b) proposed a cultural assessment framework with specific guidelines for the identification of major areas (e.g., demographics and cultural characteristics, epidemiological factors, health beliefs and practices) that need to be considered when assessing individuals and communities from different ethnic and racial groups. Although health educators have successfully used traditional planning and implementation models (i.e., PRECEDE/PROCEED), they must integrate those suggestions that incorporate cultural assessment into the development of health education and promotion interventions. This action goes directly to the core of the responsibilities and competencies for the health education profession.

Health educators must develop cultural desire or motivation to work with people from different racial and ethnic backgrounds. Developing this desire can be challenging for some people, as most health educators practicing in the United States are White non-Hispanic and perhaps lack the experience of working with diverse groups. Health educators must make an effort to take every opportunity they have to interact with people from other racial and ethnic groups (Stoy, 2000). For example, every day we are faced with opportunities to interact with students, colleagues, friends, neighbors, clients, and others from different cultural backgrounds. The more health educators make the effort to seek out these encounters, the better they will be able to work within a multicultural society. In addition, this effort might provide the motivation to question their cultural knowledge and to seek ways to improve their cultural competence. Health educators



who are motivated to work within a multicultural population are not only doing a good service to the community they serve, but also to the profession.

National Standards for Culturally and Linguistically Appropriate Services

Health educators can learn from and incorporate some of the recommendations from federal initiatives in the area of culture and health. In December 2000 the Office of Minority Health (OMH) released the Final Standards for Cultural and Linguistic Competency (CLAS) (OMH, 2002). The purpose of the CLAS is to “respond to the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner” (para. 1). The standards provide a blueprint to follow for building culturally competent health care organizations and workers. The CLAS standards are primarily directed at health care organizations, but the OMH encourages individual providers and other health professionals to use the standards to make their practices more culturally and linguistically accessible.

Although not all the standards are appropriate for the field of health education, several of these can be easily applied to health education programs in all settings. For example, Standards 2 and 3 call for the implementation of strategies for the recruitment and retention of diverse staff representatives of the target population and the ongoing education and training of staff in culturally and linguistically appropriate services. Several times at national and local health conferences health educators and others alike have discussed the issue of recruitment and retention of diverse staff. It is time for the field of health education to take some actions in promoting health education as a viable career for culturally diverse students at colleges and high schools across the country. Similarly, there should be a strong emphasis in the preparation and ongoing education of culturally competent health educators at all settings. Some of the other standards (i.e., Standards 4-7) provide recommendations on language-

appropriate services to people with limited English proficiency. Health educators must ensure that every health education and promotion program they implement includes bilingual/bicultural staff and education materials in every language represented in the target population. These are examples of ways the field of health education can incorporate the CLAS recommendations. In addition, the CLAS standards could serve as a framework for the development of culturally and linguistic standards for the field of health education.

CONCLUSION

The racial and ethnic diversification of the U.S. population presents a clear call for health educators to conquer the barriers they have encountered in reaching culturally diverse groups in the United States. As the population becomes more culturally and ethnically diverse, the preparation of culturally competent health educators and the development of culturally appropriate health education and promotion programs become fundamental. This article provides a discussion of some of the issues surrounding cultural competence and some strategies by which health educators can become culturally competent. Cultural competence has been identified as a requirement to deal with a diverse population. Until the field of health education develops discipline-specific definition and guidelines for cultural competency, reliance on definitions and models developed to address these issues within the health care system is our best option to address cultural competency. To better serve our profession, clients, students, and community, we, as individuals and organizations, must strive to achieve cultural competency at all levels. Although many challenges are still ahead, we must overcome these as we serve a multicultural population.

REFERENCES

Abrums, M. E., & Leppa, C. (2001). Beyond cultural competence: Teaching about race, gender, class, and sexual orientation. *Journal of Nursing Education, 40*, 270-275.

Airhihenbuwa, C. O. (1995a). *Health and culture: Beyond the western paradigm*. Thousand Oaks, CA: Sage Publications.

Airhihenbuwa, C. O. (1995b). Culture, health education, and critical consciousness. *Journal of Health Education, 26*, 317-319.

American Association for Health Education (AAHE). (1994). *Cultural awareness and sensitivity: Guidelines for health educators*. Reston, VA: Author.

Beatty, C. F., & Doyle, E. I. (2000). Multicultural curriculum evaluation of a professional preparation program. *American Journal of Health Studies, 16*, 124-132.

Bonder, B., Martin, L., & Miracle, A. (2001). Achieving cultural competence: The challenge for clients and healthcare workers in a multicultural society. *Generations, 25*(1), 35-42.

Campinha-Bacote, J. (1999). A model and instrument for addressing cultural competence in health care. *Journal of Nursing Education, 38*, 203-209.

Campinha-Bacote, J. (2001). A model of practice to address cultural competence in rehabilitation nursing. *Rehabilitation Nursing, 26*(1), 8-12.

