

**UTILIZATION AND ACCESS TO HEALTH CARE SERVICES AMONG AFRICAN  
IMMIGRANTS LIVING IN PITTSBURGH**

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Research indicates the health of many immigrant populations' deteriorates the longer they live in the U.S., leading to the "immigrant health advantage" phenomenon. Several studies suggest new immigrants tend to have healthier behaviors when they first arrive in America compared to U.S. natives. Immigrants tend to originate from cultures with patterns of lower stress levels and strong familial and societal networks that promote healthier lifestyles. Structural and systematic barriers to accessing and utilizing health care services could potentially explain the eventual decline in immigrant health. Immigrants lacking access to health care services are likelier to have poorer health outcomes. According to research studies, many African immigrants face barriers to accessing and utilizing health care due to limited English proficiency, lack of insurance, immigration status and overall lack of understanding of the complex American health care system. African immigrants have arguably been the most underserved communities within the United States despite being one of the fastest growing immigrant subgroups.

As economic pressures and political conflicts continue to influence increased African migration to the U.S., host communities must prepare to become one of the major destinations for African immigrants. Public health agencies, health care providers and community-based nonprofit organizations must understand the needs of these communities and address their health attitudes to better promote access and utilization of health care services. If the health care needs and practices of African immigrants remain poorly understood, they are at risk for worsening

health outcomes. The result would be increased burden on health care service providing agencies. This incomplete understanding warrants a further evaluation.

To answer this question, a congregation of African immigrants from the Pittsburgh Gospel Tabernacle Church served as a representative sample of immigrants accessing and utilizing health care services in Pittsburgh. The congregation was asked to participate in a voluntary survey. The survey questions were organized around 3 major themes 1) Perceived barriers to access of healthcare services; 2) Perceived quality of healthcare provided; 3) Previous access to healthcare services.

Results were not completely consistent with current literature but data did reveal patterns of barriers to accessing and utilizing health care among participants. The reasons for disparity in access to health care were mainly attributable to income, transportation and language barriers. Newly arriving immigrants face tremendous challenges and the lack of country-of-origin data on African immigrant populations provides an even further limited understanding of the barriers immigrants face in utilizing and accessing health care services. The African immigrant population's burden of disease can affect their social and economic capital, which determines their long-term success in acclimating in the U.S. This research intends to shed light on the possibility of interventions that can improve the health of African immigrants and increase their potential for upward mobility.

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## **PREFACE**

I would like to extend my sincerest gratitude to the people and organizations without whom this Bachelor of Philosophy thesis would not have been possible. The Pittsburgh Gospel Tabernacle Church congregation provided their precious time to participate in completing the survey, thank you to the church leaders who facilitated survey distribution and data collection. Without their willingness to share their personal experiences, this project would not have been possible. The thesis director for this project was Dr. Abimbola Fapohunda who was gracious enough to provide endless guidance and support. Her advice was critical in the development and progression of this study. To Dr. Macrina Lelei and Dr. Daniel Romesberg, thank you for your suggestions and feedback on drafts that led to the refined structure of this work. Thank you Dr. Richard Zoucha for sitting as an external committee advisor and providing constructive feedback and encouragement throughout the development of this project.

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## 1.0 INTRODUCTION

The American Community Survey (ACS) counted the 2008-2012 foreign-born population at 39.8 million, including 1.6 million from Africa or approximately 4 percent of the total foreign-born population.<sup>1</sup> In spite of the small number of African immigrants, their numbers are growing and have roughly doubled every decade since 1970 according to a new Pew Research Center analysis of Census Data. There were approximately 1.8 million African immigrants living in the U.S. in 2013, which was an increase from 881,000 in 2000 and a considerable increase from 1970, when the U.S. was home to only 80,000 African immigrants.<sup>1</sup> When African immigrants are compared to other major immigrant groups who settled in the U.S. in the past five years, Africans had the fastest increase at 41 percent from 2000 to 2013.<sup>1</sup>

Of the 1.6 million African immigrants in the U.S., 36 percent were from Western Africa, 29 percent were from Eastern Africa, 17 percent were from Northern Africa, 5 percent were from Southern Africa and 5 percent were from Central Africa.<sup>1</sup> When combined, New York, California, Texas and Maryland represent 36 percent or over one-third of the African-born immigrant population.<sup>1</sup> Pittsburgh, Pennsylvania represents less than 5 percent of the African-born immigrant population as a percentage of total foreign-born populations. As of 2014, roughly 5,000 African immigrants live in Allegheny County, which was a substantial increase from 2,000 in 2010 and a substantial increase from 200 in 1980.<sup>8</sup>

