Research Output Journal of Public Health and Medicine 5(1):92-99, 2025

ROJPHM ISSN ONLINE: 1115-9715
ISSN PRINT: 1115-6147
https://rojournals.org/roj-public-health-and-medicine/

https://doi.org/10.59298/ROJPHM/2025/519299

The Impact of Cultural Practices on Health Outcomes

Nambi Namusisi H.

School of Natural and Applied Sciences Kampala International University Uganda

ABSTRACT

Cultural practices profoundly shape individual and collective experiences of health, wellness, illness, and care. This paper examines the dynamic interplay between cultural beliefs, traditions, and health outcomes, emphasizing the influence of culturally-rooted behaviors on health-seeking behavior, perceptions of illness, and responses to medical interventions. Drawing on interdisciplinary insights from anthropology, sociology, public health, and ethnomedicine, this study examines diverse cultural contexts—from traditional healing systems and dietary customs to gender roles, mental health attitudes, and socioeconomic disparities. Special attention is given to the limitations of biomedical models in addressing culturally nuanced health needs, highlighting the importance of integrating culturally competent care approaches. By illuminating how culture governs health behaviors, this paper underscores the necessity of cross-cultural engagement and inclusive health systems that respect diverse epistemologies. The findings call for policy frameworks and healthcare models that are responsive to the lived realities of culturally distinct populations.

Keywords: Cultural practices, Health outcomes, Traditional medicine, Cultural competence, Health beliefs, Socioeconomic determinants.

INTRODUCTION

Health care consumers navigate their communities armed with centuries of knowledge about health and healing. Past experiences, family and friends, social networks, and cultural beliefs, customs and traditions all play an integral role in that navigation. What constitutes "health" and "health care" often significantly differs between representatives of cultural communities and the medical establishment. The cultural interplay of science, spirituality and social practices is further compounded with the input of diverse professions that have a stake in health care decisions. In each community there are healers, curers, shamans, rootworkers, herbalists, flebotomists, researchers, mothers, fathers, social workers and clergy all of whom can play a role in shaping what health care choices are available, accepted, and effective. There are innumerable subtle gradations in custom and belief that influence health care choices. Yet, no medicine has been shown to address all of these cultural aspects of spirituality, humanity or health. In this context, it is paramount to ensure collaboration, acceptance and partnership between health care practitioners of all systems of care in cultural communities. When trying to understand health in developing countries, however, this negotiation of choice and acceptance is far from complete. To many health care consumers, "health" has remained a "development" issue, and there is a staggering gap in both the available literature and the collective professional knowledge of the standing and practice of rest of health care systems aside from the biomedical one. Without a fully developed and researched body of literature on cultural health beliefs, practices and health care systems, it is virtually impossible to successfully negotiate an approach that respects and engages with cultural belief systems. Without this respect and understanding, it is unlikely for the home system to develop an understanding of other systems of care [1, 2].

Cultural Practices Defined

Cultural practices encompass those behaviors, beliefs, customs, modes, or social institutions — expressive forms and practices, as received or reused from folk sources — that, in a given place, time, and context, promote the continuity and effective functioning of a social unit. The stated behaviors or beliefs can be both positive or negative and may encompass social practices; beliefs; oral traditions; rituals; social identity; attachment to land, or places; and expressions of social cohesion. The study of cultural practices is concerned with cultural products and processes that provide information on the concept, construction, use, and audience of a cultural practice in a defined time and place or context. Cultural practice is in the domain of the social sciences and of the arts. Cultural practices are social and "performed" acts of the social. It is thus possible to identify the content of cultural practices, but equally significant to identify their social context. Cultural practices are studied by a variety of perspectives and fields, including anthropology, ethnomusicology, oral tradition; with sociology, history, literature, psychocology, linguistics, semiotics, and philosophy contributing interrogations of varying influence. Unfortunately, this polysemous state of cultural practice can complicate interdisciplinary discussion and research. Nonetheless, there has been progress in determining a working definition or conceptual framework for cultural practice. Initially, similar terms include cultural performance, cultural event, cultural expression, cultural activity, and socio-cultural demonstration seem prefigured in the term cultural practice. All of these definitions, however, confine cultural practices to the domain of the arts or expressivity, as represented as opposed to cultural rituals and belief systems, cultural social institutions, and cultural materiality [3, 4].