Cross, T. L., Bazron, B. J., Dennis, K. W., & Isaacs, M. R. (1989). *Towards a culturally competent system of health care: A monograph of effective services for minority children who are severely emotionally disturbed* (vol. 1). Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

Dean, R. G. (2001). The myth of cross-cultural competence. *Families in Society, 82*, 623-630.

Denboba, D. L., Bragdon, J. L., Epstein, L. G., Garthright, K., & McCann Goldman, T. (1998). Reducing health disparities through cultural competence. *Journal of Health Education, 29*, S47-S53.

Doyle, E. I., Liu, Y., & Ancona, L. (1996). Cultural competence development in university health education courses. *Journal of Health Education, 27*, 206-213.

Garcia, B., & Bregoli, M. (2000). The use of literary sources in the preparation of clinicians for multicultural practice. *Journal of Teaching in Social Work, 20*(1/2), 77-102.

Goode T. D., & Sockalingam, S. (2000).



Cultural competence: Developing policies to address the health care needs of culturally diverse clientele. *Home Health Care Management & Practice*, 12(5), 49–55.

Grassi, K., González, M. G., Tello, P., & He, G. (1999). La vida caminando: A community-based physical activity program designed by and for rural Latinos. *Journal of Health Education*, 30, S-13–S-17.

Green, B. L., Maiskai, R., Wang, M. W., Britt, M. F., & Ebeling, N. (1997). Participation in health education, health promotion, and health research by African Americans: Effects of the Tuskegee syphilis experiment. *Journal of Health Education*, 28, 196–204.

Health Resources and Service Administration, Bureau of Health Professions. (2002). *Definitions of cultural competence*. Retrieved July 12, 2002 from bhpr.hrsa.gov/diversity/cultcomp.htm.

Huff, R. M. (1999). Cross-cultural concepts of health and disease. In R. M. Huff & M. V. Kline (Eds.), *Promoting health in multicultural populations: A handbook for practitioners* (pp. 23–39). Thousand Oaks, CA: Sage Publications.

Huff, R. M., & Kline, M. V. (1999a). Health promotion in the context of culture. In R. M. Huff & M. V. Kline (Eds.), *Promoting health in multicultural populations: A handbook for practitioners* (pp. 3–22). Thousand Oaks, CA: Sage Publications.

Huff, R. M., & Kline, M. V. (1999b). The cultural assessment framework. In R. M. Huff & M. V. Kline (Eds.), *Promoting health in multicultural populations: A handbook for practitioners* (pp. 481–499). Thousand Oaks, CA: Sage Publications.

Joint Terminology Committee. (2002). Report of the 2000 Joint Committee on Health Education and Promotion Terminology. *Journal of School Health*, 72(1), 3–7.

Marin, G. (1993). Defining culturally appropriate community interventions: Hispanics as a case study. *Journal of Community Psychology*, 21, 149–161.

Marin, G., & Marin-VanOss, B. (1991). *Research with Hispanic populations*. Newbury Park, CA: Sage Publications.

Nakamura, R. M. (1999). *Health in America: A multicultural perspective*. Boston: Allyn & Bacon.

National Center for Cultural Competence (NCCC). (2002). Developing cultural competence in health care settings. *Pediatric Nursing*, 28, 133–137.

Office of Minority Health (2002). *Assuring cultural competence in health care: Recommendations for national standards and an outcomes-focused research agenda*. Retrieved January 15, 2002 from www.omhrc.gov/clasfinalcultural1a.htm.

Pinzón, H. L., & Pérez, M. A. (1997).

Multicultural issues in health education programs for Hispanic/Latino populations in the United States. *Journal of Health Education*, 28, 314–316.

Redican, K., Steward, S. H., Johnson, L., E., & Frazee, A. (1994). Professional preparation in cultural awareness and sensitivity in health education: A national survey. *Journal of Health Education*, 25, 215–218.

Spector, R. E. (1996). *Cultural diversity in health and illness* (4th ed.). Stamford, CT: Appleton & Lange.

Spigner, C. (1994). Black participation in health research: A functionalists overview. *Journal of Health Education*, 25, 210–214.

Stoy, D. B. (2000). Developing intercultural competence: An action plan for health educators. *Journal of Health Education*, 31, 16–19.

U.S. Census Bureau. (2002). *Projections of the resident population by race, Hispanic origin, and nativity: Middle series, 2016 to 2020*. Retrieved June 5, 2002 from www.census.gov/population/www/projections/natproj.html.

U.S. Census Bureau. (2000). *United States census 2000*. Retrieved June 5, 2002 from www.census.gov.

U.S. Department of Health and Human Services. (2000). *Healthy people 2010: Understanding and improving health* (2nd ed.) Retrieved January 15, 2002 from www.health.gov/healthypeople.