

**Dimensions of Diversity: Terminology in
health research**

Hannah Bradby and Tilman Brand

IRIS WORKING PAPER SERIES, No. 12/2016

IRiS Working Paper Series

The Institute for Research into Superdiversity (IRiS) Working Paper Series is intended to aid the rapid distribution of work in progress, research findings and special lectures by researchers and associates of the Institute. Papers aim to stimulate discussion among scholars, policymakers and practitioners and will address a range of topics including issues surrounding population dynamics, security, cohesion and integration, identity, global networks, rights and citizenship, diasporic and transnational activities, service delivery, wellbeing, social exclusion and the opportunities which superdiverse societies offer to support economic recovery.

The IRiS WP Series is edited by Dr Nando Sigona at the Institute for Research into Superdiversity, University of Birmingham. We welcome proposals for Working Papers from researchers, policymakers and practitioners; for queries and proposals, please contact: n.sigona@bham.ac.uk. All papers are peer-reviewed before publication.

The opinions expressed in the papers are solely those of the author/s who retain the copyright. They should not be attributed to the project funders or the Institute for Research into Superdiversity, the School of Social Policy or the University of Birmingham.

Papers are distributed free of charge in PDF format via the IRiS website. Hard copies will be occasionally available at IRiS public events.



This Working Paper is also part of **UPWEB Working Paper Series** (No.1/2015)

For more info on UPWEB: <http://www.birmingham.ac.uk/generic/upweb/index.aspx>

Dimensions of Diversity: Terminology in health research

Hannah Bradby and Tilman Brand

Abstract

This short review considers how 'ethnicity' and 'superdiversity' are used alongside 'diversity' in health research in a sample of recent journal articles. Diversity appears regularly in health inequalities research where the term is used to justify a focus on particular minorities presented as especially vulnerable to ill health or to being in receipt of inadequate services. Given the complexity of what is covered by 'diversity' there is a tendency to focus on a single dimension for intervention, such as language or 'health literacy'. The development of cultural competency or cultural safety is a common response to diversity in health service provision. The review considers gaps in how diversity is treated and the way that superdiversity is largely being used as yet another synonym of diversity. The translation of terms into English, as the dominant language in the political economy of academic publishing, introduces further uncertainty in pinpointing the local dimension of diversity that is under research. The ways that 'superdiversity' is gradually appearing does not (yet) undo such uncertainty.

Highlights

- Diversity appears regularly in health inequality literature but is poorly defined
- Diversity used synonymously with other terms (culture, ethnicity, race, language)
- Superdiversity used as an amplifier
- Language or 'health literacy' often nominate as aspect of diversity for intervention
- Cultural competence or cultural safety encompass progressive aspirations but less often specific practical responses to the challenges of diversifying diversity
- Health professionals do not see responding to diversity as their responsibility

Gaps

- Specified relationships between inequality, inequity and diversity
- Positive effects of diversity on health outcomes and on inequality
- Evaluation of effect of increased workforce diversity on health equality
- Evaluation of effectiveness of cultural competency/safety programmes
- Professional structures and culture rarely included as part of the problem
- Effects of political and economic context, especially austerity and globalisation, on health services' response to diversity
- How dimensions of diversity relate to one another across locations
- How vocabulary of superdiversity relates to that of ethnicity, racism and multiculturalism

Citation

Bradby, H. and Brand, T. (2016) 'Dimensions of Diversity: Terminology in health research', *IRIS Working Paper Series*, No. 12/2015 (*UPWEB Working Paper Series*, No. 1/2016) Birmingham: Institute for Research into Superdiversity

About the authors

Professor Hannah Bradby, Department of Sociology, Uppsala University. Email address for correspondence: Hannah.bradby@soc.uu.se

Tilman Brand, Leibniz Institute for Prevention Research and Epidemiology – BIPS, Germany
Email address for correspondence: brand@bips.uni-bremen.de

Contents

Introduction	6
Health inequality	6
Diversity referring to particular minority groups	8
Diversity as a an indicator of problems and as a problem in itself	9
Focussing on a single aspect of diversity: newness/language/health literacy	9
Responses to diversity	10
Gaps and silences	11
Beyond diversity?	12
Bibliography	13

Introduction

The term 'diversity' is a standard, mainstream term, used in a wide range of health research settings from Kenya (Achia and Mageto, 2015) to Massachusetts (Alegría et al., 2014) and Myanmar/Burma (Low et al., 2014).

The rise of 'diversity' as an acceptable term in research and policy is part of the ongoing development whereby the language of race has been usurped by ethnicity (Bradby, 1995), which has in turn been seen as inappropriate due to its compromised and frequently racialised usage (Bradby, 2003). As with other contested terms, the intended meaning of term 'diversity' varies by context, both through time and across cultures. Furthermore, since the term is regularly used without being defined, its intended meaning can be impossible to ascertain.

Health inequality

Demographic shifts driven by migration are held to present new challenges to the equitable provision of health-care and to promoting equity in health outcomes. The term 'diversity' regularly appears in discussions of health inequality to broaden the debate beyond divisions round age, gender and social class, a trend driven in part by the requirements of research funding councils (Helberg-Proctor et al., 2015).

Migration is held responsible for producing 'ethnic culturally diverse nations' of countries that previously saw themselves as ethnically homogenous (Bäärnhielm et al., 2013). Global migration (Norredam et al., 2007) is described as producing an 'increasingly multicultural population' (Alegría et al., 2014) with 'multicultural' used as a synonym for diversity, further elaborated as 'language, cultural, religious and ethnic diversity' (Riggs et al., 2015a). The tendency to use a range of dimensions of diversity including linguistic, ethnic, cultural (Horton and Dickinson, 2011), and/or to use hybrid terms such as ethnic and racial (Alegría et al., 2014), or ethnocultural (Zanchetta and Pourselami, 2006) indicates the imprecision of what is indicated by 'diversity'.

