A summary report from *Speaking for Ourselves: A Study with Immigrant and Refugee Communities in the Twin Cities*

SPEAKING for OURSELVES

Perceptions of Health, Mental Health, and Health Care Access among Immigrants and Refugees in the Twin Cities

Minnesota is home to more than 400,000 immigrants and refugees. The majority live in the Twin Cities. *Speaking for Ourselves: A Study with Immigrant and Refugee Communities in the Twin Cities* looks at the experiences of Hmong, Karen, Latino, Liberian, and Somali immigrants and refugees living in Hennepin and Ramsey counties.

With the guidance of our advisory group (see a list on page 16), we interviewed 459 immigrants and adult children of immigrants about their lives – their families, education, jobs, health, and engagement in their communities to learn: What are the biggest needs of immigrant and refugee communities in the Twin Cities? What are the issues that are of greatest concerns? What assets are available to address them? For more information about the study methods and participants, see page 12.

This summary highlights what *Speaking for Ourselves* participants had to say about health, mental health, and health care access. It highlights common themes, and suggests potential strategies to support these communities. Other *Speaking for Ourselves* summary reports focus on civic participation and social engagement; education; employment; personal money management; transportation, housing, and safety perceptions; and the immigrant experience in the Twin Cities. All of these reports can be found at wilderresearch.org.

SEPTEMBER 2015

Wilder Research

Information. Insight. Impact.

Cultural communities at-a-glance

The Latino population makes up the largest foreign-born population in Minnesota. About 7 percent of people living in in the Twin Cities are Latino. The vast majority of these immigrants originate from Mexico, although Minnesota is also home to Latino immigrants from many other Central and South American countries. About 40 percent, or nearly 100,000, are foreign-born.

Hmong refugees began arriving in Minnesota in the 1970s and 1980s following the Vietnam War, with a smaller second wave arriving in the early 2000s as a result of the closing of a refugee camp in Thailand. The Twin Cities metropolitan area is now home to over 64,000 Hmong residents, making it one of the largest Hmong populations in the country. Karen refugees have recently begun to settle in Minnesota fleeing the violence of the Burmese civil war. At least 3,000 refugees have settled in the Twin Cities; 85 percent came to the U.S. within the last 10 years.

Somali and Liberian refugees came to the United States following civil wars in their countries. Somali refugees first started arriving in the U.S. in large numbers during the 1990s. An estimated 32,000 or more Somalis reside in Minnesota, which makes it the largest Somali community in the United States. Over 10,000 foreign-born Liberian refugees have settled in the Twin Cities. About 80 percent have arrived within the last 15 years.

What are some of the most important issues to remember when communicating the study results?

- Because each cultural community is unique, any and all comparisons made between or across communities should consider the unique historical, social, and economic contexts of these communities.
- Recognize the difference between perception data and incidence data. The *Speaking for Ourselves* study mainly focuses on perceptions of respondents from immigrant and refugee communities; this study does not provide representative incidence data.
- Because immigrant and refugee communities are smaller and close-knit (including, in some cases, the interviewers who worked on this study), and the questions may broach subjects that are sensitive, interpretation of findings must take social desirability bias into account.
- In order to ensure positive impact, data from *Speaking for Ourselves* should be used in conjunction with other data sources. Any policy or programming decisions should be made only in collaboration with affected immigrant and refugee communities.

Key findings

Study participants were slightly less likely than the overall population of Minnesota as well as Hennepin and Ramsey counties to rate their overall health as "good" or better.

Somali and Liberian respondents were more likely than respondents from other communities that participated in *Speaking for Ourselves* to rate their health as "very good" or better, whereas Karen respondents rated their health lower than respondents from other communities (Figure 1).

Within these immigrant and refugee communities, disparities exist across subgroups – females, older adults, and those with lower education report poorer overall health compared with males, younger adults, and those with higher education. These differences among subgroups within these communities mirror gender, age, and education disparities in the broader society.