Health Outcomes Overview

This section begins the mapping of health outcomes across diverse societies in terms of population health, service access, and service quality, by focusing on the more tangible health outcomes or consequences of health systems. Health status is often described in terms of morbidity and mortality, with mortality measured in terms of the number of deaths in a privileged period of time. While health statistics rigorously derived from census data or population-based mortality register births may seem more credible than health perceptions, concerns have been raised in richer countries that surplus mortality may fail to reflect inequality since it also depends on the degree of poverty. Studies have tended to uncritically accept mortality figures from the WHO databases. This study addresses this by considering how mortality as well as morbidity, both as direct estimates and as perceptions, may vary across the globe. A clear tendency for poorer countries to have poorer health status is suggested, with the lower middle income countries in South Asia and Sub-Saharan Africa generally presenting the greatest mortality rates and worse health perceptions. In contrast, the richer countries in Northern and Southern America, Europe, East Asia and the Pacific, and Australia significantly enjoy improved health. However, while mortality roughly follows income growth, morbidity is less straightforward. This may reflect sociocultural factors or conceptual differences in measuring disease, with more pronounced stigma attached to mental health than to cardiovascular problems. This suggests going beyond quantifying or ranking health status in a particular societal world and representing what knows invisibly fuelling this, which cultural reality affects health populations in many different ways [5, 6].

Historical Context of Cultural Practices

Cultural practice refers to the shared beliefs and actions of a group. It varies widely across continents, countries, ethnic groups, and communities, and is transmitted from parents to children through generations. Culture shapes the laws, norms, and customs that characterize the daily lives of diverse groups, even among those with different ethnic backgrounds. Analyzing historical practices helps us understand contemporary cultural practices, often rooted in fundamental beliefs about birth and death. Events surrounding these times may be seen as linked to individuals' actions, influencing societal customs. Periods of sacredness require emotional 'cooling off' to allow spirits to leave bodies peacefully, often invoking taboo practices like food restrictions. Childbirth, in particular, entails varying taboos that can limit a woman's autonomy. In cultures prioritizing status or ethnicity, multiple women may attend a birth, and a mother's presence may be restricted to uphold sacred traditions. These cultural beliefs can significantly impact the family unit. Despite differing perspectives from leaders, culture shock can manifest as social isolation or hostility. Young Western women have reported feeling marginalized and exploited during hospital births, expressing a lack of support. Aboriginal cultural practices around childbirth also reveal differing views on women's emotional needs in the birthing process [7, 8].

Cultural Beliefs and Health Perceptions

Culture serves as a lens through which people encounter and navigate their surroundings. Culture includes religion, language, customs, lifestyle, and heritage, framing individuals' views on health and disease, thus determining their perceived health status. Culture is thus expected to modulate the understanding of cardiac symptoms and response to treatments. In understanding a disease and deciding to respond, a patient is expected to go through three steps: perception of a change in health status; concern that the change is abnormal; and interpretation of the change as indicating a disease requiring attention. Accordingly, a culture-related perception of an event as a disease is important in deciding to seek treatment. Cultural beliefs relevant to health or disease address the distrust of established medical therapies, belief in aetiological explanations not (or poorly) accepted in established medicine, and preference for non-pharmacotherapy. In Hong Kong, where Chinese tradition is predominant, Guanxi or relationships, Confucianism, the concept of Yin-Yang, and Feng Shui or geomancy are important culture elements, which have been shown to shape patients' beliefs on health and disease. In Benghazi, occurrences of chronic diseases are attributed to non-human agents. Other possible cultural beliefs include (a) understanding of AF, (b) beliefs regarding cardioversion, (c) interpretation and response to cardiac symptoms. Cultural beliefs may also affect the way a patient interprets and responds to various treatments. For example, fluoxetine, a common antidepressant, may impair sexual function. While this adverse effect may be regarded as an unavoidable risk in Western countries, it might result in more pervasive challenges in Hong Kong, where Chinese culture is predominant. In this context, any drop in sexual function may be interpreted such that Wang Shih, a Chinese traditional term for this belief, will develop [9, 10].

