Culturally Responsive Care

ACCESS TO CARE, SERVICES, AND PROGRAMS THAT ARE CULTURALLY-SPECIFIC, HONORING AND APPROPRIATE

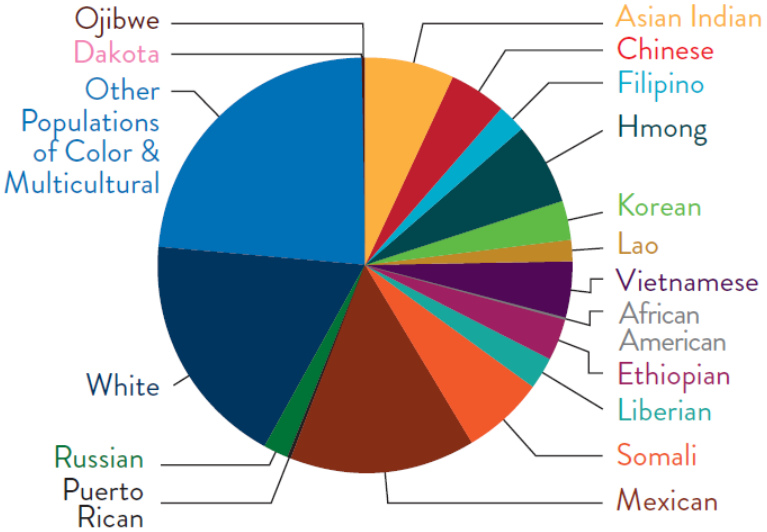
Why It's Important

Culture plays a huge role in how women and families define health and how they interact with the health care system. The National Institutes of Health defines culture as "the combination of a body of knowledge, a body of belief and a body of behavior. It involves a number of elements including personal identification, language, thoughts, communications, actions, customs, beliefs, values and institutions that are often specific to ethnic, racial, religious, geographic or cultural groups." In order to provide culturally responsive care, providers and systems must understand the importance of culture and consider culture when providing resources, education, and services to women and their families. Cultural competency is critical to providing equitable, effective and respectful care and services. It includes but is not limited to being responsive to diverse beliefs and values related to health and well-being, delivering services in preferred languages, and being mindful of health literacy and numeracy.

Providing culturally appropriate care is increasingly important as Minnesota becomes more diverse. Minnesota has seen a 26 percent growth in its population of color since 2010 (the seventh highest among U.S. states).[1] As the state's demographics change, it becomes home to more cultures, religions, and languages (see Figure 1). To reduce disparities and provide equitable and effective health care, it is crucial to provide care that is culturally responsive and community-driven.

> *"Families of color and indigenous populations are the most underserved. They need culturally appropriate care, free of racial biases, with providers who listen!" – Needs Assessment Discovery Survey*

Figure 1. Minnesota's Foreign-Born & Indigenous Populations, by Cultural Group



Source: Minnesota State Demographic Center, American Community Survey, 2012-2016

Focus on Health Equity

American Indian Maternal & Child Health

There are 11 tribes in Minnesota: seven Anishinaabe (Chippewa and Ojibwe) tribes and four Dakota (Sioux) tribes. Members of these tribes and their ancestors have lived in Minnesota for thousands of years, long before Minnesota was established as a state. The Anishinaabe and Dakota reservations were established in the 19th century via treaties. American Indians represent nearly 2 percent of the total population of Minnesota and most American Indians live on federal-designated reservation lands in greater Minnesota. In 2016 there were 25,764 American Indian children and youth age 17 and younger. Of the American Indian children and youth under the age of 19 in Minnesota, 64 percent (18,098) live in Greater Minnesota.[2]

American Indian women, children and families experience worse health outcomes than other populations in Minnesota. These inequities are caused by historical trauma, systems of oppression, and current racism and structural violence that act as barriers to opportunity and thriving. The American Indian child poverty rate in 2016 was 36 percent compared to 14 percent of all Minnesota children living in poverty.[3] 51.4 percent of American Indian children are growing up in single mother families.[4] Only 50 percent of American Indian youth will graduate from high school.[5]

Providing culturally responsive care to American Indian patients may require the inclusion of traditional healing practices and complementary interventions. Examples of these cultural activities include: smudging/purification, talking circles, and songs and drumming.[6]

Non-English Speakers

Over 11 percent of people living in Minnesota speak a language other than English at home, and in 2016 there were more than 100,000 people in the state who spoke English less than "very well". [6] Schools and systems are not always equipped to serve children and families who speak a language other than English. Adults with limited English skills have a harder time gaining and maintaining employment.[7] Language impacts health literacy, which is the degree to which people can understand and process basic health information. Our health care systems are not easily navigable for people with limited health literacy (e.g. complex forms, needing to identify providers and services).