The structural influences on health outcomes, which have been the main focus of health inequalities research, are often acknowledged alongside dimensions of diversity:

determinants of these disparities include baseline health status, race and ethnicity, culture, gender identity and expression, socioeconomic status, region or geography, sexual orientation, and age (Awosogba et al., 2013: 17).

(The term 'disparity' is used as a synonym for 'inequality' in US literature. The phrase 'health disparities' has echoes of the British 'health patterning' terminology of the 1990s, which sought to down-play the social injustice encoded in the phrase of 'health inequality'.)

In defining the problem around diversity and health inequality, there is a tension between explanations around cultural difference often coded as 'ethnic' (Gwede et al., 2010) and those around socio-economic status or material inequality (Sheridan et al., 2011).

Socio-economic inequalities/social determinants of health work tend to emphasize financial and material resources, whereas the diversity agenda, whether on ethnicity, gender, sexual orientation or disability, puts as much if not even more emphasis on cultural matters. By combining perspectives we create a more powerful 'equity lens' (Bhopal, 2012: 171).

If we take up this view, diversity is something like cultural heterogeneity – a horizontal inequality dimension involving differing ideas and perceptions of physical and mental wellbeing and this applies to all groups and situations and not only to migrants or ethnic minorities (Napier et al., 2014). Socio-economic inequalities represent a vertical inequality dimension, which may produce new cultures, e.g. senses of social insecurity and limited choice (Napier et al., 2014). Although conceptualized as a horizontal inequality dimension (or categories without an inherent order), it is quite clear that cultural heterogeneity and diversity is not a plain field but is linked to privileges and systems of oppression involving less access to material resources, discrimination and limited access to health care. Social categories or groups that are often mentioned in terms of diversity are also labelled as axes of inequality or axes of differences (Veenstra, 2011).

As migration or ethnic minority status is in many cases associated with a lower socio-economic status, the latter has to be taken into account when analysing migrant health and/or access to healthcare (Ingleby, 2012). But it is also known that common indicators of socio-economic position do not work in the same way across migrant groups (Agyemang et al., 2010; Kelaher et al., 2009; Oakes and Kaufman, 2006). Even when socio-economic position is effectively controlled for, the interpretation and implication of differences in health between 'diversity group' are not so clear: in the past differences between ethnic groups in epidemiological studies have often been attributed to genetic variation, current studies tend to interpret differences as inequities. But in most cases we do not know whether these differential health outcomes are due to specific exposures (e.g. discrimination) or access barriers, and thus inequity (Whitehead and Dahlgren, 2006), or due to cultural factors, such as health beliefs or patient preferences, and thus 'merely' inequalities.

The introduction of ethnicity terminology in British and US data sought to disaggregate structural and identity aspects of diversity and their influence on health outcomes (Bradby and Nazroo, 2010; Davey-Smith et al., 2000). This approach led to an assessment of ethnicity as an independent variable, which could be used 'to investigate critically the role of ethnicity in the provision of services more generally' (Griffith, 2010: 289). Criticism suggests that ethnic terminology has become reified into reductionist and over-simplified categories that fail to reflect the dynamic complexity of diversity. But, as with each iteration of terminological change, the language of diversity has not replaced that of ethnicity, but rather is used in tandem.

Generally missing from research articles is a discussion of the relationship between equality, equity and how diversity might intervene, an issue taken up by a review of policy guidance relevant to mental health services in the UK:

Diversity in a broad sense is about the recognition and valuing of difference, whereas equality is essentially about creating a fairer society where everyone can participate and has the opportunity to fulfil their potential. Equality and diversity are not inter-changeable but are inter-dependent (Owen and Khalil, 2007: 468).

Where 'inequality' refers to difference between groups without comment on the source of that difference, 'inequity' refers to a normative principle of social justice that considers the differences to be unfair and unjust to the extent that they are avoidable. Until we know the extent to which the major chronic diseases are socially determined, the lack of precision in attributing their inevitable or avoidable nature encapsulated by the term 'inequality' is an appropriate description of the dimensions of the problem (Siegrist and Marmot, 2006). While racial discrimination has a measurable effect on health outcomes (Nazroo, 2003), the wider implications of diversity for health outcomes are less clear. Positive effects of diversity on health outcomes are very little examined.

The extent to which good quality, equitable health services can address population health inequalities remains contested. Nonetheless, population diversity is assumed to place particular demands on health service provision. There are regular assertions that 'increases in population diversity emphasize the need for culturally competent, patient-centered, participatory care' (Beck and Gordon, 2010). What is less often noted is that changes that would benefit the needs of particular minorities 'have the potential to create more inclusive and responsive ... health services for all' (Reitmanova and Gustafson, 2008: 101).