Dietary Practices Across Cultures

Food is central to celebrations and culturally significant events for Native Hawaiian and Pacific Islander (NHPI) women, connecting them to their heritage. A well-prepared meal reflects cultural knowledge and dignity, often made using traditional methods passed down through generations. Their diet, rich in green vegetables and seafood, transitioned post-immigration due to new cultural influences. Commercial agriculture led to a decline in native plants, replacing traditional foods with marketed processed options, resulting in cravings for sweetened foods. Iron-fortified foods, once a health innovation, contributed to unhealthy processed food consumption. The high-fat and sugar content in marketed foods raised concerns, alongside the overwhelming advertising amid poor access to fresh produce. Participants expressed a sense of loss associated with their shift towards processed diets, which may lead to grieving and health issues. Observations showed an understanding of sweetened foods correlating with larger family sizes and weight issues due to migration and mass marketing. Non-agency in food choices emerged alongside cultural transitions. Barriers such as work-related time scarcity affected family meal preparation and bonding. The lack of cultural heritage in food and its interaction with stress led to unhealthy habits, compounded by family size, sleep, physical activity, food selection, and preparation times. Equipment gaps in meal preparation were also highlighted. Participants frequently questioned how to regain control over family meal practices while preserving cultural food traditions and promoting healthier eating [11, 12].

Traditional Medicine and Healing Practices

Inflated by societal context and cultural beliefs, diverse healing choices among cultural groups highlight distinct methods for wellness. Many historical healing practices are cultural, linking culture to individuals' health outcomes. Non-Western groups often reject conventional Western wellness paths for culturally specific healing methods. Although the role of culture in wellness is acknowledged, it remains underexplored. There is a movement in Western health approaches toward holistic and culturally-informed treatments. Healing is often experienced as a social process, profoundly impacting individuals, despite an influx of various wellness modalities. Attempts to simply transplant Western medicine to other cultures have typically failed, revealing biomedicine's limitations in addressing complex issues like addiction. Exposure to various healing modalities underscores how definitions of wellness are shaped by culture, religion, and philosophy. Scientific understanding and adherence to biomedicine are not universal, leading to varied assessments of illness. Subcultures promoting anthropological beliefs often exist within or outside Western populations. Where cultural beliefs shape healing modalities, unsuccessful treatments are unlikely to be approached again within that system. Nonparticipants in a culture typically won't engage with its treatment methods. Culture instructs how people organize their lives and influences their

health care decisions, acting as a powerful force that often resists alternative reasoning. The acceptance or rejection of healing options is heavily influenced by specific cultural attitudes, reflecting the values and beliefs of a group [13, 14].

Cultural Attitudes Toward Mental Health

The current study investigates the attitudes of the British Punjabi Sikh community towards mental illness. The South Asian community, and particularly the Punjabi Sikh community, has had little research directed towards it. A wider understanding regarding the knowledge of mental health issues is necessary for greater awareness and the possibility of modifying cultural stigma surrounding mental illness in this population. Mental health issues such as schizophrenia or depression, often referred to as 'bipolar mood disorder persistence', and the ways in which they are framed are explored in this project. A series of semi-structured interviews were carried out, with a sample of Punjabi Sikhs aged 30 and over. Transcriptions of interviews identified key ideas and perceptions regarding mental illness. They were coded according to commonalities, and group themes emerged which were used to analyse the narratives. Key barriers to seeking help were identified in regards to stigma and beliefs in 'natural' causes of illness, such as 'tana' (the evil eye). Local cultural practitioners took centre stage in healing mental illness difficulties, while the potential role of statutory services was diminished. Taken collectively, the narratives provide a glimpse into the culturally laden perceptions of mental health rituals and how they are shaped locally. The current study analyses a fresh perspective on a crucial conceptual issue influencing individual hopes, behaviour, the doing of selves and bodies, as well as the managing of others within the Asian communities. This is done through an ethnographic reading of the beliefs of distress in the Punjabi community. It asks how cultural understandings of distress (cusesa) construct 'hope' (aaas) in a small Punjabi township. It introduces ongoing social and individual aspirations within which 'hope' comes into being. A firm communal horizon of hope is traced in which 'healthy behaviour' is shaped through hefty discourses and practices of religion and success education. In the study of Muslims in India, and now targeting Sikhs in the UK, these firm communal frameworks are shown to take on individual form. Relying upon the sociality of hope, these arguments are illustrated through how a 'healthy body' (swasth sharir) is formed by managing ritual virtues, regulating borderline bodies, as well as through a biopolitics of propriety concerning economic security and professional success [15, 16].