Providing culturally responsive care to non-English speakers may include (but is not limited to) the use of interpreters, using plain language, and communicating in a way that is both linguistically and culturally appropriate.

U.S. Born African American/Black

In Minnesota, 41 percent of babies born to mothers who identify as African American/black are U.S. born versus 59 percent foreign-born. This is important because when we look at data in aggregate for African American/blacks, we mask disparities impacting U.S. born blacks. This is in some part due to a healthy immigrant effect – a well-known phenomenon where immigrants are on average healthier than those who were born in the United States. The disparities are also attributable to structural racism and historical trauma that have negatively impacted outcomes across generations. We see these disparities between U.S. and foreign-born black populations in Minnesota across education and health outcomes, such as: Minnesota Comprehensive Assessment (MCA) test scores, high school graduation rates, infant mortality, and birth outcomes. For example, the infant mortality rate for babies born to U.S. born African American/black mothers is nearly two times higher than the rate for babies born to foreign-born black mothers (12.4 vs 6.7 per 1,000 live births respectively).

Providing culturally responsive care to U.S. born black women and children living in Minnesota includes (but is not limited to) acknowledging the historical trauma that has affected black communities in Minnesota and the current oppression and racism that restricts access to resources, education and health care.

Immigrant & Refugee Health

Minnesota is home to large immigrant and refugee populations. In 2017, the largest groups of foreign-born people living in Minnesota were born in Mexico (66,605), Somalia (27,373), India (28,403), Laos (25,436) and Vietnam (18,330) (these estimates do not include the U.S.-born children of these immigrants).

Refugee health is especially important in Minnesota, as we are home to more refugees per capita than any other state in the U.S.[8] Refugees are individuals who leave their countries due to persecution and threat of harm. Refugee women, children and families navigate new homes and health care systems as well as working through the trauma associated with their need to seek refuge. There are more than 30,000 documented torture survivors living in Minnesota alone; women, men, and children who endured devastating trauma and are now rebuilding their lives in a new community.[9]

Providing culturally responsive care to immigrants and refugees may include (but is not limited to) trauma-competent approaches and practices, as well as the use of interpreters when needed.

Additional Data Considerations

There are significant data limitations when talking about culturally responsive care, including:

- Many non-English speakers are excluded from research due to insufficient support and funding. As such, many of our evidence-based services and programs may not be appropriate for non-English speakers or other communities not included in initial studies.
- Data collection methods can mask trends and outcomes. Being able to break down data by race and ethnicity helps us understand the needs of different communities; however we often group together many cultures into broad categories, for example “Asian” and “African American”.

Discovery Survey Results

In the summer of 2018, Minnesota’s Title V Maternal and Child Health Needs Assessment distributed a Discovery Survey asking people living in Minnesota, “What are the biggest unmet needs of women, children, and families in your community?” More than 2,700 people responded. Culturally Responsive Care was in the top 15 mentioned needs overall and in the top 10 for Hispanic and Asian/Pacific Islanders respondents.

Important Note on Equity and Intersectionality

The Minnesota Department of Health’s Title V Needs Assessment team acknowledges that structural (social, economic, political and environmental) inequities can result in poor health outcomes across generations. They have a greater influence on health outcomes than individual choices or a person’s ability to access health care, and not all communities are impacted in the same way.

All people living in Minnesota benefit when we reduce health disparities.

We also acknowledge that the topic addressed in this data story does not exist in isolation– which is important to remember as we do needs assessments and as we start thinking about how we approach

solutions. In addition to the needs themselves being intersectional, there are also intersecting processes and systems through which power and inequity are produced, reproduced, and actively resisted.

Citations

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