Diversity referring to particular minority groups

The term 'ethnicity' tends to be used as if it was a characteristic of minorities only (Bradby, 1995), and in the same way, diversity is regularly used to justify a focus on particular minorities in a way that can have an 'othering' if not a 'racialising' effect. Groups indicated as included under the 'diversity' heading are constructed as being 'vulnerable and isolated communities' (Riggs et al., 2015b) with unmet healthcare need or unknown healthcare practices (Venters and Gany, 2011). 'African communities' (Shangase and Egbe, 2015), Arab speakers (Ahmed et al., 2010), 'immigrants' (Dias et al., 2008), 'migrant communities' (Ford et al., 2013), 'visible minority immigrants' (Reitmanova and Gustafson, 2009), pregnant Muslim immigrant women (Reitmanova and Gustafson, 2008), refugees (Jensen et al., 2013), 'disadvantaged communities, including refugee and migrant populations' (Riggs et al., 2012) or 'older adults' (Solway et al., 2010) are indicated as sub-groups of an over-arching category, 'diversity'. The focus on specific groups is justified by their vulnerability to poor health outcomes or tendency to receive poor health services. Thus a study of access to primary mental health care for hard-to-reach groups includes Black and minority ethnic (BME) groups (Kovandžić et al., 2011) even though there is not necessarily anything inherently 'hard to reach' about belonging to a minority ethnic group. The centrality of evidence-based medicine has hampered attempts to attend to diversity in effectively tackling health inequalities. The formal evidence base cannot discriminate sub-populations' responses to methodologically rigorous interventions since these interventions tend to be aimed at easy-to-reach population segments, rather than the multiply-deprived sections that both service providers and researchers find hard to reach (Asthana and Halliday, 2006). The methods employed in evidence-based public health simply cannot detect the potential effectiveness of public health interventions in these populations, for which other forms of evidence are necessary.

Diversity as a an indicator of problems and as a problem in itself

The diverse nature of ‘older adults’ is described as including barriers to accessing health services ‘related to race and ethnicity, socioeconomic status, location, age, gender, immigrant status, language, sexual orientation, and diagnosis’ (Solway et al., 2010: 360). The inclusion of ‘diagnosis’ as an aspect of diversity means that illness outcomes that might be driven by diversity are also included as an element of that diversity. Definitions of diversity often try to keep a range of factors in play as potentially contributing to ‘health disparities in the population’, such as ‘socioeconomic, geographic, and race/ethnicity factors’ (White et al., 2014: 51). While trying to keep definitions broad, there is a tendency to use diversity as both an indicator of health vulnerability and as a causal or explanatory factor. In a paper describing health in a global region, not only are the populations of southeast Asia described as diverse, but so are the area’s health systems, with history, geography, and the trading of goods and services identified as causative of such diversity (Chongsuvivatwong et al., 2011). When everything is diverse, it is hard to see what is analytically indicated by the term.

The ‘development of evidence-based mental health interventions for refugees is’ said to be ‘complicated by the cultural and linguistic diversity of the participants’ (Birman et al., 2008: 121), suggesting that diversity is an aberration that gets in the way of the normal delivery of health services. The observed within-group variation (diversity among the refugees) is something that is also highlighted by the term superdiversity (although not mentioned here). Circular reasoning whereby diversity is both cause and effect of health disparities cannot be simply dismissed as evidence of a lack of logic; it can also be taken as indicative of the complexities and uncertainties of the direction of causation of the social processes in play.

Focussing on a single aspect of diversity: newness/language/health literacy

While rarely mentioned, the state of being a new arrival or ‘newcomer’ is described in Canadian research as resulting in ‘less effective use of these preventive services’ on the grounds that ‘linguistic, religious, and cultural factors contribute to the newcomers’ social isolation’ (Zanchetta and Pourselami, 2006: S26).

Language is often nominated as the key variable of exclusion when a single dimension of diversity is needed around which to design an intervention to improve the health outcomes of an ethnic or migrant group (Murray and Buller, 2007). The phrase ‘language diversity’ (Schiaffino et al., 2014) has been used, without explaining how this might differ from a person or community being multilingual. Linguistic groups are used as a sampling frame to operationalize an aspect of diversity assumed to be relevant for health (Ahmed et al., 2010).

Another candidate for intervention is ‘health literacy’ which goes beyond linguistic skills to highlight how ‘newcomers’ may be unfamiliar with the health care system ‘in terms of navigating needed services and/or seeking health-related information’ (Zanchetta and Pourselami, 2006: S26). The need for better health literacy is linked to ‘cultural and linguistic competence in health care’ (Kalengayi et al., 2012) (see below for discussion of cultural competence). Where professionals report ‘difficulties in communicating effectively with [minority] populations about risk-taking behaviours’ and these minorities lack health literacy, problems ensue. Specifically, ‘educational resources and approaches only partially reach people from cultural minorities’ resulting in ‘less effective use of these preventive

services. Linguistic, religious, and cultural factors contribute to the newcomers' social isolation' (Zanchetta and Poursalami, 2006). The European Health Literacy Survey has indicated lower health literacy levels in migrants (based on a German subsample) (Kickbusch et al., 2013).

The term 'health literacy', when used in combination with discussions of diversity, can imply the existence of an appropriate way to use health services which new arrivals or visible minorities, or at least those with health problems, fail to follow. Critical conceptual frameworks go beyond individual competencies to access, understand and appraise information about health and health services (functional literacy), adding an interactional (e.g. social support) and a critical dimension (empowering communities) (Sørensen et al., 2012). Nevertheless, these two dimensions are often ignored in empirical health literacy studies. The concept of health literate health service organization (similar to migrant friendly hospitals (Kickbusch et al., 2013), or intercultural opening (Penka et al., 2012)) is interesting because it focuses on the healthcare organization as a whole and just not on the individual competencies of the patients or providers (Kowalski et al., 2015). Another problem with health literacy is that it usually focuses on formal health services, thereby ignoring the informal or less formal ways in which people look after their own health.