1. How would you rate your overall health?

	N	Excellent	Very good	Good	Fair	Poor
All respondents	**459**	**21%**	**18%**	**34%**	**21%**	**6%**
Cultural community						
Hmong respondents	105	12%	19%	49%	17%	3%
Karen respondents	101	3%	6%	18%	59%	14%
Latino respondents	101	10%	28%	47%	7%	9%
Liberian respondents	60	27%	32%	40%	2%	0%
Somali respondents	69	71%	12%	15%	1%	1%
Gender						
Female	298	17%	16%	36%	24%	7%
Male	160	28%	22%	31%	16%	4%
Age						
18-49	360	23%	19%	33%	20%	5%
50+	95	13%	15%	40%	24%	8%
Education						
High school diploma or less	320	20%	12%	31%	28%	8%
Some college or more	137	23%	31%	41%	4%	1%
County						
Hennepin County	212	27%	24%	36%	10%	3%
Ramsey County	225	15%	13%	32%	33%	7%
U.S. adults (1)		19%	32%	31%	13%	5%
Minnesota adults (2)		22%	36%	29%	10%	3%
Hennepin County adults (3)		20%	44%	27%	8%	2%
Ramsey County adults (4)		19%	42%	28%	9%	2%

Sources: (1) Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System (BRFSS), 2013; (2) Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System (BRFSS) – Minnesota data, 2013; (3) Hennepin County SHAPE survey 2010; and (4) Metro Adult Health Survey 2010, Ramsey County data.

The biggest health-related concerns *Speaking for Ourselves* participants have for their community are diabetes, unhealthy eating, and lack of access to healthy food.

What are your biggest health-related concerns for your community?

"We eat too much unhealthy food like too much meat and not enough fruits and vegetables."
– Hmong respondent

"Abuse of alcohol causes unhealthy people."
– Hmong respondent

"Some people don't have health insurance."
– Karen respondent

"Cancer and diabetes – some people have these chronic diseases."
– Karen respondent

"Not eating healthy."
– Latino respondent

"Healthcare is a big problem in this country. They can't get health insurance because of their immigration status. Medication is too expensive."
– Latino respondent

"Diabetes, obesity -- half the people I know are diabetic."
– Liberian respondent

"High blood pressure due to too much tension on the mind."
– Liberian respondent

"Unhealthy ways of eating. We eat heavy breakfast: goat heart and kidneys."
– Somali respondent

"Smoking. Way too much tobacco – especially males."
– Somali respondent

When asked to name their biggest health concern **for their community**, participants most commonly said diabetes. **Lack of health insurance** and **unhealthy eating/lack of access to healthy food** were also commonly mentioned community health concerns for participants. However, the top health concerns of participants vary by cultural community:

- In addition to diabetes and healthy eating, Hmong participants were also concerned about alcoholism and alcohol abuse.
- Karen participants were concerned about various diseases and conditions, including cancer.
- In addition to diabetes, Latino participants were very concerned about people in their community not having health insurance, as well as the cost of health care and insurance, and some of these participants also commented specifically on their lack of access to health insurance due to their immigration status.
- Liberian participants were worried about high blood pressure and heart disease, and sexually transmitted diseases and AIDS.
- Somali participants were concerned about tobacco use in their community.

Participants were also asked to indicate how much of a problem each item on a list of health concerns is for their community. **Diabetes** was most frequently cited as a major problem, closely followed by **tobacco use** and **lack of exercise** (Figure 2).

2. Percentage of participants who rated these issues as a "major problem" for their community*

	All respondents (N=459)	Hmong (N=105)	Karen (N=101)	Latino (N=101)	Liberian (N=60)	Somali (N=69)
Diabetes	65%	91%	26%	80%	55%	64%
Tobacco use/smoking	61%	68%	51%	70%	45%	68%
Lack of physical exercise	61%	72%	37%	69%	62%	68%
Alcohol abuse	59%	83%	52%	68%	58%	22%
Obesity	51%	77%	17%	72%	42%	44%
Unhealthy eating habits	50%	70%	21%	55%	52%	54%
Illegal drug use	36%	40%	24%	55%	37%	22%
Prescription drug abuse	31%	41%	26%	37%	25%	28%
Lack of access to healthy food	30%	37%	20%	31%	32%	35%

** Respondents were asked if each item is "not a problem," a "minor problem," or a "major problem" for their community.*

Lack of health insurance, cost of health care, and cost of insurance are major barriers to participants in terms of accessing needed health care for their families.

Overall, 16 percent of respondents – including nearly half (45%) of Latino respondents – listed **lack of health insurance** as the biggest health-related concern for their community.

