

## Creating Culturally Relevant and Responsive Health Care Models

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### ABSTRACT

Western-based health models situate formalized education as a distinct driver of outcomes, including health and well-being. This study, conducted as part of the Community-engaged Scholars Program, interviewed elders and practitioners in cultural communities about relationships between cultural ways of knowing and health to inform Western-based models of health service delivery. While years of schooling may translate into practical means for obtaining goods and services, cultural knowledge frames provide a foundation for addressing the complexities of health.

*Keywords:* culture, cultural ways of knowing, health, health care, knowledge, framework

Considerations of culture as a means by which individuals and communities tap into improved health are generally absent from conversations about reducing health disparities in Western-based models of health and health care. In health contexts in which culture is included, deliberations about culture most often are limited to description of culture as a risk factor, such as when measures of acculturation and perceived discrimination by groups are the focus of discussion. An understanding of the importance of culture as integral to identity, knowledge production, and ways of healing and maintaining health is necessary. An understanding of culture as central to knowledge and health production makes possible the replacement of deficit and risk models of culture with depiction of culture as a dynamic process of shared voice and a

resource for strength that patients and families bring to all health care encounters.

The reluctance of Western-based health delivery models to give value to alternate knowledge systems (e.g., systems where health and disease are connected to an ancestry or a Creator, and where the mind, body, and spirit are not separated) and to recognize their relationship to health limits the capacity of these models to contribute to the sustained health of cultural communities. Cultural communities are comprised of individuals who share a bond based on history (ancestral ties), social identity, traditions, rituals and spiritual practices, and values. Members looking for the inclusion of knowledge frameworks that create space for the embrace of diagnostic and therapeutic elements from the Earth, the Universe, and the Spirit often bypass or en-

gage in only a limited way with Western-based health models. Cultural community members perceive Western-based models as inadequate in their capacity to treat health and illness as complex and multifaceted.

The research described in this paper aimed to contribute to a better understanding of the relationships between cultural ways of knowing and health as a means to inform Western-based health service models and to create new knowledge that may ultimately contribute to the transformation of these conventional models for health and illness care. This work was conducted as part of the first author's participation in the Community-engaged Scholars Program at the University of Minnesota Extension's Children, Youth, and Family Consortium. The Scholars Program engages small cohorts of faculty and staff representing multiple disciplines to address questions related to the intersection of education and health. The goal is to generate new knowledge applicable to the work of practitioners and policymakers in the fields of education and health disparities using a community-engaged research framework. This project was developed and conducted in reciprocal collaboration with a community partner, represented by the senior author, executive director of the Cultural Wellness Center, Minneapolis, Minnesota. Specifically, in this research we carried out dialogues with elder members and health practitioners in cultural communities and gained insights regarding: (1) understanding relationships between systems of knowledge and health and well-being, and (2) identifying a role for practitioners of healing ways in informing Western models for health service delivery (practitioners of healing ways use primarily non-Western methods that connect the mind, body, and spirit to facilitate the restoration, support, and advance of individuals' health and well-being).

## LITERATURE REVIEW

The relationship between formal education and health outcomes, including risk for disease, life expectancy, and healthy development, is an established one in Western-based disciplinary literatures. For example, sociological and epidemiological literatures define a graded relationship between education and health, with higher levels of education associated with better health in most cases. More education is linked to longer life expectancy, lower individual disease burden, better socio-emotional functioning, and improved perceptions of well-being (Elo, 2009; Goesling, 2007; Liu & Hummer, 2008; Lynch, 2003, 2006; Mirowsky & Ross, 2008; Reynolds & Ross, 1998; Ross & Mirowsky, 1999; Ross & Wu, 1995, 1996).

Across disciplinary lines, several hypotheses are put forward to explain the relationship between education (i.e., years of formalized schooling completed and/or degree attainment) and physical and psychological health and well-being. Most often, education is theorized to positively influence individuals' access to resources and to guide opportunities for healthy development. Education facilitates increased access to money, information, power, and prestige, enabling individuals to avoid disease and negative outcome by positioning them to become active consumers of data and to make behavior change when necessary (Link & Phelan, 1995). Education's hypothesized health advantages have prompted some to suggest investment in education policy as a viable health intervention strategy (Cutler & Lleras-Muney, 2008).

