About the author

Atum Azzahir created and led a two-year community assessment process (1994 – 1996) that is now the foundational strategy for studying cultural knowledge that leads people to health. She has received numerous awards, including:

- Salzburg Fellowship, Salzburg Seminars, 1993, Salzburg, Austria
- Community Health Leadership Award, 1995, Robert Wood Johnson Foundation
- Leadership in Neighborhood (LIN) grant, for travel to Senegal and Benin, West Africa; Grenada in the West Indies; Jackson, Mississippi; and Cairo, Egypt to study the role of elders in African-American communities of the South
- Recognition as one of the 100 most influential health leaders in Minnesota, Physicians Monthly, August 2000 edition
- Blue Cross and Blue Shield of Minnesota Foundation 2nd Annual Upstream Health Leadership Award, 2007

In addition to serving on several community organization boards, Ms. Azzahir has also served as a consultant to area foundations, colleges and the Minnesota Department of Health. She has received certification as an Elder and as a facilitator of African thought and spirituality, International Khepran Institute, 1995.

About the Cultural Wellness Center

The Cultural Wellness Center, which opened in 1986, is a community-initiated organization where people can learn their own and each other’s cultural traditions and health practices. Its mission is to unleash the power of citizens to heal themselves and to build community. To accomplish this mission, the Cultural Wellness Center develops models to solve problems that have been created by individualism, loss of culture and loss of community, including the People's Theory of Sickness and Disease. The People's Theory informs how communities define issues such as "racial disparities" in health, economic status and education. Loss of culture and community have produced disastrous effects that only reconnection to these vital resources can heal and reverse.

The Cultural Wellness Center is in the business of positioning community knowledge at the forefront of community health and economic development ideas. For more information, visit www.ppcwec.org.
Thank you for the invitation to take part in the presentation of “The Unequal Distribution of Health in the Twin Cities” findings to our community. I am moved by the decision that you are making to create immediate opportunity for public dialogue and solution generation from the moment the study’s findings are released. The study will possibly unleash a flood of health activity. I appreciate your recognition of the work currently being done in this direction as well as your acknowledgment that the findings are linked to realities on a national and international level. This study will have a powerful influence on the mindset of officials with resources that often silence communities who are the topic of their investigations. The approach you are taking will open the door for communities to be able to reinforce what they know to do about health disparities, which have been in the making for a long time.

From our work over the years of studying why culture matters to good health, a very strong sentiment for cultural self study and revitalization has arisen among a growing contingent of cultural community organizing groups. Our groups see cultural knowledge production as a power enhancing and capacity-building strategy to equalize the relationship between the cultural groups who are referenced in this study and the other studies of this nature across the country. This includes the European American groups who have developed significant cultural self-study tools in the Cultural Wellness Center (CWC) to work together with the groups who are struggling to catch up with their community on the level of physical health, but have retained strength in the areas of spiritual and emotional health. Our cultural self study for change individual and collective behaviors through knowledge production is now the basis for community and institutional partnerships to improve health.

The work of the CWC emerged in 1996 to address concerns similar to those investigated in this study. Specifically, we spent two years (1994 to 1996) asking questions of residents in our area about the cause of poor health and chronic disease. As a result of this inquiry, a theoretical model was born, the People’s Theory of Sickness and Disease (The People’s Theory). The People’s Theory identifies and explains the health problems community members expressed through purposeful, direct and in-depth dialogue. The essential focus of this approach was to ensure community engagement in the development of a research process that activates the knowledge of its participants to create positive changes in health behavior and reduce medical inequities. The basic premise of the People’s Theory supports community-based participatory research, which is widely hailed by numerous researchers. These researchers purport that this kind of research promises to help communities find solutions to their major health issues such as health disparities by influencing change in community health, norms, systems, programs and policies.

In this light, the Peoples’ Theory supports the knowledge, experience, beliefs, values, attitudes, meanings, traditions and systems that influence health behavior or how health happens through culture and community. As a way to respond to the questions regarding the Distribution of Health in the Twin Cities, I would like to highlight what the CWC has found in over 16 years of investigation into firsthand experiences with community residents who face significant barriers
in accessing health and human services programs established for their White, non-Hispanic counterparts. Our process of carefully observing and listening to residents has allowed us to make powerful inroads by understanding the particular needs of community members who were historically on the peripheral of conventional health programs.

**What’s working to keep inequalities at bay**

One health issue the CWC has studied closely is infant mortality. For many years the research literature pointed us to teenage African American or non-European American mothers without education for its basis of developing programs to prevent infant mortality. Many of us in the community responded to this research by asking, “What have we done differently to assure that our children lived? If our children lived in spite of several health inequalities — how did this happen?” We were clear that we had not done anything different; however, we had not taken the time to study ourselves or the health outcomes of our children particularly when compared to their White, non-Hispanic counterparts. The CWC aimed to initiate this type of investigation with African American mothers who fall into the categories that the research has described, but whose children lived.

In particular, we organized African American mothers who had children during their teenage years. We inquired of them their ideas about why their children lived, considering all the factors which the research states would determine the life and health outcomes of the child. What we found is that these mothers had grandmothers, aunties, and many other women to teach, support and guide them during pregnancy as major reasons that their own children lived beyond the first year of life. They repeatedly gave recognition to women with birthing experience who had been by their side through the whole experience of pregnancy and child rearing. The CWC took this advice from women and has organized over 100 birthing teams over the years, with consistently positive results. The birthing teams attend prenatal appointments, form sharing circles, cook food and clean homes. The birthing teams are present during the delivery and support breastfeeding. We have created rites of passage groups and elder parenting classes taught by adult and older women to ensure that friendships, sisterhood and kinship networks are in place for the teen mothers and their children.