When asked if they or their family personally had **challenges accessing the care their family needed**, 15 percent reported yes, including 30 percent of Latino respondents. Those who said they had experienced challenges accessing health care were asked to explain why. Lack of health insurance was the most common reason given (40%), followed by challenges accessing or paying for health care (24%):

> "Some people aren't healthy and can't afford to pay for their health care." – *Karen respondent*
>
> "It's like a form of discrimination. I went to the hospital. They didn't accept me and referred me to a specialty private doctor, because I didn't have medical insurance." – *Latino respondent*
>
> "No insurance. People are afraid of huge bill payments and based upon income, some people are not sure." – *Liberian respondent*

In 2010, 10 percent of all Minnesotans under age 65 lacked health insurance, compared with 15 percent of residents who are Southeast Asian (U.S. born and foreign born), 29 percent who are Hispanic (U.S. born and foreign born), and 30 percent of foreign-born black residents, according to Minnesota Compass (mncompass.org).

The self-reported emotional health of respondents is good; however, much stigma around mental health problems exists in these communities, and many participants reported at least some symptoms of stress, depression, or other related issues.

Most participants rated their emotional health as "good" or better, although responses varied by community. Somali participants were most likely to rate their emotional health as "excellent," while Karen participants were most likely to report only "fair" emotional health (Figure 3).

It is important to note that this is participants' self-reported emotional health status. As far as we are aware, there are no data available about the actual incidence of mental illness by race/ethnicity or for the specific immigrant and refugee communities that participated in this study, in the Twin Cities or Minnesota as a whole.

3. How would you rate your emotional health?

	N	Excellent	Very good	Good	Fair	Poor
All respondents	458	23%	21%	30%	23%	3%
Hmong	104	12%	26%	43%	16%	3%
Karen	101	4%	8%	21%	63%	4%
Latino	101	24%	32%	32%	6%	7%
Liberian	60	30%	22%	37%	10%	2%
Somali	69	68%	15%	15%	3%	0%

Differences in stigma associated with mental illness may result in different responses to survey questions about mental illness across communities. Most *Speaking for Ourselves* participants said they would "definitely go" to see a professional if they had a serious emotional problem, except Somali participants who were more likely to say they would "probably go". Fourteen percent of study participants (and 20% of Latino participants) said they would probably not or definitely not get professional help if they had an emotional problem (Figure 4).

Twenty-two percent of *Speaking for Ourselves* participants said they would be "somewhat embarrassed" or "very embarrassed" if their friends knew they were getting professional help for an emotional problem. On the other hand, 69 percent said they would be "not at all embarrassed." Notably, only 28 percent of Somali participants would be "not at all embarrassed," whereas 48 percent would be "very embarrassed" or "somewhat embarrassed" (Figure 5).

4. People differ a lot in their feelings about professional help for emotional problems. If you had a serious emotional problem, would you…

	N	Definitely go for professional help	Probably go for professional help	Probably not go for professional help	Definitely not go for professional help
All respondents	449	59%	27%	6%	8%
Hmong	101	56%	30%	5%	9%
Karen	98	85%	6%	4%	5%
Latino	101	61%	19%	7%	13%
Liberian	60	57%	33%	5%	5%
Somali	66	32%	61%	3%	5%

5. If your friends and relatives knew you were getting professional help for an emotional problem, would you be…

	N	Very embarrassed	Somewhat embarrassed	Not very embarrassed	Not at all embarrassed
All respondents	449	5%	17%	9%	69%
Hmong	102	5%	19%	11%	66%
Karen	99	12%	10%	0%	78%
Latino	101	1%	13%	7%	79%
Liberian	58	2%	7%	2%	90%
Somali	65	6%	42%	25%	28%

Up to one-quarter of all study participants responded "not true" to nine statements that assess emotional health and social adjustment, such as: "I spend time doing things that are meaningful to me," "I feel like I belong in my community," and "I can count on someone to provide me with emotional support." Negative response to these items was especially prevalent among the Karen respondents, with over half of Karen respondents saying "not true" to three of these measures of positive emotional health and social adjustment.