The primacy of formalized schooling as a driver of health and well-being is challenged by cultural communities who know, live, and thrive by alternate frameworks for knowledge production and health. An example of an alternate framework for

knowledge production is the Cultural Knowledge Systems framework, which is situated within an African Ethos (Powderhorn/Phillips Cultural Wellness Center, 2002). This framework is built upon principles of spirituality (start with the Creator and the spirituality of experience), symbols (recognition of connections to the Creator, the ancestors, and to each other signals life and life-giving processes and prevents harm), mythos (requires self-study and function by honoring the lived experiences, practices, and wisdom that have been passed down), and harmonium (a goal—creating ways in which knowledge systems may coexist; this principle creates space for equity and value attributed to non-Western-based knowledge production). Culturally based frameworks are contrasted with Western-based knowledge frameworks, which are grounded in principles of science, technology, objectivity, and rationality (Powderhorn/Phillips Cultural Wellness Center, 2002).

Within the Cultural Knowledge Systems framework, health and well-being are defined by relationships, self-knowledge, and the capacity to create new knowledge that is informed by cultural ways of knowing. Cultural ways of knowing start with the Creator; consider the mind, body, and spirit as one; and raise up insights gained from ancestral teachings (Powderhorn/Phillips Cultural Wellness Center, 2002). In cultural ways of knowing, spiritual harmony and energy balance are the drivers of health, and chronic disease and disease burden are defined by processes in which individualism replaces collective accountability and effort, and isolation and alienation signal the loss of community (Powderhorn/Phillips Cultural Wellness Center, 2002; People's Theory of Sickness, n.d.). By querying an accepted premise outlining a positive relationship between educational achievement and health status, the current project invites consideration of alternate contexts for knowledge systems (as exemplified by the

Cultural Knowledge Systems framework) as determinants of health beliefs, health-related decision-making, and health outcomes.

## METHODS

The goal of this project was to begin dialogues with elders and practitioners of healing ways in cultural communities to gather information to improve upon health service delivery models dominated by a western biomedical framework. The partners represent a University of Minnesota faculty member (member of the Scholars Program) and the Cultural Wellness Center.

### **The Cultural Wellness Center**

The Cultural Wellness Center is a non-profit community-based organization with its main campus in Minneapolis, Minnesota. The Cultural Wellness Center's work focuses on (1) restoring indigenous and ancient cultural knowledge systems that motivate people to care for themselves before they become sick, (2) supporting health through personal responsibility, and (3) facilitating cultural and community connection once sickness is manifest. Core member services include group activities focused on cultural reconnection (e.g., birthing teams, healing circles, talking circles) and one-on-one mentoring programs. Cultural Wellness Center staff and faculty serve as teachers, advocates, translators, and facilitators for Cultural Wellness Center and neighborhood members when interfacing with physicians, nurses, social workers, and other health-related consultants.

Citizen Health Action Teams (CHATs) are part of a larger health-related project facilitated by the Cultural Wellness Center, the Backyard Initiative, which is a community partnership between Allina Hospital and residents comprising a geographic area referred to as the "backyard" (Central, Powderhorn Park, Corcoran, Ventura Village, Phillips West,

Midtown Phillips, East Phillips). CHATs are charged with developing strategies to improve the health of communities by building community capacities, including building relationships, identifying resources, strategic planning, and public organizing. One CHAT, the Circle of Healing, was approached to participate in this study because of its content focus.

### **Research Design**

As this study focused on gaining insight into cultural knowledge, practices, and experiences of cultural community members with Western-based health delivery models, an exploratory qualitative methodology, including a phenomenological approach, was used. A phenomenological approach allows for focus on the lived experience of individuals (Kuper, Reeves, & Levinson, 2008) and thus offers the benefit of grounding the research in honoring individual stories about experiences of health, illness, and recovery as well as how cultural practices anchor and guide health behaviors and decision-making. Focus groups (total of three, all taking place at the Cultural Wellness Center) and individual interviews (total of five, taking place in field settings, including three coffee shops, a professional office, and one participant's home) were conducted to hear participants' stories.

### **Elder and Practitioner Participants**

Purposive sampling, an established qualitative research technique (Glesne, 1999; Kuper, Reeves, & Levinson, 2008), was used in this study. Elder members and practitioners of the Circle of Healing CHAT were invited to participate in the project given their focus and expertise on cultural knowledge production as the foundation for individual and community health.

An initial meeting with the Circle of Healing CHAT facilitated introduction of the project to members and allowed mem-

bers to comment on concerns and to ask questions about the project. After introduction of the project and group discussion, there was consensus to participate and dates for the focus groups were set. All focus groups and individual interviews were conducted between February and April 2013.