The number of African immigrants in the U.S. is projected to increase.<sup>3</sup> Outnumbered by their Caribbean counterparts, the population of immigrants from Africa grew by 92 percent between 2000 and 2009, while the Caribbean immigrant population grew by only 19 percent.<sup>5</sup> Flow of African immigrants to the U.S. continues to grow for a variety of reasons, including family reunification, increases in Diversity Visa Immigrant Programs, refugee movements caused by social and economic disruptions, and increasing numbers of highly-educated Africans seeking work visas.<sup>4</sup> If these trends continue, by 2020 Africa will replace the Caribbean as the major region of origin for U.S. black immigrant populations.<sup>5</sup>

Despite the growing interest in this diverse population, there is limited research that studies foreign-born black groups and African immigrants as a heterogeneous population. Existing literature and data recognize variation among subgroups of foreign-born black populations but tend to ignore country-of-origin data for African-born immigrants. Researchers have limited studies on the health care needs and practices of African immigrant populations with minimal attention to heterogeneity, which has led to an incomplete analysis of the factors influencing African immigrant health.<sup>6</sup> Research on foreign-born blacks and African immigrants primarily focuses on comparative studies between foreign-born blacks, African immigrants and black American populations.<sup>7</sup> Compared to other immigrant groups, communities in the U.S. lack federal health care data on African immigrants as existing information concerning their health care needs is embedded within data from black Americans. As the number and diversity of African immigrants increases, it is necessary to assess the populations' utilization and access to health care services.<sup>6</sup>

In this thesis, the utilization and access to health care services among African immigrants living in Pittsburgh will be examined to determine their perceived barriers to access of health

care services and quality of health care provided. A congregation of African immigrants from the Pittsburgh Gospel Tabernacle Church will serve as a representative sample of people who are utilizing health care services in Pittsburgh.

There is necessity for collection of country-of-origin data due to the limited information on African immigrants as a population and even less data differentiating between national and ethnic African subgroups. Existing articles on health care access among African immigrants in the U.S. and Pittsburgh indicate that research does not differentiate data by country-of-origin or ethnicity. As a result, a general study of African-born immigrants living in Pittsburgh is provided with exclusion of information on specific national and ethnic African subgroups.

Moreover, the terms African and African immigrant will be used to refer to African-born persons who have emigrated to the U.S. by way of visa or seeking asylum (refugees) from the African continent. The term foreign-born blacks will be used to describe persons of African ancestry who have national origins outside of the continent of Africa. The term black American will be used to refer to persons of African ancestry who were forcefully settled in the U.S. through the trans-Atlantic slave trade.

As economic pressures and political conflicts continue to influence increased African migration to the U.S., host communities must prepare to become one of the major destinations for African immigrants. Public and government health care providers, resettlement agencies, and community-based nonprofit organizations must understand the health care needs and practices of these communities. They must collectively work to address Africans' health attitudes to better promote access and utilization of medical care. If the health care needs and practices of African immigrants remain poorly understood, they are at risk for worsening health outcomes and more likely to rely on overburdened health care providing agencies.

## **2.0 LITERATURE REVIEW**

### **2.1 AFRICAN IMMIGRANT HISTORY AND PROFILE IN PITTSBURGH**

In April and May 2013, the Allegheny County Department of Human Services (DHS) conducted a review of local immigrant and refugee populations to explore the emerging human service needs as well as barriers to service access and utilization. U.S. Census and administrative data revealed that in 2011 Allegheny County was home to 1,223,525 residents, 57,175 of whom were foreign-born residents, totaling only 4.7 percent of the county's total population.<sup>8</sup> Data from the 2000 U.S. Census and the 2011 American Community Survey (ACS) revealed the composition of this group by region of origin. Compared to the national average of 12.8 percent, the proportion of foreign-born residents to the total population in Allegheny County remained at a low 4.7 percent in 2011.<sup>8</sup> In 2011, Allegheny County was home to 3,175 African immigrants, which was a substantial increase from 2,013 Africans in 2000. The increase in African immigrant residents in Allegheny County represents an upward trend that began in the 1990s, the first decade to experience an increase in foreign-born residents in the Pittsburgh region since the early 20<sup>th</sup> century.<sup>8</sup>