When asked how often during the past two weeks they had little interest or pleasure in doing things (an indicator of clinical depression), 10 percent of respondents said they felt this way at least "several days." Similarly, 9 percent said they had felt down, depressed, or hopeless at least "several days" during the past two weeks. Somali respondents were the least likely to report these symptoms, and Hmong respondents were most likely to report them.

Issues to consider

These key findings should be placed within a wider context of knowledge surrounding current policies, programs, practices, and initiatives that serve immigrants and refugees in Minnesota. For example… When examining the findings of this *Speaking for Ourselves* report, it is important to recognize that immigrants typically have better health than expected, based on their socioeconomic standing in the U.S. and average health outcomes in their native countries. (Data are not available that disaggregates refugee communities from other immigrant communities.) However, evidence shows that immigrants' health declines as they spend more time in the U.S.[1]

Findings from the *Speaking for Ourselves* survey reflect the participants' perceptions of their community's health. Some data are available about incidence of health conditions by race/ethnicity through the Minnesota Department of Health, but data are not available by specific immigrant and refugee populations. For instance, Minnesota data indicate that the Latino (Hispanic) population is much more likely to be underinsured compared with other ethnic groups, and that Latinos (Hispanics) and Asian/Pacific Islanders have a lower incidence of cancer than whites in Minnesota.[2] It is important to note that data that is provided by race combines a variety of cultural communities; for example, it combines data about Southeast Asians with other Asian Americans, and combines African-born Somalis and Liberians (and other African immigrants/refugees) with African Americans. Disaggregated data is not available, as far as we know, for these communities in Minnesota. Data that aggregates distinct cultural communities that have vastly differing experiences, and data that does not separate refugees from other immigrant communities, may mask health concerns or issues within these specific cultural communities.

Differences in responses across communities who participated in the *Speaking for Ourselves* study could arise from a variety of experiences and/or attitudes. Any differences across communities on particular survey questions could be in response to actual differences in health issues and experiences across these communities. These differences could also be attributed to the community's length of time in Minnesota; communities that are newer to Minnesota, such as the Karen, may have less exposure to mainstream public health messages and health information, and are less likely to have information tailored/targeted to their specific community and presented in their own language. They may, therefore, be less concerned about these issues, but not necessarily because members of their community are not as likely to experience them. Finally, for a respondent who recently had a refugee experience, longer-term health issues like diabetes and healthy eating may be less salient. Their relative quality of life and satisfaction with their current living conditions compared with the situation they came from as refugees may be reflected in their responses to these questions.

---

1 Macmillan, R., Oakes, J. M., Duke, N., Fan, W., Luo, L., Nyseth, H., Vandormael, A. (2011, March-April). *Paradox regained: Immigrant health in 21st century United States*. Paper presented at the Population Association of America Annual Meeting, Washington, DC. Paper retrieved from http://paa2011.princeton.edu/abstracts/111852.

2 Minnesota Department of Health. (Spring, 2009). *Populations of Color in Minnesota: Health Status Report*. Retrieved from http://www.health.state.mn.us/divs/chs/POC/POCSpring2009.pdf.

Participants' responses could also be influenced by the cultural norms and expectations of the community to which they belong. Based on respondents' answers to questions about their mental and emotional health as well as their access to support, it appears that a substantial percentage of participants may be experiencing some symptoms of depression, stress, isolation, or other situations that can lead to mental illness than what is indicated by their self-reported overall emotional health. Further, the life experiences of many of these participants includes trauma and extreme poverty, which can cause and/or exacerbate mental health issues.

Differences in participants' rating of physical health issues could also be tied to the various communities' access to pathways to health, such as health insurance and healthy food options. Only about 60 percent of *Speaking for Ourselves* participants are employed (varying from 30-82% across cultural communities). And of these, about 60 percent said their job offers health insurance. Since employer-provided benefits are the primary route to health insurance for most Minnesotans, it is not a surprise that so many of these participants noted lack of insurance as a primary barrier to getting needed care given their employment status.

Access to healthy food options can be difficult to attain for members of these communities. "Food deserts"[3] are defined as geographic areas or neighborhoods where access to healthy food is limited. In 2006, nearly half of Minneapolis and one-third of Saint Paul was considered a food desert. Many Twin Cities suburbs offer 20 times the number of food stores per capita compared with their inner city counterparts. Access may not be as much of a concern for those with adequate transportation. However, a large portion of *Speaking for Ourselves* participants reported having at least occasional transportation problems (39%), and access to healthy food may be negatively impacted by this lack of transportation.