A total of 15 Circle of Healing CHAT members participated in the study (most members serve dual roles as elders and practitioners). The individual interviews included five participants of the focus groups who expressed interest in sharing more information about personal experiences with engaging Western-based models of health care and how these experiences influenced plans for self-care and recommendations to others about how to approach, achieve, and maintain health. The majority of participants were female (86%; 14% male), with an age range of 27-69 years (mean 46 years). Circle of Healing CHAT members self-identified as African (71%), Asian (0.1%), European (21%), Native (14%), and Haitian American (0.1%); cultural identification categories were not mutually exclusive. Fifty-seven percent of members were born in the United States. Additional countries of birth included the Sudan, Colombia, Somalia, and Haiti (43% of members). Time in the United States ranged from 14-69 years (mean 39 years). Members completed between 12-20 years of formal education; this range does not reflect additional training of some members, including times of apprenticeships and physician residency training. Languages spoken included English, Arabic, Creole, French, German, Spanish, and Somali. All team members completed interviews in English. Members worked as family advocates; community activists, navigators, and capacity builders; elder coaches; consultants and administrators for mental health organizations; and supervisors and providers in nursing and medicine. Practitioners used multiple methods in their work with indi-

viduals and families in the community, including therapeutic touch, holistic health coaching, massage therapy, Reiki, integrative medicine coaching, and prayer.

**Interview Guide**

A semi-structured interview guide

was used, permitting flexibility in the interview procedure to explore specific topics and questions (Table 1). Questions were informed by the first author’s advocacy and clinical experiences, with oversight by the senior author and elder members of the Cultural Wellness Center ethics committee.

**Table 1.** Example Focus Group Discussion and Individual Interview Questions

<p><b>Focus Group #1: Connecting Cultural Ways of Knowing, Education, and Health</b></p> <p>How do you define health? How do you connect cultural knowledge to health? What is the relationship between formal education and health?</p>
<p><b>Focus Group #2: Promoting Health and Healing</b></p> <p>How do you teach the wisdom of culture and how to bring wisdom into one’s life? How do healing ways work?</p>
<p><b>Focus Group #3: Informing Western Biomedical Models</b></p> <p>What are best practices when attempting to engage cultural communities about health? How may healing ways find room in a Western biomedicine framework?</p>
<p><b>Individual Interviews: Engaging Western Models</b></p> <p>How do cultural ways of knowing relate to health? How do you evaluate health education information provided in Western-based medical settings?</p>

**Data Collection**

Given the expertise provided by members of the Circle of Healing CHAT and because questions for the study were progressive in nature, with themes for each focus group building on information gained from the last, elder members and practitioners were asked to commit to attend all three focus groups. Thus, participants were the same people in all focus groups. A senior member of the Cultural Wellness Center, with extensive experience in interviewing and setting a comfortable stage for sharing personal stories, conducted the focus group interviews. The first author participated in all focus groups as a note taker and procedural resource (administering the demographic survey; obtaining consent; note taking and overseeing audio recording; dispensing participant compensation). The first author conducted all individual interviews.

Focus groups lasted approximately 90 minutes and all but one were audio rec-

orded (due to technology failure). Individual interviews were typically 90-120 minutes in length (although one interview lasted four hours) and were audiotaped. Demographic information, including age, gender, cultural identification, country of birth, years of conventional schooling, and type of practice or work, was obtained at the beginning of the first focus group for the majority of participants; for members who did not complete the brief pen and paper demographic form at the outset of the first focus group, the information was collected at the second or third focus group. Upon completion of each interview, participants were provided with a small monetary compensation to cover the cost of gas and child care.

Permission and consent for the study were obtained on multiple levels. In addition to members of the Circle of Healing CHAT providing group consensus relating to a desire to participate in the study, permission to conduct the study was grant-

ed by elder members of an ethics-focused subcommittee of the Cultural Wellness Center. Individual informed consent was obtained from all participants at the beginning of the first focus group and at the time of each individual interview. Informed consent was reviewed at each subsequent focus group to make sure each member remained agreeable to continued participation in the study. The Human Subjects Institutional Review Board at the University of Minnesota approved the study.

