Table 3. Major Historical/Cultural Influences of Racial/Ethnic Minority Groups [a]

	Key Historical Influence(s)	Core Cultural Values	Influences on Health Care Use
Mexican American	Mexicans were early migrants to the Americas; over thousands of years and several civilizations they have adapted and acculturated. Eventual settling in Mexican and border areas, then annexation to the U.S. created adverse social conditions.	Women were held in high regard in Aztec culture, but later excluded during colonial period. Traditional family values survive; loyalty, solidarity, community, and extended family are important, as are cooperation, respect, and the Catholic religion.	Use of *curanderismo*, herbal treatments, and prayer provides healing on emotional, spiritual, and physical levels. Traditional healing complements modern medicine. Revival of positive cultural attributes holds hope for disease-preventing lifestyles.
Puerto Rican	There are two distinct groups: in Puerto Rico and in the U.S. mainland. Island economy has transformed from rural to urban, service-based economy. Many in the mainland live in Northeast urban centers (e.g., New York, Philadelphia)	Strong family ties, female-headed and single-parent households are common. Lifestyles differ between U.S. mainland and Puerto Rico groups, but core values and religion cut across regions.	Cost, language, and discrimination are often barriers to care in the U.S. mainland. View that physicians are insensitive is often a barrier.
Cuban American	There have been several waves of immigration to the U.S., in 1950s–1960s and later in the 1980s. Most immigrants have been political exiles fleeing an oppressive government regime.	Cuban society is highly patriarchal, with men expected to provide for their families; this seems to have led to greater strain on males. Loyalty to family is an important value.	A sense of “specialness” and take-charge attitude may promote self-care. Early surveys found high fear and fatalism about cancer. Culturally and linguistically targeted health and cancer care programs seem to have been effective.
African American	First brought to the U.S. as slaves, African Americans are historically in a disadvantaged position. Racial integration and equal legal rights are relatively recent occurrences.	African American women are traditionally in a subordinate position. Family and kinship networks are strong, with churches often central to sense of belonging. Women have key role in stability and caring for family and children.	African Americans are more likely to use preventive care if it uses culturally appropriate methods, such as lay peer educators, family and community networks, and community outreach.

Asian American	Wide variations in history exist; more than 25 ethnic groups, ranging from 5th generation to recent immigrants and refugees. Experiences in immigration and acculturation in the U.S. are also widely divergent.	An internal balance or equilibrium is believed to support health; keeping balance between “cold” (yin) and “hot” (yang) elements leads to good health; “chi” is energy circulating through body.	Access to and use of health care are related to cultural, linguistic, and other social barriers. Traditional healers, herbal medicines are common; Asian Americans may feel no need for Westernized preventive care.
Native Hawaiian	Europeans introduced disease and brought cultural and social disruption to the indigenous Polynesian population. Hawaii, its monarchy overthrown by Americans, was annexed to the U.S. in 1898. Intermarriage has reduced the number of ethnically pure Hawaiians.	Efforts to preserve and enhance cultural heritage and overcome historical displacement have recently intensified. Emphasis is on social harmony (lokahi), family (‘ohana), interdependence/oneness (mana), ties to the land (malama ‘aina). Women are seen as powerful actors.	Provision of culturally acceptable services is a continuing problem. Women respond to personal interaction and communication, problem solving. Traditional healers and remedies are often used. Limited number of Native Hawaiian health professionals is a further barrier.
American Samoan	Residing in Samoan archipelago or U.S. mainland, American Samoans have a Polynesian heritage and village leadership systems. The U.S. has influence, and migration patterns are family related.	Communities are tightly knit, with close ties to churches and families. Some adjustment difficulty occurs among migrants, more in Hawaii than in California locales.	Culturally based beliefs about diseases are common, and many prefer traditional healers and herbalists. Belief in supernatural causes of disease may lead to delay in seeking Western health care.
American Indian	Land base and resources were lost with European migration; displacement, relocation to reservations, epidemics, and poverty ensued.	Male-oriented traditions dominated for many years. View of health is holistic, emphasizing harmony/balance in body, mind, spirit, and emotions.	Illness can have natural/supernatural causes; taboo to talk about cancer owing to “power of language.” Many are reluctant to “look for illness” (screening).
Alaska Native	Indigenous people were disrupted by European/Western culture and commerce.	Alaska Natives have strong family/communal ties, spirituality, and traditional subsistence lifestyle.	Women may neglect their health in favor of their families; traditional healing practices are common, although communication styles may differ.

[a] As with any summary of key dimensions of cultures, this table cannot fully convey the depth and variation of influences within these racial/ethnic minority groups. The information included here is respectfully considered a reasonable effort to highlight these factors.