These are just a couple examples of how challenges in other "sectors" (employment and transportation) can affect the health of an individual, family, and community. The Minnesota Department of Health (MDH) has begun to acknowledge the importance of "Health in All Policies (HiAP)." HiAP emphasizes the need to collaborate across sectors to achieve common health goals.

[3] Knuth. S. (2010). *Irrigating Minnesota's Food Deserts. Retrieved from:* http://www.mn2020.org/issues-that-matter/economic-development/irrigating-minnesota-s-food-deserts

Ideas for actions

Possible policy solutions to address the primary health concerns for immigrant and refugee populations include a suggestion that the Minnesota Department of Health (MDH) consider dedicating Statewide Health Improvement Program (SHIP) funds to immigrant and refugee communities. SHIP grants are given by MDH to Community Health Boards/county public health agencies to facilitate policy, systems, and environment changes to address nutrition, physical activity, and reducing exposure to tobacco. These issues are all major concerns in these immigrant and refugee communities in the Twin Cities.

Advocates and policymakers should also continue to support legislative steps toward improving the health and mental health of immigrant and refugee populations, including those that were evident during the 2015 Minnesota Legislative session. The following legislation that passed in the 2015 Minnesota Legislature indicates progress in this direction:

- Expansion of the loan forgiveness program for mental health professionals and public health nurses working in underserved urban communities to address a workforce shortage.
- Funding for competitive grants for nonprofit organizations to provide resources and referrals for culturally specific mental health services to Southeast Asian veterans born before 1965 who do not qualify for services available to veterans formally discharged from the U.S. Armed Forces.
- A new law requiring that the commissioner of health stratify standardized measures to assess the quality of health care services, heart disease, depression, diabetes, and asthma by race, ethnicity, preferred language, and country of origin. The commissioner of human services is also required to develop a methodology to pay a higher rate to health care providers and services that take into consideration the higher cost, complexity, and resources needed to serve patients who experience the greatest health disparities, in order to achieve quality outcomes for all populations.

Although the implementation of the Affordable Care Act of 2010 appears to have helped Latinos access health care, the ACA explicitly excludes the estimated 12 million undocumented people in the U.S. As the Latino population continues to grow locally and nationally, health policy addressing the lack of access for this population should be a priority.

The Minnesota Department of Health has begun producing several Health Impact Assessments (HIA). HIA is a tool used to ensure health is considered in important decision-making in arenas outside of public health, such as in transportation, housing, and education. Health Impact Assessments that examine the impact on particular cultural communities, including immigrant and refugee communities are especially important to consider when discussing health-related policy and programming changes that may affect these populations. This is particularly relevant as it relates to public health messaging around nutrition, obesity, diabetes, and related health issues, as well as access to and utilization of mental health services.

Consider ways of promoting and supporting healthful behaviors in immigrant and refugee communities including using culturally-based and culturally acceptable forms of physical activity and healthy foods. Bringing activities and nutritious foods directly to these communities may be one of the best ways to improve access, since in many cases mobility and financial resources may be limited. Twin Cities Mobile Market is one example of a strategy Wilder Foundation uses to bring fresh, healthy food to local communities who may not have access to big supermarkets. This and other approaches need to pay particular attention to the types of food offered to ensure accessibility and appropriateness for various cultural communities.

Stigma associated with mental health issues was particularly salient within the Latino, Karen, and Somali communities that participated in *Speaking for Ourselves*, although all of the participating communities expressed some degree of stigma or embarrassment associated with mental illness. A 2009 Wilder Research report, *Stigma reduction: Promoting greater understanding of mental health*, highlights strategies used to reduce stigma around seeking treatment for mental health concerns. This could include things like using plain language and more acceptable terms when discussing mental illness, and addressing clinical issues in more holistic ways such as gardening and art. Programs developed to educate the public and promote a more accurate view of mental illness can also decrease stigma. Other stigma reduction strategies include facilitating contact with individuals who have or are experiencing mental illness, which can alter one's attitude toward mental illness. More research is needed to address the variability in beliefs, attitudes, and behaviors across cultural groups and to address the stigma specifically within these communities. Service providers, especially those who specifically target these cultural communities, should make efforts toward ensuring the confidentiality of patients, and communicating to patients how their confidentiality will be assured. For example, Wilder Foundation recently established the Social Healing Center as a resource for more culturally relevant mental health care for Southeast Asian communities.