Gender Roles and Health Outcomes

Gender roles broadly refer to cultural prescriptions about how women and men should behave. Traditional gender roles prescribe men to be independent, self-sufficient, aggressive, and competitive, while femininity is characterized by dependence, passivity, nurturing, and connection to others. Gender roles create normative patterns of behavior with which most men and women conform to some degree. Because adherence to traditional gender roles can create conflict with health-promoting behaviors, health and health care outcomes can vary considerably. Accordingly, although the majority of research about gender roles and health outcomes focuses on those in traditional roles, other responses to normative expectations merit consideration. Sex or biological roles also refer to culturally defined and understood male and female physiology. The distinct biology of adult men and women influences health outcomes through socially shaped patterns of health risk. Gender identity refers to an individual's subjective and personal sense of one's status as a social male or female. Cognitive constructions about gender can influence health and health care behavior even among those who do not conform to traditional gender roles or who do not identify as male or female. Men and women who conform to more traditional gender roles are at greater risk of poorer health and some of the greatest health risks occur among those who strongly conform to more traditional roles. Traditional masculinity is generally characterized by perceived invulnerability, stoicism, risk-taking, emotional detachment and assertiveness, and a focus on physical health. Traditional masculinity limits both preventative help-seeking and treatment compliance while placing male patients more at risk of potentially risky health behaviors. Gendered encouragement for risk-attentive attitudes can lead to such behaviors including smoking, reckless or irresponsible driving, drug use, excessive alcohol consumption and riskier sexual behavior. Traditional femininity, characterized by nurturing, maintenance of relationships, and acceptance of and submission to others, limits the efficacy of women's health-promoting behaviors. These attitudes can lead to problems in the execution of health-protective behaviors, such as managing appointments for health screenings or maintaining a healthful diet, as well as delayed help-seeking when unwell and the underutilization of health care when ill [17, 18].

Socioeconomic Factors and Cultural Practices

Access to health care is reported to vary with socio-economic status, cultural and ethnic backgrounds and geographic location. Some variables tended to persist regardless of setting, including education, social structure, traditional cultural explanation of illness, perceived stressors, the associated lifestyle behaviours and consequently socio-economic status. In all disease states studied, those with less than post-secondary graduation and lowest income had higher rates of almost all risk factors. Ethnic differences were found primarily in contentious health behaviours. Besides, some evidence also suggested that certain ethnic groups carry the same risk of disease with a higher protective factor. In the diabetes population, socio-economic status was shown to have a major influence on the prevalence and outcomes of the disease. In the A to Z treatment of type 2 diabetes, allopathic medication showed no evidence of running trials across different ethnicities. However, there was an eight-fold higher rate of intervention in Latino populations. Continued access to care also varied racial and ethnic groups. Latina languages therefore need more consideration as the primary language. A number of lifestyle behaviours associated with having a medical diagnosis persisted with socio-economic status and education as the major risk factors for adverse behaviour. Overweight BMI and waist circumference showed a strong inverse relationship with socio-economic status. Low and lower middle-class individuals had the highest prevalence of 'below normal' weight along with the low prevalence of all positive health behaviours. Access to health care showed a direct relationship with educational background. This association was mediated by other factors, including financial strain, perceived health risks and internet access. Individuals living alone with low-wellbeing scores were far less likely to access health care. Social determinants of health and disease proved to impact a number of conditions and behaviours, including type 2 diabetes. In type 2 diabetes, social determinants such as ethnic background, socio-economic status and geographic isolation are all known to influence the disease process [19, 20].

Cultural Practices and Preventive Health

Cultural Practices and Preventive Health People's perspectives on preventive health care services vary greatly. Culture, shaped by learned beliefs and behaviors transmitted through generations, significantly impacts health behaviors and attitudes. It also influences how individuals conceptualize health promotion and preventive measures. Cultural practices can inhibit health-promoting attitudes and behaviors, with barriers to accessing preventive care reflecting societal structures and healthcare system attitudes. This discussion focuses on how culture shapes perceived norms of preventive health care among recent African immigrants in the Midwest. Collective understandings of health and illness illuminate the interplay between culture and the delivery of preventive health. Prior studies reveal a cultural emphasis among African immigrants, both in the U.S. and sub-Saharan Africa, on curative responses rather than prevention. Participants' definitions of good health were non-preventive, centering on a holistic view that includes spiritual, psychological, social, and physical aspects. Health was defined as the absence of serious illness, and there was a disconnect between how African immigrants understand preventive health and the perspectives of health professionals. Consequently, individuals engage in health-promoting practices only if they align with culturally accepted norms. In California, immigrant Africans may change behaviors by adopting practices encouraged within their networks, such as moving to safer areas, reducing smoking and alcohol use, improving diet and exercise, and utilizing health services. To enhance preventive health, culturally appropriate strategies should be developed and disseminated to diverse communities [21, 22].