Despite the increase in foreign-born residents, Allegheny County continues to fall behind other regions that are comparable in industrial history and economy. Dauphin County in Harrisburg (5.8 percent) and Erie County in Buffalo (6.2 percent) have proportionately larger

foreign-born populations.<sup>8</sup> The larger proportion of foreign-born residents in comparable regions indicates an anticipated increase of foreign-born residents in Allegheny County, requiring a greater understanding of the needs of the population. Specifically, a greater focus on the needs of African immigrants living in Pittsburgh is required, as the population is largely excluded from research on issues of health care access and utilization confronting immigrants.<sup>9</sup>

Similar to other regions in the U.S., Allegheny County's foreign-born residents are becoming increasingly diverse in terms of language, culture and country-of-origin.<sup>8</sup> Among the African immigrants in Allegheny County who may need health care services are refugees who entered the U.S. through the U.S. Refugees Admissions Program. Located in various communities in Pittsburgh, refugees are resettled with the help of nonprofit agencies and generally become naturalized citizens. Facilitated by official refugee resettlement agencies from 2001 through 2013, the refugee placement for Pittsburgh (largely representative of Allegheny County) totaled 3,101 resettlements.<sup>8</sup> Based on country-of-origin data refugees were resettled from Northern Africa, Eastern Africa, Western Africa and Central Africa: Sudan (93), Burundi (70), Eritrea (14), Somalia ((263), Gambia (6), Liberia (75), Democratic Republic of the Congo (15).<sup>8</sup> Patterns of refugee resettlement in Pittsburgh suggest an increase of refugees from the Democratic Republic of the Congo.<sup>8</sup>

In addition to refugees, other immigrants settle in Allegheny County seeking economic opportunity, family reunification and other services.<sup>8</sup> Without existing official resettlement information for immigrants, however, these populations are more difficult to describe. Nevertheless, the Immigrants and Refugees in Allegheny County: Scan and Needs Assessment Report has made some basic observations.

Arriving in Allegheny County without resources or support can isolate immigrants from their larger host-community. A number of combined factors such as limited housing availability, lack of access to employment, public transportation, placements arranged by resettlement agencies and ineligibility for social services affect the residential location of immigrants.<sup>10</sup> As populations settle in distinct neighborhoods, they build networks of familiar social relationships thereby attracting newcomers through chain migration. The largest geographic concentration of foreign-born populations in Allegheny County is the Prospect Park apartment complex in Whitehall Place.<sup>8</sup> The Prospect Park Family Center estimates that approximately 65 to 75 percent of residents are foreign-born and represent 25 to 30 different countries of origin.<sup>8</sup> Large concentrations of Somali-Bantus have been reported in Lawrenceville and the Hill District. Sharpsburg and Highland Park have an emerging population of immigrant and refugees whereas the neighborhoods of Baldwin, Carrick, Mount Oliver and Castle Shannon have existing sizable immigrant and refugee populations.<sup>8</sup>

Service providing organizations in Allegheny County provide immigrants and refugees with tools to assist in integration as well as a place where individuals can meet and receive advice on adapting to American culture without forgoing their own traditions. Currently there are four resettlement agencies in Allegheny County: Jewish Family & Children's Services (JF&CS); Northern Area Multi-Service Center (NAMS); Acculturation for Justice, Access and Peace Outreach (AJAPO); and Catholic Charities. JF&CS and NAMS each resettle 200 refugees per year. Catholic Charities and AJAPO each resettle approximately 60 refugees per year.<sup>8</sup>

Other service providing agencies assist immigrants and refugees with case management support. Located within the Prospect Park housing development in Whitehall, the Prospect Park Family Support Center serves 75 families per year. Their services focus on



families with children ages zero to five. The Center provides home visits and child development screenings to ensure healthy development and appropriate health care for children. Weekly Family Group sessions provide guest speakers on issues related to health and safety to foster community development. FORGE (Facilitating Opportunities for Refugee Growth and Empowerment) and Keep It Real are student-led volunteer organizations that assist refugee families in acculturation and children's schoolwork. FORGE focuses on education and advocacy work while providing volunteer assistance in the home. Keep It Real works with Somali-Bantu refugees by providing in-home tutoring services for children. However, members have also provided translation services ranging from communicating with hospitals to explaining utility bills.

Immigrants and refugees receive health services from various health clinics, hospitals and private practitioners in Allegheny County. The Squirrel Hill Health Center (SHHC) provides primary and preventive health care and social services to immigrants and refugees. Their services include medical, dental and some behavioral health services with or without insurance. SHHC provided services to 3,683 patients in 2012, of which 42 percent were served in a language other than English.<sup>8</sup> Multilingual staff, on-site translators and contracted interpreters assist in meeting the needs of this population.