In addition, mental health service providers and other entities that come into direct contact with immigrants and refugees should be prepared to observe indications of mental illness or emotional distress even if the individual is not outwardly discussing their symptoms or requesting assistance. Organizations should adopt a "trauma-informed approach" to serving immigrant and refugee communities, recognizing that many people within these communities have experienced significant trauma and that many community members may continue to struggle with isolation, stress, and symptoms of mental illness.

Finally, many immigrant families are of "mixed status," with members having different immigration and citizenship statuses. These families are able to apply for Medicaid and Children's Health Insurance Program (CHIP) and cover dependents without citizenship status. More education and outreach may be needed to get eligible families this coverage.

Study methods

A community advisory board made up of individuals who are members of and/or work with one or more of the participating communities provided guidance throughout this study. Wilder Research designed the survey instrument, developed and implemented the data collection approach, and conducted the analysis and reporting after gathering input from the advisory board and directly from the community.

An innovative data collection approach called Respondent Driven Sampling was used to identify and recruit eligible community members to participate in the study. This approach involves randomly selecting a handful of "seed" respondents within each community and asking those respondents to refer up to three additional people from their community. Those respondents are then asked to refer other respondents, ultimately creating respondent referral "chains" that in some cases carried out as far as 11 "waves" (Figure 6).

Adults who were born outside of the U.S., or had a parent who was born outside of the U.S., who were from one of the cultural communities included in the study, and who live in Hennepin or Ramsey counties were eligible to participate. Respondents who were referred to the study could **not** be a biological family member or live at the same address as the person who made the referral.

Speaking for Ourselves
Buy-A-Question Partners

The following partner organizations contributed to this study by funding one or more study questions and by committing to using the results to improve service access or delivery:

- Hennepin County Public Health
- Metropolitan Library Service Agency
- Minnesota Children's Museum
- Minnesota Historical Society
- Minnesota Humanities Center
- Minneapolis Institute of Arts
- Science Museum of Minnesota
- Family and Community Knowledge Systems Project, Wilder Research, and Training and Development, Inc., with funding from the Kellogg Foundation

6. Respondent Driven Sampling: Number of seeds, referrals, and waves in the referral chains

Total number of:	All respondents[a]	Hmong	Karen	Latino	Liberian	Somali
Seeds	52	11	7	11	3	9
Referrals	407	94	94	90	57	60
Maximum number of waves	--	11	7	8	9	6
Total number of respondents	459	105	101	101	60	69

[a] In addition to the five main cultural communities listed in the table, the "all respondents" group also includes 6 Lao, 7 Oromo, and 10 Vietnamese respondents. We did not obtain enough completed surveys from members of these cultural communities to be able to report data for these communities separately.

Wilder Research hired bilingual staff from participating communities to help with data collection; interviews were conducted in the respondents' preferred languages, either over the phone or in-person. Respondents received $20 for completing the survey and $5 for each referral they made, up to three.

By using Respondent Driven Sampling, we were able to survey a group of study participants who are more representative of these cultural communities in the Twin Cities than if we had used convenience sampling methods (i.e., survey people who are all affiliated with one program, religious organization, housing site, neighborhood group, etc.) However, study participants are **not** statistically representative of their broader cultural communities because scientific random sampling was not used, and the full Respondent Driven Sampling method for weighting and analyzing data was not appropriate given these data.

Therefore, the data presented here should be interpreted with caution; we do not claim that the results exactly mirror the overall experiences of the broader community. Rather, we suggest that in many cases the data produced by this study are better than any other existing source of data about these immigrant and refugee communities in the Twin Cities. The key findings included in this report have been endorsed strongly enough by a wide enough range of study participants and community stakeholders to be considered valid and actionable for all practical purposes.