Case Studies: Cultural Practices and Health Outcomes

While it is clear that the cultural domain has an impact on health, research examining its origins and effects is limited, particularly in light of socio-political changes. Cultural practices and health outcomes indicators at the societal level for twenty-one Latin American and Caribbean countries are examined in the first section of this chapter. The statistical analytical techniques applied are a combination of descriptive statistics, correlations, and regression. Results show a clear cultural impact of both production and the use of cultural goods and services on levels of perceived health, infant mortality, and people's perception of the health care system. Next, four case studies addressed the question whether all cultural practices potentially have a positive health impact or whether it is rather some cultural practices that have a definite positive health impact. These case studies focused specifically on cultural practices relating to music, dance, a specific cultural movement among indigenous women, and cultural irrelevant care. Finally, attention was drawn to the limitations indicated for both the individual-level analysis and case studies as well as the study approach in general. However, in order to better understand the interplay

between the cultural domain and health, there remains an urgent need for research in this underexplored field. Five cases of intercultural health initiatives operating in Latin America are analyzed. The evaluation of these programs studies the impact on their health care provision and satisfaction with these health systems from both an indigenous perspective and a public health lens. The analysis of the initiatives suggests that a strengthening on both sides, indigenous and western, and a commitment to synergy through cooperation may be the key to optimizing an inclusive care provision. As the case studies illustrate, this requires an open, lengthy, and resource-intensive process. Nevertheless, achieving it has clear evidence-based benefits for both systems and peoples involved, even in extremely challenging contexts. Some nutrition indicators are included as broader health determinants which have been employed for public health reasons as well to relate to the topic at hand. The case studies indicate the strategy is especially relevant in social-political environments of extreme oppression and marginalization [23, 24].

Policy Implications and Cultural Sensitivity

The exploratory analysis presents several policy implications. Cultural practices have a direct correlation with health outcomes, which can be seen on a macro-level as wider inequalities between different ethnic groups, or a micro-level in differences between individuals in any one group. Where culture is relevant to health outcomes or the delivery of health services, consideration should be given to the appropriateness of different medium types to diverse populations if health inequalities are to be improved. Service managers and planners should consider who they are targeting with health campaigns, offending communities recruited and listed best-case scenarios of potential participants, others would be considered more traditional or susceptible to interception by prejudices, or stereotypes particularly by young people who used ethnic slurs and veiled threats of violence. Consideration should be given to policy implications funded by the government, but managed by community-based organizations that hire from the communities that they work within. Similar acute issues may present, however the already established, pre-existing nature of such organizations may allow for the development of social marketing approaches that more appropriately account for ethnic background. This study did not focus on how monolingual children of immigrants cope with not being able to communicate in English, nor did it include how the parents of these children cope with not being able to communicate with the school or health professionals or the broader social environment. Nevertheless, this study investigates how these children manage to accumulate knowledges and language, and, thus would highlight how social context and desires affect language learning [25, 26].

Future Directions in Research

Future studies will enhance this research by expanding to other hospital systems for comparisons on communication and cultural approaches, which may influence care outcome disparities. Refining the model for analyzing the 30 diverse job categories could yield intriguing findings, particularly in understanding how these categories relate metaphorically to health issues. Additionally, longitudinal analyses would provide insights into the changes TMH aims to implement within the organization. A broader examination of competing values frameworks beyond healthcare may reveal insights into organizational structures that serve communities versus those driven by corporate obligations. Health care organizations should aim to invest in communities to improve quality of life, unlike companies that extract resources. This investigation suggests that TMH's significant cultural changes and intercultural communication focus can positively impact community values and health. TMH's goal of reducing health disparities while becoming strategically focused has implications that extend beyond healthcare into civic responsibility, often overlooked. Increased attention to these organizations and the links between culture and civic engagement is essential. The research highlights a lack of studies on cultural impacts on medical interviews, emphasizing the need for future research to develop culturally effective medical interview strategies [27-31].