The above example is offered for two reasons. The first is to highlight how critical it is to begin the dialogue with local people as an authentic and authoritative form of research when seeking to unravel and discern one of society’s long standing human struggles — inequalities in health care and delivery. Second, it is critical to report the successes revealed from these health imbalances that are helping to restore cultural communities with a number of these groups residing in the Twin Cities. The latter statement is also of significance because it is directed at the deficit versus strength-based process for translating stories into findings and knowledge to be used in program design and policy development. The strength-based model for developing new knowledge, which has become a cornerstone of the CWC’s approach to research and community empowerment, is of growing value to academic institutions and health care organizations that are doing innovative work to reduce health inequities.
We are establishing cultural wellness as a health improvement imperative for health care and community based organizations. Most importantly, for community groups who are examining their culture for instructions to make changes which will transcend the existing community life situations and barriers to optimal health status such as underemployment, underinsurance, lack of quality care, and low education. Community groups of African and Native heritage who are historically indigenous to this land are beginning to take the lead in turning around some of these old, stubborn patterns that have developed over time in many cases as a result of forces beyond their control. As we review the distribution of health in the Twin Cities, it is clear to us that life expectancy rates for African Americans and Native Americans reflect the historical terror that each has experienced in this nation and by extension in this state. The CWC recognizes that these cultural groups are playing catch up in ways that astound the mind and are doing the work of cultural reconstruction with promising outcomes. An example of this work is the 2010 Allina Health Systems Backyard Initiative, which is organized by the CWC. Through this work, the native Dakota team is creating a Language Revitalization House in the Phillips residential community with plans to open its doors as a backyard pilot in August.

The significance of language revitalization to the restoration of traditional life ways, vision and hope is going to be revealed as the team and the many community members work together to remove challenges for this group as they implement this pilot. In the Initiative’s story, told by the Dakota elder who is leading the team, there were many references to restoring the well-being of the people generation by generation. The Dakota people are starting with the young children and will bring in adults who still have or have learned the language to work with these children. However, she spoke of everyone beginning to work on their language skills, since it provides the capacity to understand and participate in creative structures that give life longevity. The CWC, as partner to this effort, sees language revitalization a standard in culturally and linguistically appropriate health strategies. This is because the cognitive process that is impeded when you lose your language means that you and your people have also lost concepts and meanings that direct life behavior, including health. As we work to make progress to equalize access to human and health services and design tailored approaches to reduce health inequities, the Language Revitalization House is a symbol of commitment of cultural communities to revitalize and restore their own health.

Already the CWC is hearing from cultural groups new to this country that the Backyard Initiative is valuable, as these groups discuss how critical culture and language are to their well-being and ability to navigate different values and customs of this society. This learning presents a recurring theme of remaking the state of “Being-ness” as the experience new cultural groups have when they immigrate to the United States. What is often overstated is the immigrant advantage but these reports do not speak to the sustenance of language, values, beliefs, concepts, etc., which instruct perspective and behavior and are often become lost to individuals and families in the nuances and complexities of the acculturation process. Many of these cultural groups have reported a sense of fear of losing culture making them more susceptible to illness and disease. Some of the illnesses and diseases cited by new people to America and people who have been long term in America during the community dialogue are depression, bi-polar disorder, migraine headaches and premature death. In a number of instances, this was a point of agreement between the groups on the impact of the loss of culture and language. Our work is to establish culture as a
resource for health, which begins with language and interpretations of situations that are out of balance, diseased and harmful to the continuation of life ways across generations. In his book on *Minority Populations and Health* Thomas A. LaVeist speaks of “cultural tailoring.” He advises that health interventions should be tailored specifically to the groups’ language and culture.

In the CWC’s work on language, we have found that the work on health literacy is critical for the cultural groups for whom English is their second language. Further, that language is especially critical also for African Americans. This is because the prevailing mindset is that African Americans speak English, yet due to the grave isolation and geographic concentration of African Americans historically at the community level, low proficiency in the English language has been passed down from generation to generation. We have also found that as with the Native people, loss of language and culture for African and African American groups have improved when this loss is identified and instructions happens from one another.

**What could be done to reduce inequalities**

The above reports are only a few examples of how programs and policies can promote health equalities when there is a high degree of ownership by the communities being studied. However, to fully realize optimal health outcomes in all populations on the state, national and international levels, effective initiatives and policies will not only have to draw upon the experience and knowledge of community members, but will need to strategically support these groups in leading interventions that target gaps in conventional health planning. Most importantly, support of these types of interventions must be encouraged by health care professionals, academicians and public health officials to ensure that community-driven research methods and solutions become an independent versus dependent resource for health.

Finally, the CWC in its response to the study *Unequal Distribution of Health in the Twin Cities* is proposing that known health disparities research be continually evaluated and challenged for its deficiencies to ensure that studies lead to programming that is transformative. Current research methods lack the capacity to do this, and in many cases, are known to impede community progress in moving beyond historical barriers and inequities that illustrate themselves in disproportionate illness and disease.