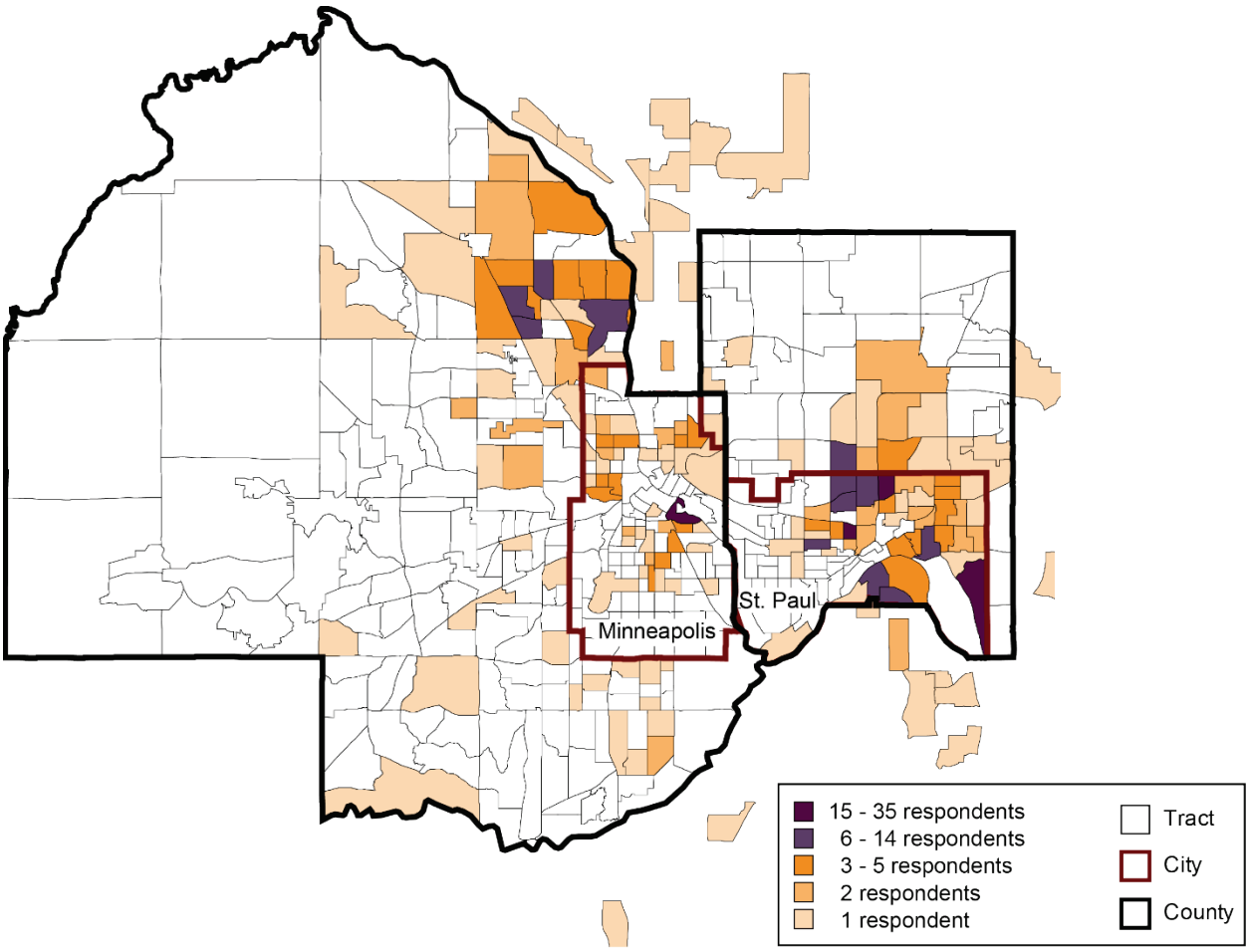
Differences among groups may be attributable to actual differences in their experiences, but may also be due to differences in survey responding patterns (e.g., some groups are more likely to give moderate responses, other groups are more likely to give extreme responses, regardless of the type of question). Therefore, as noted previously, comparison across communities should be done with caution and only with consideration of the unique contextual factors that influence these and any research findings.

See the detailed study methodology report and data book for more information about the study methods and limitations (*Speaking for Ourselves: A Study with Immigrant and Refugee Communities in the Twin Cities Data Book*).

Study participants

A total of 459 immigrant and refugee community members participated in the study. Participants' locations (home address) generally reflect the geographical spread of these cultural communities in Hennepin and Ramsey counties (Figure 7). A few respondents live outside of the target counties.