Responses to diversity

Increasing population diversity, however described, is regularly connected to the need for cultural competency or cultural safety in the provision of health services. The term 'cultural competency' implies policy and training that will ensure that patients receive appropriate services. The likelihood of achieving cultural competency is often connected with workforce diversity (Jacob and Sánchez, 2011; Quist and Law, 2006; Sarto et al., 2013):

It is widely accepted that diversifying the nation's health-care workforce is a necessary strategy to increase access to quality health care for all populations, reduce health disparities, and achieve health equity (Williams et al., 2014: 32).

While the promotion of workforce diversity may be a social good, clear-cut evidence that it will reduce health inequalities across dimensions of diversity is lacking.

'Cultural safety' (Taylor et al., 2013) implies going beyond the mere formulation of policy to create a culturally safe environment through programs and services that meet the diverse needs of both staff and patients (Gurm and Cheema, 2013). Recognition that diversity is a feature of staff as well as patients (McKimm and Webb, 2010; Solway et al., 2010) avoids some of the 'othering' effects of diversity terminology.

While the terms 'cultural competence' and 'cultural safety' may represent important and progressive aspirations, if 'health care professionals do not consider it to be their responsibility to adapt to ethnic diversity' (Dauvrin and Lorant, 2014: 1), then such aspirations amount to nothing. Not only may staff feel no responsibility for adapting to diversity, in maternity services 'ethnic minority women are expected to adapt to the system rather than the maternity services being responsive or adapting to the new multi-cultural population' (Lyons et al., 2008). The whole edifice of evidence-based knowledge, which has dominated debates about variable medical practice since the 1990s, may be

unsuited to the 'ways of knowing' of minority cultures (Kirmayer, 2012) and reinforcing an exclusionary medical culture that 'cultural competency' cannot address.

Policies that aspire to 'cultural competence' or 'migrant friendly services' have to be delivered by professionals whose attitudes and values are crucial for day-to-day practice (Markey et al., 2012). Professionals' lack of responsibility for responding to population diversity is supported by the powerful scientific claims of biomedicine: scientifically-informed medical practice is assumed to be immune to the vagaries of culture, despite evidence that medicine is a social institution, subject to bias and prejudice, like any other. The presumed scientific neutrality of medical knowledge and practice means that minorities whose cultural needs might differ from the majority population are constructed as irrational and the opposite of the scientific rational modernity that medicine represents.

Limitations to the idea of cultural competence in addressing health inequalities around diversity, include 'inadequate recognition of the 'culture of medicine'' and the scarcity of outcomes-based research that provides evidence of efficacy of cultural competence strategies' as well as 'narrow concepts of culture often conflate culture with race and ethnicity, failing to capture diversity within groups and thus reducing the effectiveness of cultural competence strategies' (Thackrah and Thompson, 2013). As with terminology around diversity, definitions of what constitutes cultural competency are lacking and are not treated critically. Such uncritical treatment means that 'cultural competence' comes to mean 'inclusive' (e.g. Riggs et al., 2015a).

Gaps and silences

The standard critique of the language of diversity is that it does not conceptualise power and therefore fails to assess both discrimination and structural issues that create inequalities of wealth, education and employment.

The breadth of what is implied by the term 'diversity' means that any presumption that groups that are labelled 'diverse' must share some health vulnerability should be treated critically. Investigation of the extent to which dimensions of diversity relevant to health are shared across contexts (Lazear et al., 2008) is not often under-taken.

Local, regional or national issues tend to be investigated in the name of diversity, with less attention to a transnational or global dimension. An exception is a paper considering Chinese-African relations which uses the term 'health diplomacy' to describe a 'growing interface between foreign policy and global health', encompassing 'both the concept of using health to further foreign policy objectives as well as the idea that diplomatic tools can be helpful for attaining public health goals' (McLaughlin et al., 2014: 579). Global economic recession and its effects on health equity (Bacigalupe and Escobar-Pujolar, 2014) and the challenges of 'integrating indigenous and/or cross-border health systems' (Low et al., 2014: 1) are seldom addressed.

While the focus on the local is understandable given the key role that national and regional policy and funding structures play in determining health services, there is little recognition of the importance of political will in improving the outcomes of these processes (Salway et al., 2013). This is particularly important in the context of global recession.

Beyond diversity?

In emphasizing that diversity is a key dimension of health inequalities and in planning equitable service provision, the terms ‘superdiversity’ and ‘hyperdiversity’ are gradually appearing. In general these terms are neither defined nor explained, but function as amplifiers of the multicultural or multi-ethnic character of the population under examination. For instance, reference to the ‘hyperdiversity of patient populations’ alongside the ‘unequal treatment on the basis of cultural, racial, or ethnic group membership’ in medicine is used to justify why such difference cannot be ignored (DeVecchio Good and Hannah, 2015).

How superdiversity adds to our understanding is described in publications dealing with maternity services in the West Midlands (Newall et al., 2012) where the superdiverse nature of the population is described in terms of migration status, ethnicity and language (Phillimore, 2011). A helpful distinction is drawn between ‘ethnic-specific issues and minority position factors’ with factors that are ethnic-specific to South Asian families named as the impact of parental and professional knowledge and beliefs, health service utilisation pattern explanations and the impact of prejudice and stigmatisation, whereas language barriers are said to reflect a ‘minority position’ (Lakhanpaul et al., 2014).

Where papers describe the complexity of identity and its interaction with healthcare need, the necessity of treating each person individually becomes clear (e.g. Culley, 2014). Where population-level diversity interacts with individual identity, then superdiversity offers a frame work for ‘theorising how and why social conditions shape health and how a range of social characteristics and diverse understandings of healthcare might influence the negotiation and navigation of healthcare systems’ (Green et al., 2014).