## **2.2 FUNCTION OF THE COMMUNITIES**

African immigrants emphasize communalism as an entity that represents the values of traditional African life.<sup>11</sup> Living together and the sense of brotherhood are the foundation of the

extended family system in Africa. Communalism guarantees individual responsibility within the communal relationship and provides access to extended social support and community networks.<sup>11</sup> The existence of a strong community among immigrants and its importance in fostering assimilation has long been recognized.<sup>13</sup> These communities function by assisting their newly immigrated members in acclimating to American society and easing the strains associated with immigration (e.g. adapting to culture, language and lifestyle). Community ties strengthen ethnic identity and provide assistance and support to ensure stable transitions.<sup>12</sup> Immigrant groups assimilate culturally but retain distinct social identities indicating the centrality of the immigrant community.<sup>13</sup> Integrating from a position of strength and sustaining traditional cultural frameworks reduces the danger of social disorganization.<sup>13</sup> The presence of traditional social networks provides psychological security, control and satisfaction necessary to interact with the larger society.<sup>13</sup>

Ethnic communities measure their success to the extent that they participate in the American economy and the subsequent increase in standard of living in their country-of-origin rather than their American living standard.<sup>11</sup> As a result they maintain justification for the long and often times arduous journeys they have endured. The sense of belonging and community kinship proves essential for healthy assimilation.

### **2.2.1 Function of Faith-Based Organizations**

African immigrants migrating to the United States bring their religious identities with them and often times their religion means more to them away from home.<sup>14</sup> Religious organizations are essential for creating a sense of community and hold a variety of positions in the community. With less extended family available, faith-based organizations function as a

source of social and spiritual support as well as economic assistance. Traditions of community service combined with cultural, spiritual and social comforts increases participation in faith-based organizations for newly arrived immigrants.<sup>15</sup> Immigrants engage with ethnic churches and temples to strengthen primary relationships among members who have familiar and meaningful spiritual needs. Traditional foods, customs, religious expectations and linguistic practices provide a comfortable code of conduct that reinforces cultural identity in the African diaspora.<sup>15</sup>

## **2.3 HEALTH STATUS OF AFRICAN IMMIGRANTS**

Although African immigrants arrive in the United States with unique health problems largely attributable to infectious diseases, literature indicates they are generally healthier than their native-born counterparts.<sup>6</sup> Among all immigrants life expectancy is between two and four years longer than persons born in the U.S. Foreign-born blacks have a seven to nine year longer life expectancy compared to U.S.-born blacks. Foreign-born blacks also experience lower mortality rates than black and white U.S.-born cohorts.<sup>6</sup> Among self-reported health statuses compared to white Americans, African immigrants reported better health, West Indian nations reported equal health and European nations reported poorer health.<sup>16</sup>

### **2.3.1 Better African Immigrant Health**

The better of health status of immigrant groups has been identified as an “immigrant health advantage” where immigrants experience healthier outcomes compared to their native-born counterparts.<sup>17</sup> The immigrant health advantage has been attributed to various factors,

including migrant selectivity, acculturation patterns and differences in behavioral patterns and access to health care. Evidence suggests that African immigrants are healthier than their U.S.-born counterparts but literature is limited to comparative studies between black foreign-born populations and African Americans or between African immigrants and African Americans.<sup>16</sup> African immigrants differ in their behavioral patterns and characteristics compared to foreign-born black populations from other regions as a result of migration flows, human capital and inherent racial and ethnic diversity.<sup>18</sup> As a result it is essential to consider their unique health outcomes with respect to country-of-origin data.

The immigrant health advantage is often explained by migrant selectivity whereby those who are chosen to migrate are selective in terms of the propensity to contribute to the U.S. economy and experience positive health outcomes.<sup>19</sup> For example, African immigrants are likelier to speak English compared to other immigrant groups, making them healthier.<sup>7</sup> Second, new immigrants are known to have healthier behaviors upon first arriving to the U.S. compared to U.S. born natives. Studies suggest that immigrants may have cultural and lifestyle differences as well as stronger familial ties that help overcome periods of stress and illness.<sup>20</sup> Third, African immigrant health advantages have been explained by specific lifestyle patterns in countries of origin, which may not exist in host countries due to systematic and structural barriers.<sup>6</sup>