7. Participants' locations in Hennepin and Ramsey counties



Most participants were born outside of the U.S. They are split nearly evenly between Hennepin and Ramsey counties, although some specific cultural communities are concentrated in one county or the other. Two-thirds of respondents are female; they are split fairly evenly across the age spectrum from younger adults to older adults. Although participants fall into all education levels, most have a high school diploma or less. Similarly, although all income ranges are reflected, over half have household incomes below $30,000 annually (Figure 8).

8. Demographic characteristics of study participants

	All respondents (N=459)	Hmong (N=105)	Karen (N=101)	Latino (N=101)	Liberian (N=60)	Somali (N=69)
County of residence						
Hennepin	47%	40%	0%	58%	85%	57%
Ramsey	49%	51%	100%	40%	10%	35%
Other	4%	9%	0%	2%	5%	9%
Generational status						
1st generation – born outside the U.S.	95%	87%	100%	92%	98%	100%
2nd generation – born in U.S.	5%	13%	0%	8%	2%	0%
Gender						
Female	65%	61%	77%	81%	42%	55%
Male	35%	39%	23%	19%	58%	45%
Age						
18-29	25%	26%	24%	20%	37%	18%
30-49	54%	32%	68%	66%	48%	65%
50+ years	21%	42%	8%	14%	15%	18%
Education						
No formal education	17%	46%	21%	1%	0%	10%
Elementary/some high school (no diploma)	27%	21%	57%	30%	0%	33%
High school diploma or GED	27%	1%	20%	43%	17%	39%
Some college/Associate degree	21%	0%	2%	19%	62%	15%
Bachelor's degree or higher	9%	10%	0%	7%	22%	3%
Household income						
Under $10,000	17%	10%	26%	7%	7%	33%
$10,000 to under $20,000	16%	5%	24%	22%	12%	17%
$20,000 to under $30,000	22%	8%	31%	28%	24%	22%
$30,000 to under $50,000	23%	20%	12%	31%	34%	26%
$50,000 or more	9%	21%	1%	7%	9%	1%
Don't know or refused	13%	37%	6%	4%	15%	0%

Acknowledgements

Wilder Research would like to thank the study participants and their communities who entrusted us with their perspectives and shared with us their time. The participation of the *Speaking for Ourselves* advisory board members, our partners, and the community members through each phase of the project, made this study possible and made its findings more meaningful. We would also like to thank our Wilder Research and Wilder Foundation staff who contributed to the completion of this study.

Speaking for Ourselves Advisory Board

Sunny Chanthanouvong, Lao Assistance Center of Minnesota
Angelique Cooper-Liberty, Angel Eyes Foundation
Kim Dettmer, Lutheran Social Service of Minnesota
Hsajune Dyan, Saint Paul Public Schools
MayKao Fredericks, Wells Fargo Foundation
Michele Garnett McKenzie, The Advocates for Human Rights
Rodolfo Gutierrez, HACER
Roda Hassan, University of Minnesota Medical Center, Fairview
Thang Le, Vietnamese Science & Cultural Center-Minnesota
Kristine Martin, Amherst H. Wilder Foundation
MyLou Moua, Minneapolis Public Schools
Ahmed Muhumud, City of Minneapolis (former)
Mimi Oo, African & American Friendship Association for Cooperation and Development
Chanida Phaengdara Potter, The SEAD Project
Francisco Segovia, Pillsbury United Community – Waite House
Pablo Tapia, La Asamblea de Derechos Civiles
Danushka Wanduragala, ECHO
Pahoua Yang, Amherst H. Wilder Foundation
Tony Yang, Amherst H. Wilder Foundation (former)
Ladan Yusuf, CrossingBarriers

Wilder Research
Information. Insight. Impact.

451 Lexington Parkway North
Saint Paul, Minnesota 55104
651-280-2700
www.wilderresearch.org

AMHERST H WILDER FOUNDATION
ESTABLISHED 1906
Here for good.

For more information
For more information about this report or the *Speaking for Ourselves* study, contact Nicole MartinRogers at Wilder Research, 651-280-2682.
Authors: Nicole MartinRogers, Anna Bartholomay, and Denise Hanh Huynh

SEPTEMBER 2015