Superdiversity appears as a keyword despite not being used (much less defined), in the article text. For instance, papers that consider how ethnic monitoring questions are asked (Leydon et al., 2013), the under-representation of minority ethnic groups in research (Redwood and Gill, 2013), self-reported health variation between indigents and immigrants (Dzúrová and Drbohlav, 2014), immigrant naturalisation and measures of social cohesion (Kesler and Demireva, 2011) and the experience of ‘multicultural people’ navigating identities and how the relationship with well-being (Yampolsky et al., 2013). In this respect superdiversity is emerging as yet another synonym for diversity, ethnicity, ethnic minority or multiculturalism. This is particularly problematic when diversity terminology from other languages is so regularly translated into English-language terms, given the dominance of Anglophone journal publication. In the processes of translation, the local specificity of the dimension of diversity or difference is lost and processes of reductionism and racialization intervene (Helberg-Proctor et al., 2015). Developing terminology that avoids such reductions in meaning is a contribution that cross-country and multidisciplinary comparative work can offer (e.g. Phillimore et al. 2015).

Bibliography

- Achia, T.N.O., Mageo, L.E., 2015. Individual and Contextual Determinants of Adequate Maternal Health Care Services in Kenya. *Women Health* 55, 203–226. doi:10.1080/03630242.2014.979971
- Agyemang, C., van Valkengoed, I., Hosper, K., Nicolaou, M., van den Born, B.-J., Stronks, K., 2010. Educational inequalities in metabolic syndrome vary by ethnic group: Evidence from the SUNSET study. *Int. J. Cardiol.* 141, 266–274. doi:10.1016/j.ijcard.2008.12.023
- Ahmed, A.I., Cameron, S., Dickson, C., Mountain, K., 2010. Arabic-speaking students' primary care experiences in Scotland. *Community Pract. J. Community Pract. Health Visit. Assoc.* 83, 23–26.
- Alegría, M., Cook, B., Loder, S., Doonan, M., 2014. The time is now: tackling racial and ethnic disparities in mental and behavioral health services in Massachusetts. *Issue Brief Mass. Health Policy Forum* 1–53.
- Asthana, S., Halliday, J. 2006. *What Works in Tackling Health Inequalities? : Pathways, Policies and Practice Through the Lifecourse.* Bristol, GBR: Policy Press. <http://site.ebrary.com/lib/alltitles/docDetail.action?docID=10281205>.
- Awosogba, T., Betancourt, J.R., Conyers, F.G., Estapé, E.S., Francois, F., Gard, S.J., Kaufman, A., Lunn, M.R., Nivet, M.A., Oppenheim, J.D., Pomeroy, C., Yeung, H., 2013. Prioritizing health disparities in medical education to improve care. *Ann. N. Y. Acad. Sci.* 1287, 17–30. doi:10.1111/nyas.12117
- Bäärnhielm, S., Jávo, C., Mösko, M.-O., 2013. Opening Up Mental Health Service Delivery to Cultural Diversity: Current Situation, Development and Examples from Three Northern European Countries, in: Alarcón, R.D. (Ed.), *Advances in Psychosomatic Medicine.* S. KARGER AG, Basel, pp. 40–55.
- Bacigalupe, A., Escolar-Pujolar, A., 2014. The impact of economic crises on social inequalities in health: what do we know so far? *Int. J. Equity Health* 13, 52. doi:10.1186/1475-9276-13-52
- Beck, B.J., Gordon, C., 2010. An approach to collaborative care and consultation: interviewing, cultural competence, and enhancing rapport and adherence. *Med. Clin. North Am.* 94, 1075–1088. doi:10.1016/j.mcna.2010.08.001
- Bhopal, R.S., 2012. Research agenda for tackling inequalities related to migration and ethnicity in Europe. *J. Public Health Oxf. Engl.* 34, 167–173. doi:10.1093/pubmed/fds004
- Birman, D., Beehler, S., Harris, E.M., Everson, M.L., Batia, K., Liataud, J., Frazier, S., Atkins, M., Blanton, S., Buwalda, J., Fogg, L., Cappella, E., 2008. International Family, Adult, and Child Enhancement Services (FACES): a community-based comprehensive services model for refugee children in resettlement. *Am. J. Orthopsychiatry* 78, 121–132. doi:10.1037/0002-9432.78.1.121
- Bradby, H., 2003. Describing Ethnicity in Health Research. *Ethn. Health* 8, 5–13. doi:10.1080/13557850303555
- Bradby, H., 1995. Ethnicity: not a black and white issue. A research note. *Sociol. Health Illn.* 17, 405–417.