## **2.4 BARRIERS TO HEALTH CARE ACCESS AND UTILIZATION**

Immigrants have been identified as vulnerable to inadequate health care due to systematic and structural barriers within the health care system.<sup>21</sup> Systematic causes of health care barriers have been attributed to patterns of behavior embedded in stereotypical attitudes about racial and

ethnic minorities.<sup>11</sup> During the clinical encounter, physicians are likelier to give more attention and adequate time to patients with whom they share commonalities such as racial background. Patients experienced enhanced quality of care with physicians with whom they shared cultural familiarity and racial background.<sup>22</sup> Racial and ethnic minorities typically receive lower quality of health care even when structural factors such as insurance coverage, status and income are controlled factors.<sup>22</sup> In urban settings health care providers are encountering increasing numbers of African immigrants and finding that there is a lack of awareness of cultural background and language.<sup>24</sup> Racial and ethnic minorities experienced poorer access to health care services and varying patterns of utilization in comparison to white Americans, including lesser use of preventive health care.<sup>23</sup>

Structural barriers to health care such as language, income, immigration status, insurance, and navigating the U.S. health care system can inhibit access to quality medical services.

#### **2.4.1 Language**

Although the population of African immigrants living in the U.S. continues to grow, few studies have examined the relationship between limited English proficiency (LEP) and utilization and access to health care services among African immigrants. In 2007, 28.8 percent of African immigrants indicated they speak English less than very well.<sup>25</sup> Limited English skills can have high-risk consequences and formidable barriers for medical encounters between patients and medical providers.

Adults with LEP are less likely to receive preventive health care and a consistent source of care compared to those who speak English fluently. LEP affects quality of care immigrants receive due to fewer physician visits, lower self-reported understanding of medical jargon and

decreased overall satisfaction.<sup>21</sup> Patient safety risks and adverse reactions to medications increase resulting from problems in understanding medical advice and instructions and misunderstandings in diagnosis, treatment and adherence to consultation. Studies reveal immigrants are less likely to seek health care services for themselves or their children if they are unsure their doctor will speak their language or provide interpretation services.<sup>28</sup> Interpretation can improve quality of health care outcomes, but professional interpreters are rare and expensive and most interpretation provided by family members or other patients proves suboptimal.<sup>24</sup> Written instructions in patients' native language can prove ineffective as some older and less formerly educated immigrants may have limited literacy in native languages.<sup>26</sup>

The U.S. Department of Health and Human Services Office of Minority Health established a federal policy requiring health care providers to ensure language assistance is provided for patients with limited English skills.<sup>28</sup> Patients still face insufficient language assistance and interpretation services remain uneven subsequently posing a challenge for patients and health care providers.<sup>26</sup>

#### **2.4.2 Cultural Beliefs**

There have been minimal studies concerning African immigrants and the use of traditional medicine and healing practices in the U.S., but published data indicates traditional medicine and healers maintain a prominent role in the lives of newly arrived African immigrants.<sup>6</sup> Traditional healing practices refer to African immigrants' use of traditional skills and knowledge embedded in African values, morals and beliefs to treat ill health and resolve conflict.<sup>30</sup> African traditional practices are embedded in material culture such as artifacts that Africans have given meaning to and nonmaterial culture such as rituals, beliefs, skills and

customs. Which of the two is used as a coping mechanism to overcome the strenuous process of resettlement is a personal preference.<sup>30</sup> However, it is important to emphasize that not all Africa immigrants utilize traditional medicine and healing practices and Africans who do utilize traditional practices rely on complex cultural diversity within the continent, which cannot be homogenized.

Scholars have tried to explain the changing perceptions about traditional medicine among Africans as they leave their country of origin. Some have argued that as African immigrants acculturate to Western traditions their views about the practice of traditional medicine become less prominent.<sup>27</sup> However, settlement and integration can pose a challenge for immigrants who have been born and raised in other parts of the world. Prevailing institutions such as industrialization and individualism in Western society significantly contrasts the traditional values and communal interaction in African societies.<sup>27</sup> Difficulties in cultural integration among immigrants with non-European backgrounds have been attributed to cultural differences between country of origin and host country. Evidence suggests that among some immigrants the longer they remain in host countries the more they rely on original cultural values. Moreover, individuals that do not fully acculturate to Western norms are likelier to utilize traditional medicine and healing.<sup>29</sup>

### **2.4.3 Stigma and Marginalization**

African immigrants and issues affecting their livelihood in the U.S. are often times overshadowed by the failures of race relations in America, including prejudices, fear and lack of knowledge.<sup>24</sup> Compared to other immigrant populations, African immigrants are likelier to suffer the same discriminatory treatment African Americans receive. This further stigmatizes

perceptions of Africans and their status as immigrants, marginalizing their health care outcomes.<sup>24</sup> Being associated with stigmatized groups can inhibit immigrants' willingness to seek health care for fear of poor treatment and inadequate resources to ensure quality care.<sup>26</sup>

Differences in cultural and traditional practices, appearance and language barriers exacerbate immigrant vulnerabilities. Adaptation can be inhibited by perceived discrimination or overt racial, religious and cultural discrimination.<sup>32</sup> Perceived discrimination impacts the mental health of refugees who are particularly from African countries.<sup>6</sup> Comparative studies between East Africans, West Africans and Eastern Europeans revealed that perceptions of discrimination are more likely to be self-reported among African immigrants.<sup>32</sup> Immigrants are more likely to report being discriminated against in a health care setting compared to U.S.-born populations.<sup>26</sup> Discrimination reinforces feelings of marginalization and can lead to decreased utilization of health care services.