### **Analysis and Member Checking**

The first author transcribed the audiotapes. Interpretive analysis proceeded in three stages: deconstruction, interpretation, and reconstruction (Sargeant, 2012). Multiple readings of the transcripts and notes were performed independently by the first and senior author to identify major ideas and themes revealed by participants' words, phrases, metaphors, and examples. Frequently expressed ideas and themes were studied for patterns and grouped according to broader questions addressed during the interviews. In the interpretive phase, discussions between the first and senior author took place to compare findings and identify similarities and differences in themes categorized. Once the first and senior author agreed no further meaningful ideas could be identified, themes were revisited and situated within a larger framework for cultural knowledge production and a context for how education (learning produced in Western and non-Western contexts) may support and/or hinder health. Results were reviewed and critiqued by Circle of Healing CHAT members in three two-hour meetings in which the first author presented findings to the group (June 2013-August 2013). A final community presentation facilitated feedback from all members of the CHATs about general themes and interpretations of results.

## **RESULTS**

Three dominant themes emerged from the focus groups and individual interviews: (1) cultural ways of knowing represent a form of study and knowledge that is integral to producing health and managing the complexity and unpredictability of health; (2) a paradigm shift is necessary for conventional health care models to be better able to care for cultural communities; and (3) practitioners of healing ways have a role in informing the design of health delivery models.

### **Cultural Ways of Knowing**

Cultural ways of knowing are intuitive processes. They reflect an awareness of a dynamic interplay between the personal self and the environment. Learning comes through a lived experience. Knowledge is produced and passed down by elders, family, and community members. Several elders described cultural ways of knowing as a context in which knowledge is produced, as highlighted by this elder:

*Ways of knowing are a process for study and knowledge production. They require one to be present with the self and in the moment, to listen to the body. Ultimately one becomes mindful of how they feel in certain settings and this provides understanding on how to act. Like in the case of eating, paying attention to how certain foods make one feel gives instruction on how to eat.*

In contrast to what is perceived as an external focus maintained by Western-based educational frameworks, cultural ways of knowing require one to turn inward. Ways of knowing acknowledge that there is a lot more to the self and for the self than is put forward by Western-based models of reality that assume a separation of the mind, body, and spirit. One elder noted:

*Our ways require one to turn to a whole self, to look inward, to sense, to hear the ancestors and to seek guidance from them on the ways to approach a situation. Being in touch with the whole self is the only way you can hear and sense. Being one self allows you to walk between the visible and the invisible world without sacrificing one for the other.*

As in the case of Western-based educational contexts, investment is required. Cultural ways of knowing represent a form of knowledge production that come with time, practice, and study. Several elders described the importance and seriousness of the learning process, as explained by this practitioner of healing ways:

*Ways of knowing involve a cultivation of intuition. They represent owning a system of personal discernment, facilitated by meditation and cultural teachings. Learning comes with staying connected, aligning with the forces of the Creator, repetition and practice, and maintaining rituals which honor the body as more than the physical being.*

Elder members and practitioners identified several ways in which cultural ways of knowing relate to health. The importance of envisioning the mind, body, and spirit as one is revisited by this practitioner: “Ways of knowing provide a foundation for understanding what is happening within the body in a way that the mind, spirit, and body as a unit are considered.”

Intra- and interpersonal connections and self-study represent tools for achieving health. For example, one elder described the salience of nurturing relationships as a vehicle for achieving and maintaining health:

*Ways of knowing make health possible. Ways require one to return to a core [principle] of health—the culti-*

*vation of relationships. For example, we develop and strengthen our relationships during gatherings to break bread that make possible learning about cultural roots and history. Healing comes when you realize health is about the ritual, honoring relationships that tell us life is something bigger than the individual.*

Within the theme relating cultural ways of knowing as integral to managing the complexities of health, a sub-theme emerged, defining the role of conventional schooling as limited in its ability to produce health and well-being. Elders described ways in which Western-based frameworks for education contribute to contexts for fear, anxiety, and illness. For example, one elder spoke of a need to recognize the costs that may come with reliance on conventional schooling as a resource for health production:

*Yes, there are practical reasons for achieving in Western-based schooling...education may help with getting a job...help with financial stability; but there is a need to moderate the reverence given to Western-based frameworks for knowledge, moderate it with the realization that, if left unchecked, these frameworks separate the mind from body and spirit, separate the individual from community, and may be used as a weapon to oppress and stigmatize groups of people.*

Elders and practitioners challenged the premise that conventional education produces health, questioning the significance of education for health in the absence of being grounded in and connected to culture and community. One elder noted:

*There is a need to get back to the spirit and the heart when we are thinking about health, which gives*

*way to ways of knowing that authorize an inner wisdom for maintaining health and a means for the body to right itself in the context of disease.*