CONCLUSION

The findings presented in this study affirm that cultural practices play a central role in shaping health outcomes across global populations. From dietary customs and traditional healing methods to mental health perceptions and gendered behaviors, culture mediates how individuals experience illness, seek treatment, and respond to care. The persistence of biomedical dominance, particularly in developing nations, has led to a systemic marginalization of alternative and indigenous health paradigms. Without a nuanced understanding and integration of cultural belief systems, healthcare delivery risks being both

ineffective and exclusionary. Addressing health disparities thus requires a paradigm shift—one that embraces cultural diversity as a strength rather than a barrier. Policy-makers, practitioners, and researchers must foster culturally respectful environments that validate multiple worldviews of healing and wellness. Ultimately, health systems that are inclusive of cultural practices will not only enhance patient outcomes but also build trust and equity in global health frameworks.

REFERENCES

1. Qomi SM, Mohebbi S, Shahrabi MA, Shojaeifar A. Assessment of the Role of Cultural Navigation in the Development of Cultural Identity. Management Strategies and Engineering Sciences. 2024 Jun 30;6(2):50-8. msesj.com
2. Chan RJ, Milch VE, Crawford-Williams F, Agbejule OA, Joseph R, Johal J, Dick N, Wallen MP, Ratcliffe J, Agarwal A, Nekhlyudov L. Patient navigation across the cancer care continuum: an overview of systematic reviews and emerging literature. CA: a cancer journal for clinicians. 2023 Nov;73(6):565-89. wiley.com
3. Hechavarría DM, Brieger SA. Practice rather than preach: cultural practices and female social entrepreneurship. Small Business Economics. 2022 Feb;58(2):1131-51.
4. Brownell KM, Hechavarria DM, Robb CC, Kickul J. Culture and social entrepreneurship: the role of value-practice misalignment. Small Business Economics. 2025 Mar;64(3):863-87. springer.com
5. Meierrieks D. Weather shocks, climate change and human health. World Development. 2021 Feb 1;138:105228.
6. Teo KK, Rafiq T. Cardiovascular risk factors and prevention: a perspective from developing countries. Canadian journal of cardiology. 2021 May 1;37(5):733-43.
7. de Diego-Cordero R, Rivilla-Garcia E, Diaz-Jimenez D, Lucchetti G, Badanta B. The role of cultural beliefs on eating patterns and food practices among pregnant women: a systematic review. Nutrition reviews. 2021 Sep 1;79(9):945-63. [HTML]
8. Omer S, Zakar R, Zakar MZ, Fischer F. The influence of social and cultural practices on maternal mortality: a qualitative study from South Punjab, Pakistan. Reproductive health. 2021 May 18;18(1):97.
9. Reis FJ, Nijs J, Parker R, Sharma S, Wideman TH. Culture and musculoskeletal pain: strategies, challenges, and future directions to develop culturally sensitive physical therapy care. Brazilian Journal of Physical Therapy. 2022 Sep 1;26(5):100442. nih.gov
10. Bajwah S, Koffman J, Hussain J, Bradshaw A, Hocaoglu MB, Fraser LK, Oluyase A, Allwin C, Dunleavy L, Preston N, Cripps R. Specialist palliative care services response to ethnic minority groups with COVID-19: equal but inequitable—an observational study. BMJ Supportive & Palliative Care. 2021 Sep 12;14(e1):e1478-87. bmj.com
11. Playdon M, Rogers TN, Brooks E, Petersen EM, Tavake-Pasi F, Lopez JA, Quintana X, Aitaoto N, Rogers CR. Sociocultural influences on dietary behavior and meal timing among Native Hawaiian and Pacific Islander women at risk of endometrial cancer: a qualitative investigation. Cancer Causes & Control. 2023 Jan;34(1):23-37.
12. Tiedje K, Wieland ML, Meiers SJ, Mohamed AA, Formea CM, Ridgeway JL, Asiedu GB, Boyum G, Weis JA, Nigon JA, Patten CA. A focus group study of healthy eating knowledge, practices, and barriers among adult and adolescent immigrants and refugees in the United States. International Journal of Behavioral Nutrition and Physical Activity. 2014 Dec;11:1-6.
13. Ibeneme S, Eni G, Ezuma A, Fortwengel G. Roads to health in developing countries: understanding the intersection of culture and healing. Current therapeutic research. 2017 Jan 1;86:13-8.
14. Mehl-Madrona L, Mainguy B. An exploration of the elements of effective cultural healing in North America. European Psychiatry. 2021 Apr;64(S1):S686-7.
15. Barrow E, Thomas G. Exploring perceived barriers and facilitators to mental health help-seeking in adolescents: a systematic literature review. Educational Psychology in Practice. 2022 Apr 3;38(2):173-93.
16. Ongesa TN, Ugwu OP, Ugwu CN, Alum EU, Eze VH, Basajja M, Ugwu JN, Ogenyi FC, Okon MB, Ejemot-Nwadiaro RI. Optimizing emergency response systems in urban health crises: A