#### **2.4.4 Insurance**

According to the Kaiser Commission's 2003 findings on Medicaid and the Uninsured, citizenship status is a strong determinant of insurance coverage. A third of immigrants are each categorized as naturalized citizens, legal permanent residents or undocumented immigrants. Approximately 45 percent of permanent resident immigrants living in the U.S. are uninsured whereas lack of coverage for naturalized citizens is comparable to U.S. born populations. However, 65 percent of undocumented immigrants are uninsured compared to only 32 percent of permanent residents.<sup>26</sup> Legal status can pose an obstacle for immigrants trying to access social services and job-based health benefits, leading to consistently lower rates of health care coverage compared to U.S. born populations.<sup>26</sup>



Educational background, occupation and earnings directly and indirectly impact immigrants' access to and utilization of health care. Despite strong educational attainment, African immigrants are likelier to work in jobs that do not provide health insurance.<sup>6</sup> Approximately 38 percent of Africans have a college level education, indicating a greater percentage than Caribbean blacks and African Americans.<sup>31</sup> Whereas 44 percent of African workers in Minnesota held jobs in unskilled labor or service jobs compared to 24 percent of the general workforce.<sup>6</sup> Literature suggests African immigrant men are less likely to seek medical care for health concerns compared to African Americans as a result of insurance status and differing cultural practices. Although African immigrants earn higher incomes compared to African Americans, they have greater financial burdens of sending remittances to their families in Africa. Lower rates of health insurance coverage may lead to greater dependence on Emergency Departments for health care services normally provided in clinical settings.<sup>6</sup>

### **3.0 METHODOLOGY**

A congregation of African immigrants from the Pittsburgh Gospel Tabernacle Church served as a representative sample of African immigrants accessing and utilizing health care services in Pittsburgh. Formally established in the West End of Pittsburgh in 2012, this faith-based organization served as a key link between research and communities of interest as African immigrants remain a growing but hard-to-reach population.

To become familiar with the congregation, church leaders facilitated introductions to individuals in the communities. The identified church leaders were a Zambian man and woman who had lived in Pittsburgh for more than ten years, serving as a support system for Pittsburgh's African immigrant community and senior pastor of Pittsburgh Gospel Tabernacle. Once leaders had been identified and permission had been granted to distribute surveys, a letter explaining the project and a request to complete the voluntary demographic questionnaire and health survey was sent to the congregation. The surveys were distributed and collected on a Sunday church service with the assistance of church leaders.

The survey questions were organized around 3 major themes 1) Perceived barriers to access of healthcare services; 2) Perceived quality of healthcare provided; 3) Previous access to healthcare services. Participants were offered the opportunity to share information not addressed by survey questions. Surveys were distributed and collected by the church pastor at the Pittsburgh Gospel Tabernacle between June and July 2015. The University of Pittsburgh

Institutional Review Board exempted this research study.

## 4.0 RESULTS

### **Participant Characteristics**

A total of 30 surveys were distributed with fourteen Zambian (4 male and 10 female), three Sudanese (1 male and 2 female), one Sierra Leonean (1 female), three Nigerian (3 female), one Liberian (1 male), three Kenyan (1 male and 2 female), one Gambian (1 male) and three Congolese (1 male and 2 female) respondents. Participants' age ranged from 19 to 56 years, while length of residence in the U.S. ranged from 2 months to 20 years. All participants received some type of education before or after emigrating to the U.S. and most participants were employed full-time or part-time. For example, one participant was an account executive, another participant was a trained social worker and two others were self-employed business owners (see Table 1).