Using the example of the importance of balance, elders and practitioners offered evidence of ancestral teachings, which establish ways of knowing as the authority in creating paths to health and well-being. For example, one practitioner commented:

*In this process we are reminded of what we know, our innate health; there is no sense of the individual, of being lost, but of the grace of loved ones and ancestors. So even though there is information out there, for example, about not smoking or eating healthy, we know that these insights were first informed by what is known from our innate self and traditional healing methods...about the importance of taking in things that are life giving, and avoiding things that bring imbalance.*

### **The Paradigm Shift**

In order to facilitate health, elders and practitioners identified the necessity for a shift in how health is conceptualized and advocated. Elders and practitioners encouraged change on multiple levels: (1) the system built on time-based value (numbers of patients seen in a prescribed time period); (2) provider structure and hierarchy; (3) value placed on increasing division of the body to fit into specialty services; (4) failure of conventional providers to recognize the wisdom of patients and families; (5) and provider lack of self study.

Elders and practitioners pointed to the importance of relationships in promoting health. Building relationships takes time. An investment in time from the beginning is necessary to promote care of the whole person. Several elders commented on

the way in which taking time facilitates understanding a patient in context. For example, one elder commented: "Enough time must be given to relationship development and hearing the whole story of patients and families. We can't let what is deemed professionalism, keeping distance and working within scripted time frames, get in the way of humanity."

Practitioners in particular focused on the need to create broader frameworks in which alternative and complementary methods of care are positioned as having equal value for patients and families. Ascribing equal value included having third party payment structures in which patients and families would no longer have to pay out of pocket for visits to non-Western-based providers. To describe the need to remove the hierarchy that currently exists between Western and non-Western-based providers, one practitioner said:

*A true paradigm shift involves relinquishing the assumption that the Western biomedical model is the primary resource for patients and families. There needs to be a willingness to listen to the contributions made by alternate care contexts. Listening should be followed by interprofessional coordination and referral. Insurance companies must try to understand people will live better if covered to see natural doctors and medical doctors.*

Practitioners and elders stressed the importance of health care models getting back to addressing the wholeness of patients and creating a system that does not fragment care. In speaking to the importance of treating the whole individual, one practitioner noted:

*The system is about breaking things down into specialized parts for service delivery. It must come back to a place of wholeness and address peo-*

*ple from this perspective. It [the Western-based system] is made of fragmented care models. It must be created on the premise of seeing the person as a whole.*

In addressing the whole person, elders and practitioners requested that Western-based providers give recognition of the wisdom and value patients and families bring to each encounter from the start. Health was described as an innate quality, accessible by all. Providers must honor different ways of knowing. The knowledge held by patients and families must be respected and asked about during every visit. Health information is seen as reciprocal, as one elder stated:

*The current system dumps information on people; it does not support understanding the meaning behind behaviors for individuals, families, and communities. Providers are dumping information because it's a guideline; they are not discerning what needs to be said; they are not working to see what is meaningful for the patient.*

In response to the elder comment about dumping information, another elder stated:

*When instructing on food, think of the meaning behind the food. When people, a culture, have been consuming a food for years, how can you just come and expect the person to stop eating it? The doctor is insulting when he or she then comes back and asks—why are you not doing what I said?*

All participants agreed that Western-based providers should use the following question as a guide to facilitate meaningful dialogue when giving health information: How does this information resonate within you?

In order to care for patients and families, elders and practitioners stressed

the importance of the provider being in good health and a good state of mind. In order to be able to provide care, providers need to engage in self-care through self-study. Being connected to self helps in the identification and release of biases that can bring harm to patients and families. Several participants commented on the reciprocal benefit that comes from provider self-study. For example, one participant filling elder and practitioner roles commented, "Providers must be about or getting into their core. Meditative moments, which allow getting to the core, help the provider to protect self and the patient."

One elder commented on the importance of creating a space for provider self-study: "The system should build in a process for creating space for provider self-study."