- Bradby, H., Nazroo, J.Y., 2010. Health, ethnicity and race, in: Cockerham, W.C. (Ed.), *The New Companion to Medical Sociology*. Blackwell, Malden MA, pp. 113–129.
- Chongsuvivatwong, V., Phua, K.H., Yap, M.T., Pocock, N.S., Hashim, J.H., Chhem, R., Wilopo, S.A., Lopez, A.D., 2011. Health and health-care systems in southeast Asia: diversity and transitions. *Lancet* 377, 429–437. doi:10.1016/S0140-6736(10)61507-3
- Culley, L., 2014. Editorial: Nursing and super-diversity. *J. Res. Nurs.* 19, 453–455. doi:10.1177/1744987114548755
- Dauvrin, M., Lorant, V., 2014. Adaptation of health care for migrants: whose responsibility? *BMC Health Serv. Res.* 14, 294. doi:10.1186/1472-6963-14-294
- Davey-Smith, G., Chaturvedi, N., Harding, S., Nazroo, J., Williams, R., 2000. Ethnic inequalities in health - a review of UK epidemiological evidence. *Crit. Public Health* 10, 375–407.
- DelVecchio Good, M.-J., Hannah, S.D., 2015. “Shattering culture”: perspectives on cultural competence and evidence-based practice in mental health services. *Transcult. Psychiatry* 52, 198–221. doi:10.1177/1363461514557348
- Dias, S.F., Severo, M., Barros, H., 2008. Determinants of health care utilization by immigrants in Portugal. *BMC Health Serv. Res.* 8, 207. doi:10.1186/1472-6963-8-207
- Dzúrová, D., Drbohlav, D., 2014. Gender Inequalities in the Health of Immigrants and Workplace Discrimination in Czechia. *BioMed Res. Int.* 2014. doi:10.1155/2014/480425
- Ford, A., de Silva, D., Haririan, S., 2013. Cutting A&E use and health inequalities. *Nurs. Times* 109, 14–16.
- Green, G., Davison, C., Bradby, H., Krause, K., Mejías, F.M., Alex, G., 2014. Pathways to care: how superdiversity shapes the need for navigational assistance. *Sociol. Health Illn.* 36, 1205–1219. doi:10.1111/1467-9566.12161
- Griffith, L., 2010. Motherhood, ethnicity and experience: a narrative analysis of the debates concerning culture in the provision of health services for Bangladeshi mothers in East London. *Anthropol. Med.* 17, 289–299. doi:10.1080/13648470.2010.526698
- Gurm, B.K., Cheema, J., 2013. Cultural safety assessment of an urban Canadian hospital. *J. Cult. Divers.* 20, 177–183.
- Gwede, C.K., William, C.M., Thomas, K.B., Tarver, W.L., Quinn, G.P., Vadaparampil, S.T., Kim, J., Lee, J.-H., Meade, C.D., 2010. Exploring disparities and variability in perceptions and self-reported colorectal cancer screening among three ethnic subgroups of U. S. Blacks. *Oncol. Nurs. Forum* 37, 581–591. doi:10.1188/10.ONF.581-591
- Helberg-Proctor, A., Meershoek, A., Krumeich, A., Horstman, K., 2015. Ethnicity in Dutch health research: situating scientific practice. *Ethn. Health* 1–18. doi:10.1080/13557858.2015.1093097
- Horton, K., Dickinson, A., 2011. The role of culture and diversity in the prevention of falls among older Chinese people. *Can. J. Aging Rev. Can. Vieil.* 30, 57–66. doi:10.1017/S0714980810000826

- Ingleby, D., 2012. Ethnicity, Migration and the “Social Determinants of Health” Agenda. *Psychosoc. Interv.* 21, 331–341. doi:10.5093/in2012a29
- Jacob, S.R., Sánchez, Z.V., 2011. The Challenge of Closing the Diversity Gap: Development of Hispanic Nursing Faculty through a Health Resources and Services Administration Minority Faculty Fellowship Program Grant. *J. Prof. Nurs.* 27, 108–113. doi:10.1016/j.profnurs.2010.09.013
- Jensen, N.K., Norredam, M., Priebe, S., Krasnik, A., 2013. How do general practitioners experience providing care to refugees with mental health problems? A qualitative study from Denmark. *BMC Fam. Pract.* 14, 17. doi:10.1186/1471-2296-14-17
- Kalengayi, F.K.N., Hurtig, A.-K., Ahlm, C., Ahlberg, B.M., 2012. “It is a challenge to do it the right way”: an interpretive description of caregivers’ experiences in caring for migrant patients in Northern Sweden. *BMC Health Serv. Res.* 12, 433. doi:10.1186/1472-6963-12-433
- Kelaheer, M., Paul, S., Lambert, H., Ahmad, W., Smith, G.D., 2009. The applicability of measures of socioeconomic position to different ethnic groups within the UK. *Int. J. Equity Health* 8, 4. doi:10.1186/1475-9276-8-4
- Kesler, C., Demireva, N., 2011. Social Cohesion and Host Country Nationality among Immigrants in Western Europe, in: *Naturalisation: A Passport for the Better Integration of Immigrants?* Organisation for Economic Co-operation and Development, pp. 209–235.
- Kickbusch, I., Pelikan, J.M., Apfel, F., Tsouros, A.D., World Health Organization (Eds.), 2013. *Health literacy: the solid facts*. World Health Organization Regional Office for Europe, Copenhagen.
- Kirmayer, L.J., 2012. Cultural competence and evidence-based practice in mental health: epistemic communities and the politics of pluralism. *Soc. Sci. Med.* 1982 75, 249–256. doi:10.1016/j.socscimed.2012.03.018
- Kovandžić, M., Chew-Graham, C., Reeve, J., Edwards, S., Peters, S., Edge, D., Aseem, S., Gask, L., Dowrick, C., 2011. Access to primary mental health care for hard-to-reach groups: from “silent suffering” to “making it work.” *Soc. Sci. Med.* 1982 72, 763–772. doi:10.1016/j.socscimed.2010.11.027
- Kowalski, C., Lee, S.-Y.D., Schmidt, A., Wesselmann, S., Wirtz, M.A., Pfaff, H., Ernstmann, N., 2015. The health literate health care organization 10 item questionnaire (HLHO-10): development and validation. *BMC Health Serv. Res.* 15, 47. doi:10.1186/s12913-015-0707-5
- Lakhanpaul, M., Bird, D., Manikam, L., Culley, L., Perkins, G., Hudson, N., Wilson, J., Johnson, M., 2014. A systematic review of explanatory factors of barriers and facilitators to improving asthma management in South Asian children. *BMC Public Health* 14, 403. doi:10.1186/1471-2458-14-403
- Lazear, K.J., Pires, S.A., Isaacs, M.R., Chaulk, P., Huang, L., 2008. Depression among low-income women of color: qualitative findings from cross-cultural focus groups. *J. Immigr. Minor. Health Cent. Minor. Public Health* 10, 127–133. doi:10.1007/s10903-007-9062-x