### **Analysis**

Table 1 displays participant demographic characteristics and Figs. 1-15 summarizes participant responses. The tables and figures also illustrate country-of-origin data to examine the differences in African immigrant health care access and utilization rather than combining all foreign-born black populations into one survey. As shown in Figure 1, respondents were more likely to visit health clinics or doctor's offices less than 3 times in the past three months (70% more likely), whereas fewer participants utilized health care 3 to 6 times (30%). Most respondents cited annual check-ups followed by blood pressure issues as their reason for visiting

a health clinic. Participants were more likely to be referred to a health clinic or doctors office by a community organization or family/friend. Of the twelve individuals who responded to seeking health care services from other sites, five sought medical care from health centers and four utilized the emergency room.

Barriers to accessing medical care were most apparent in ability to pay and clinic hours. Despite most participants indicating full-time employment status, ability to pay was the most likely barrier preventing access to health care services (30% moderate barrier and 20% huge barrier). Participants viewed clinic hours as the second most likely barrier with 30% feeling clinic hours were a little to huge barrier. In Table 1 the five most common languages are represented amongst participants with English being the most spoken followed by Bemba and Nyanja. Language represented a little to huge barrier for 23% of participants.

Utilization of health care services measured on a scale of understanding the medical diagnosis, treatment plan, follow-up plan and medications provided at the health clinic or doctor's office was found to be excellent amongst most participants. Clarity of medicinal directions was least understood with 40% of respondents feeling good or less than good about their understanding. Follow-up plan (37% understood good or less than good) followed by treatment plan (37% understood good or less than good) produced difficulty in understanding. Despite excellent understanding of the information provided by health care professionals, most participants were only likely to follow medical advice provided (23% very likely, 53% likely and 17% somewhat likely). In a similar pattern, respondents felt the health clinic or doctor's office served their health care needs very well followed by good (20% excellent, 50% very good and 23% good).

## 5.0 DISCUSSION

Studies suggest the reasons for disparity in access to and utilization of health care among Africans may be attributable to systematic and structural barriers such as English language proficiency, cultural and traditional beliefs, lack of insurance coverage and stigmatization and marginalization in the health care system. It is understood that issues of health care disparity that inhibit access and utilization are complex and involve a number of factors. Despite obtaining high levels of education, data reveals African immigrants are more likely to work for employers that do not provide employee-sponsored insurance, creating a dependency on emergency room services. Language barriers are key determinants as African immigrants who emigrate from non-English speaking countries are less likely to work for employers who provide health benefits.<sup>6</sup> Lack of English language proficiency can have high-risk consequences for medical encounters between patients and physicians. Mistrust in the U.S. health care system as a result of discrimination, prejudiced attitudes and lack of access to language interpreters can lead to low quality care and discourage access and utilization. Greater reliance on traditional medical practices and cultural beliefs can reduce likelihood of seeking a regular source of health care.

Surveys revealed that barriers to access and utilization of health care services among African immigrants living in Pittsburgh were not entirely consistent with current literature but did reveal similar patterns as discussed in the literature. As shown in Table 1, respondents were more likely to visit health clinics or doctor's offices fewer than 3 times and less likely to seek

health care 3 to 6 times in the past three months. Less frequent visits could be attributed to high costs of health care and lack of access to health insurance coverage, which are two important challenges that confront African immigrants. Despite most participants indicating full-time employment status, ability to pay was the most likely barrier preventing access to health care. All participants received some type of education before or after emigrating to the U.S. and most were employed full-time or part-time with some participants indicating a status of self-employed business owners. However, data reveals that health insurance coverage is less common amongst even highly educated African immigrants as a result of working for employers who do not provide health insurance. Affording and maintaining health insurance coverage without subsidization from employers can be challenging for self-employed business owners.

Utilization of health care services at the health clinic or doctor's office was found to be excellent amongst most participants. Clarity of medicinal directions was least understood followed by follow-up plan and treatment plan. Despite most participants indicating excellent understanding of the information provided by health care professionals, most participants were only likely to follow medical advice provided. Lack of clarity in understanding health care services has been linked to language barriers and difficulty in overcoming cultural barriers between patient and physician. Limited English proficiency affects quality of care immigrants receive due to lower self-reported understanding of medical jargon and decreased overall satisfaction.<sup>26</sup> Immigrants are more likely to report being discriminated against, which reinforces feelings of marginalization and reduces likelihood of receiving preventive health care and a consistent source of medical access. Barriers to accessing and utilizing health care services was reflected in respondents overall satisfaction with the health clinics and doctor's offices serving their health care needs as very well followed by good.





## **6.0 LIMITATIONS AND CHALLENGES**

Due to the sampling approach, it is necessary to recognize that the perceptions of 30 African immigrant respondents do not represent the entire African community in Pittsburgh. The sample was collected in a non-random sampling pattern based on existing social networks and facilitation by community leaders. All subgroups of national and ethnic African communities were not represented by the sample, but there was substantial diversity amongst respondents and their country-of-origin data. Despite the consistency of participant responses on a number of issues, this study offers broad cultural generalizations as a result of the small sample size and lack of specific data along national and ethnic communities.