### **Informing the Design of Health Delivery Models**

Elders identified a role for cultural ways of knowing and practitioners of healing ways to inform current health delivery models, in training and in clinical care contexts. Trainings may be directed at the level of leadership and administration, providers, and trainees. For administrators, trainings should focus on defining what it means when healing ways are a part of the health care model. One practitioner provided her vision for what this might look like:

*Here the priorities change for how to organize the therapeutic environment and to work with patients. Engagement becomes priority. Time is not the enemy. There is a shift away from worry about overtime. There is also a shift away from charting and documentation in the electronic health record as a primary focus [i.e., provider typing in the medical record in front of the patient, precipitating lack of eye contact].*

For current practitioners and trainees, elders re-emphasized the importance of creating a space for provider self-study. Elders and practitioners identified self-study as a means to foster a commitment to being present with patients and families and honoring their wisdom. One practitioner likened self-study to a vehicle for creating space for patients to share values and communicate cultural requisites for achieving health:

*Providers need to define well-being and healing in the context of relationships. They need skills for being present with patients, rather than just focusing on organs and symptoms, and for creating a space that allows for discussions about healing ways and cultural ways of knowing. Provider self-study is needed to help them reconnect with culture and community.*

Participants were quick to identify types of training that were deemed useless in creating a space to engage patients and families. The shortfall of cultural competency trainings was identified by multiple practitioners, as evidenced by the comments of one practitioner:

*Cultural competency training is not sufficient or even relevant for the process. The provider must honor different ways of knowing and recognize [they] are dealing with a whole person, one with a history, ways of being, ways of coping, spirituality, and environmental impacts.*

In addition to trainings, elders identified creating space for open dialogues as a means to inform Western-based health delivery models. Open dialogues were described as bringing practitioners from all fields of health to a common table for the purpose of facilitating on-the-ground discussions on how to create community care networks that would be prepared to work

with the conventional system, but also maintain their integrity by existing in parallel. As one elder noted:

*The goal is not to require giving up on what exists. The existing system describes one way of knowing. However, the goal is to create a space for new ways of knowing to exist. The two systems would work closely together so that patients and families don't fall through the cracks. The two systems could hold each other accountable.*

Open dialogues were also viewed as a place for consideration of an alternate context for measuring health, one that is culturally relevant and responsive. One practitioner commented on the importance of transforming benchmarks:

*Currently meaningful use benchmarks [e.g., body mass index measurement] are meaningless in the context of healing ways. The benchmarks have no relation to connecting to self-wisdom and facilitating health as freedom from fear and anxiety. We need benchmarks that provide a better sense of self in relation to the earth and our ancestors. These benchmarks may be in use alongside those originating from a Western framework.*

Elders and practitioners identified multiple ways to transform benchmarks as captured in one practitioner's reflections: "Evaluation could measure the presence of healing ways as part of treatment plans or measuring patient functional capacity by ability to connect with community. Evaluation could include measuring peace and joy in context, and the quality of provider-patient relationships."

## DISCUSSION

This research used focus groups and individual interviews to gain insights into cultural ways of knowing as a means to facilitate health. Cultural ways of knowing are intuitive and represent a framework in which the mind, body, and spirit are one. Cultural ways of knowing place physical health within a larger framework—the body as a metaphor for life. Illness is a manifestation of imbalance and disconnection from community. In the absence of grounding in culture and community (e.g., language, values, beliefs, and concepts that instruct perspective and behavior), conventional education, rooted in individualism and objectivity, may signal the loss of self and increased susceptibility to illness and disease.

Cultural ways of knowing have much to offer Western-based health delivery models to become more culturally relevant and responsive. They require evaluation of illness at multiple levels, including its source, the message that is sent and established, and therapeutic elements from the Earth, the Universe, and the Spirit. This knowledge framework presents elements that are critical to building a true foundation for health promotion in care contexts: being present with patients and families; creating space to honor patient and family values, knowledge, and wisdom; understanding the importance of the quality of the patient-provider relationship in providing a space for healing to take place; and recognizing community and community care networks as resources for achieving and maintaining health.

The road to creating a model of health care that is responsive to the needs of cultural communities does not have to position Western, conventional models and cultural ways of knowing as mutually exclusive; however, it does require thinking outside of pre-formed biomedical boxes. At

present, outside of language translation for health education brochures and the provision of interpreter services when needed, Western models of health care delivery do little to engage members of cultural communities when accessing health services. The models assume that when individuals access care, they must embrace fully Western explanations for disease and related treatment approaches. The models do not routinely ask patients and families about their ways of knowing, requisites for healing, illness perceptions, and goals for care. The hope is that this early work will contribute to the development of a larger project dedicated to the creation of culturally relevant health assessment tools and identification of ways in which diverse cultural constructs for health may be interwoven to create health delivery systems in which individuals, families, and providers are truly partners in maintaining and restoring health.

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Circle of Healing Citizen Health Action Team, composed of residents of South Minneapolis with the goal of maintaining and improving individual health, is part of an initiative of the Cultural Wellness Center and Allina Health's Backyard Initiative.

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