- Leydon, G.M., Ekberg, K., Kelly, M., Drew, P., 2013. Improving ethnic monitoring for telephone-based healthcare: a conversation analytic study. *BMJ Open* 3. doi:10.1136/bmjopen-2013-002676
- Low, S., Tun, K.T., Mhote, N.P.P., Htoo, S.N., Maung, C., Kyaw, S.W., Shwe Oo, S.E.K., Pocock, N.S., 2014. Human resources for health: task shifting to promote basic health service delivery among internally displaced people in ethnic health program service areas in eastern Burma/Myanmar. *Glob. Health Action* 7, 24937.
- Lyons, S.M., O’Keeffe, F.M., Clarke, A.T., Staines, A., 2008. Cultural diversity in the Dublin maternity services: the experiences of maternity service providers when caring for ethnic minority women. *Ethn. Health* 13, 261–276. doi:10.1080/13557850801903020
- Markey, K., Tilki, M., Taylor, G., 2012. Strategies to surmount the potential barriers to providing anti-discriminatory care in Irish healthcare settings. *Contemp. Nurse* 40, 269–276. doi:10.5172/conu.2012.40.2.269
- McKimm, J., Webb, H., 2010. Diversity, equal opportunities and human rights. *Br. J. Hosp. Med. Lond. Engl.* 2005 71, 465–469. doi:10.12968/hmed.2010.71.8.77671
- McLaughlin, M.M., Lee, M.C., Hall, B.J., Bulterys, M., Ling, L., Tucker, J.D., 2014. Improving health services for African migrants in China: A health diplomacy perspective. *Glob. Public Health* 9, 579–589. doi:10.1080/17441692.2014.908935
- Murray, S., Buller, A.M., 2007. Exclusion on grounds of language ability--a reporting gap in health services research? *J. Health Serv. Res. Policy* 12, 205–208. doi:10.1258/135581907782101642
- Napier, A.D., Ancarno, C., Butler, B., Calabrese, J., Chater, A., Chatterjee, H., Guesnet, F., Horne, R., Jacyna, S., Jadhav, S., Macdonald, A., Neuendorf, U., Parkhurst, A., Reynolds, R., Scambler, G., Shamdasani, S., Smith, S.Z., Stougaard-Nielsen, J., Thomson, L., Tyler, N., Volkmann, A.-M., Walker, T., Watson, J., Williams, A.C. de C., Willott, C., Wilson, J., Woolf, K., 2014. Culture and health. *Lancet Lond. Engl.* 384, 1607–1639. doi:10.1016/S0140-6736(14)61603-2
- Nazroo, J.Y., 2003. The structuring of ethnic inequalities in health: economic position, racial discrimination, and racism. *Am. J. Public Health* 93, 277–284.
- Newall, D., Phillimore, J., Sharpe, H., 2012. Migration and maternity in the age of superdiversity. *Pract. Midwife* 15, 20–22.
- Norredam, M.L., Nielsen, A.S., Krasnik, A., 2007. Migrants’ access to healthcare. *Dan. Med. Bull.* 54, 48–49.
- Oakes, J.M., Kaufman, J.S., 2006. *Methods in social epidemiology*, 1st ed. ed, Public Health / Epidemiology and Biostatistics. Jossey-Bass, San Francisco, CA.
- Owen, S., Khalil, E., 2007. Addressing diversity in mental health care: a review of guidance documents. *Int. J. Nurs. Stud.* 44, 467–478. doi:10.1016/j.ijnurstu.2006.08.024
- Penka, S., Kluge, U., Vardar, A., Borde, T., Ingleby, D., 2012. The concept of “intercultural opening”: the development of an assessment tool for the appraisal of its current implementation in the mental

health care system. *Eur. Psychiatry, Migration and Mental Health* 27, Supplement 2, S63–S69. doi:10.1016/S0924-9338(12)75710-3

Phillimore, J., 2011. Approaches to health provision in the age of super-diversity: Accessing the NHS in Britain's most diverse city. *Crit. Soc. Policy* 31, 5–29. doi:10.1177/0261018310385437

Phillimore, J., Bradby, H., et al. 2015. Understanding healthcare practices in superdiverse neighbourhoods and developing the concept of welfare bricolage. Protocol of a cross-national mixed-methods study. *BMC Int Health Hum Rights* 15:16

Quist, R.M., Law, A.V., 2006. Cultural competency: Agenda for Cultural Competency Using Literature and Evidence. *Res. Soc. Adm. Pharm. RSAP* 2, 420–438. doi:10.1016/j.sapharm.2006.07.008

Redwood, S., Gill, P.S., 2013. Under-representation of minority ethnic groups in research — call for action. *Br. J. Gen. Pract.* 63, 342–343. doi:10.3399/bjgp13X668456

Reitmanova, S., Gustafson, D.L., 2009. Mental health needs of visible minority immigrants in a small urban center: recommendations for policy makers and service providers. *J. Immigr. Minor. Health Cent. Minor. Public Health* 11, 46–56. doi:10.1007/s10903-008-9122-x

Reitmanova, S., Gustafson, D.L., 2008. “They can't understand it”: maternity health and care needs of immigrant Muslim women in St. John's, Newfoundland. *Matern. Child Health J.* 12, 101–111. doi:10.1007/s10995-007-0213-4