project management approach to public health preparedness and response. Medicine. 2025 Jan 17;104(3):e41279.
17. Elshaikh U, Sheik R, Saeed RK, Chivese T, Alsayed Hassan D. Barriers and facilitators of older adults for professional mental health help-seeking: a systematic review. BMC geriatrics. 2023 Aug 25;23(1):516. springer.com
18. Sosa MV, Chin E, Sethares KA. Perspectives Regarding Engagement in Physical Activity in Women: Traditional Gender Role–Based Themes. Journal of Cardiovascular Nursing. 2024 Oct 1:10-97. [HTML]
19. Ugwu CN, Ugwu OP, Alum EU, Eze VH, Basajja M, Ugwu JN, Ogenyi FC, Ejemot-Nwadiaro RI, Okon MB, Egba SI, Uti DE. Sustainable development goals (SDGs) and resilient healthcare systems: Addressing medicine and public health challenges in conflict zones. Medicine. 2025 Feb 14;104(7):e41535.
20. Michaelson V, Pilato KA, Davison CM. Family as a health promotion setting: A scoping review of conceptual models of the health-promoting family. PloS one. 2021 Apr 12;16(4):e0249707.
21. Radinmanesh M, Ebadifard Azar F, Aghaei Hashjin A, Najafi B, Majdzadeh R. A review of appropriate indicators for need-based financial resource allocation in health systems. BMC health services research. 2021 Dec;21:1-2. springer.com
22. Bazargan M, Cobb S, Assari S, Kibe LW. Awareness of palliative care, hospice care, and advance directives in a racially and ethnically diverse sample of California adults. American Journal of Hospice and Palliative Medicine®. 2021 Jun;38(6):601-9. [HTML]
23. Thiel de Bocanegra H, Gany F. Good provider, good patient: changing behaviors to eliminate disparities in healthcare. The American journal of managed care. 2004;10:SP20-8.
24. Roberts DA, Abera S, Basualdo G, Kerani RP, Mohamed F, Schwartz R, Gebreselassie B, Ali A, Patel R. Barriers to accessing preventive health care among African-born individuals in King County, Washington: A qualitative study involving key informants. PLoS One. 2021 May 10;16(5):e0250800.
25. Matute SE, Martinez EZ, Donadi EA. Intercultural Childbirth: impact on the maternal health of the Ecuadorian Kichwa and mestizo people of the Otavalo region. Revista Brasileira de Ginecologia e Obstetrícia/RBGO Gynecology and Obstetrics. 2021 Jan;43(01):014-9. thieme-connect.com
26. Paul-Chima UO, Ugwu CN, Alum EU. Integrated approaches in nutraceutical delivery systems: optimizing ADME dynamics for enhanced therapeutic potency and clinical impact. RPS Pharmacy and Pharmacology Reports. 2024 Oct;3(4):rqae024.
27. Bugelli A, Borgès Da Silva R, Dowbor L, Sicotte C. The determinants of infant mortality in Brazil, 2010–2020: a scoping review. International journal of environmental research and public health. 2021 Jun 15;18(12):6464. mdpi.com
28. Turpel-Lafond ME, Johnson H. In plain sight: Addressing Indigenous-specific racism and discrimination in BC health care. BC Studies: The British Columbian Quarterly. 2021 May 5(209):7-17. ubc.ca
29. Armitage R. Bullying in children: impact on child health. BMJ paediatrics open. 2021 Mar 11;5(1):e000939.
30. Budiwiyanto A. Penyerapan kosakata bahasa daerah ke dalam bahasa Indonesia pada Kamus Besar Bahasa Indonesia edisi keempat. Mabasan. 2009;3(1):1-4.
31. Yılmaz AA. Cultural Harmony in Defense Industry: A Case Study on Innovative Intercultural Communication. Elektronik Sosyal Bilimler Dergisi. 2025 Jan 1;24(1):491-508.

CITE AS: Nambi Namusisi H. (2025). The Impact of Cultural Practices on Health Outcomes. Research Output Journal of Public Health and Medicine 5(1):92-99. https://doi.org/10.59298/ROJPHM/2025/519299