Riggs, E., Gibbs, L., Kilpatrick, N., Gussy, M., van Gemert, C., Ali, S., Waters, E., 2015a. Breaking down the barriers: a qualitative study to understand child oral health in refugee and migrant communities in Australia. *Ethn. Health* 20, 241–257. doi:10.1080/13557858.2014.907391

Riggs, E., van Gemert, C., Gussy, M., Waters, E., Kilpatrick, N., 2012. Reflections on cultural diversity in oral health promotion and prevention. *Glob. Health Promot.* 19, 60–63. doi:10.1177/1757975911429872

Riggs, E., Yelland, J., Szwarc, J., Casey, S., Chesters, D., Duell-Piening, P., Wahidi, S., Fouladi, F., Brown, S., 2015b. Promoting the inclusion of Afghan women and men in research: reflections from research and community partners involved in implementing a “proof of concept” project. *Int. J. Equity Health* 14, 13. doi:10.1186/s12939-015-0145-3

Salway, S., Turner, D., Mir, G., Bostan, B., Carter, L., Skinner, J., Gerrish, K., Ellison, G.T.H., 2013. Towards equitable commissioning for our multiethnic society: a mixed-methods qualitative investigation of evidence utilisation by strategic commissioners and public health managers, Health Services and Delivery Research. NIHR Journals Library, Southampton (UK).

Sarto, G.E., Brasileiro, J., Franklin, D.J., 2013. Women's Health: Racial and Ethnic Health Inequities. *Glob. Adv. Health Med. Improv. Healthc. Outcomes Worldw.* 2, 50–53. doi:10.7453/gahmj.2013.052

Schiaffino, M.K., Al-Amin, M., Schumacher, J.R., 2014. Predictors of language service availability in U.S. hospitals. *Int. J. Health Policy Manag.* 3, 259–268. doi:10.15171/ijhpm.2014.95

Shangase, P., Egbe, C.O., 2015. Barriers to accessing HIV services for Black African communities in Cambridgeshire, the United Kingdom. *J. Community Health* 40, 20–26. doi:10.1007/s10900-014-9889-8

Sheridan, N.F., Kenealy, T.W., Connolly, M.J., Mahony, F., Barber, P.A., Boyd, M.A., Carswell, P., Clinton, J., Devlin, G., Doughty, R., Dyall, L., Kerse, N., Kolbe, J., Lawrenson, R., Moffitt, A., 2011. Health equity in the New Zealand health care system: a national survey. *Int. J. Equity Health* 10, 45. doi:10.1186/1475-9276-10-45

Siegrist, J., Marmot, M., 2006. *Social inequalities in health : new evidence and policy implications*. Oxford University Press, Oxford.

Solway, E., Estes, C.L., Goldberg, S., Berry, J., 2010. Access barriers to mental health services for older adults from diverse populations: perspectives of leaders in mental health and aging. *J. Aging Soc. Policy* 22, 360–378. doi:10.1080/08959420.2010.507650

Sørensen, K., Broucke, S.V. den, Fullam, J., Doyle, G., Pelikan, J., Slonska, Z., Brand, H., 2012. Health literacy and public health: A systematic review and integration of definitions and models. *BMC Public Health* 12, 80. doi:10.1186/1471-2458-12-80

Taylor, K.P., Bessarab, D., Hunter, L., Thompson, S.C., 2013. Aboriginal-mainstream partnerships: exploring the challenges and enhancers of a collaborative service arrangement for Aboriginal clients with substance use issues. *BMC Health Serv. Res.* 13, 12. doi:10.1186/1472-6963-13-12

Thackrah, R.D., Thompson, S.C., 2013. Refining the concept of cultural competence: building on decades of progress. *Med. J. Aust.* 199, 35–38.

Veenstra, G., 2011. Race, gender, class, and sexual orientation: intersecting axes of inequality and self-rated health in Canada. *Int. J. Equity Health* 10, 3. doi:10.1186/1475-9276-10-3

Venters, H., Gany, F., 2011. African immigrant health. *J. Immigr. Minor. Health Cent. Minor. Public Health* 13, 333–344. doi:10.1007/s10903-009-9243-x

Whitehead, M., Dahlgren, G.I., 2006. Concepts and principles for tackling social inequities in health. *Levelling up. Part 1* | National Collaborating Centre for Determinants of Health [WWW Document]. URL <http://nccdh.ca/resources/entry/concepts-and-principles-for-tackling-social-inequities-in-health> (accessed 7.1.15).

White, K.M., Zangaro, G., Kepley, H.O., Camacho, A., 2014. The Health Resources and Services Administration diversity data collection. *Public Health Rep. Wash. DC* 129 Suppl 2, 51–56.

Williams, S.D., Hansen, K., Smithey, M., Burnley, J., Koplitz, M., Koyama, K., Young, J., Bakos, A., 2014. Using social determinants of health to link health workforce diversity, care quality and access, and health disparities to achieve health equity in nursing. *Public Health Rep. Wash. DC* 129 Suppl 2, 32–36.

Yampolsky, M.A., Amiot, C.E., de la Sablonnière, R., 2013. Multicultural identity integration and well-being: a qualitative exploration of variations in narrative coherence and multicultural identification. *Front. Psychol.* 4. doi:10.3389/fpsyg.2013.00126

Zanchetta, M.S., Poureslami, I.M., 2006. Health literacy within the reality of immigrants' culture and language. *Can. J. Public Health Rev. Can. Santé Publique* 97 Suppl 2, S26–30.