It has been well recorded that African immigrants are a hard-to-reach population despite the substantial increase in number of African immigrants and refugees. Collecting data from the congregation at the Pittsburgh Gospel Tabernacle Church proved difficult and required modification of the initial approach. The first strategy of distributing surveys at a church service and collecting completed surveys the following week resulted in low numbers of completed surveys. As a result, surveys were distributed and collected on one Sunday church service by church leaders. Furthermore, there is limited literature that studies foreign-born black groups and African immigrants as heterogeneous populations. Although existing literature recognizes variations among subgroups of foreign-born black populations, researchers ignore country-of-origin data for African-born immigrants. Exclusion of country-of-origin has significant

implications for understanding health care needs, practices and outcomes as each African nation ascribes to varying cultural beliefs, languages, education attainment and patterns of emigration.

## **7.0 POSSIBLE INTERVENTIONS**

Barriers to accessing and utilizing health care services must be put into context of issues facing African immigrants as they assimilate into their host communities. Developing appropriate data collection tools for African immigrants can help determine their health care needs. The limited information that is available excludes country-of-origin data and often times African immigrant data is embedded within the larger population of black Americans. In general, further research is necessary to determine how to understand the health care needs of subgroups within Africa as the African continent is complex and cannot be studied as a single unit. Using credible community-based organizations, faith-based institutions and community leaders to collect data on African immigrants can improve interpretation and collection of information.

Mandating regular training of health care professionals in immigrant health attitudes, beliefs and practices increases cultural competence of staff and improves health outcomes for immigrant populations. Designing and implementing a community-led health care advocacy group can increase awareness of health issues in a culturally acceptable manner and encourage health education in African languages. Community-led initiatives can promulgate knowledge of health care agencies and service organizations where questions can be answered. Increasing access to English training programs can improve language proficiency and reduce feelings of alienation. Confidence in English speaking skills can improve understanding of medical jargon between physicians and patients thereby increasing positive health outcomes.

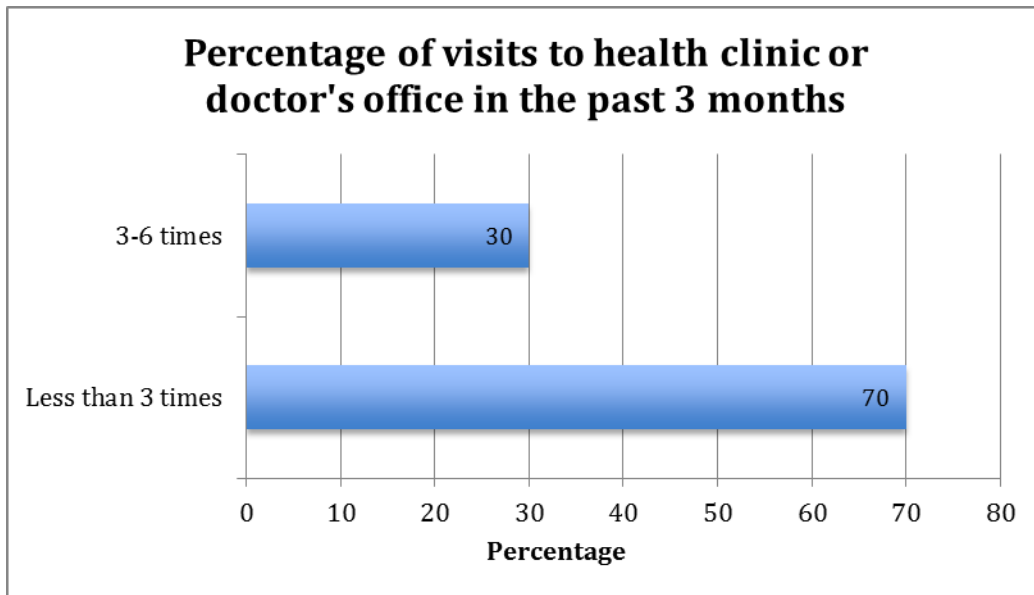
Conducting focus group interviews with the church members can provide more insight into the specific health care needs of congregation members. It can also serve as a mechanism to follow-up with participants to obtain detailed answers regarding survey questions.

## 8.0 APPENDIX: FIGURES AND TABLES

**Table 1:** Participant Demographics and Characteristics

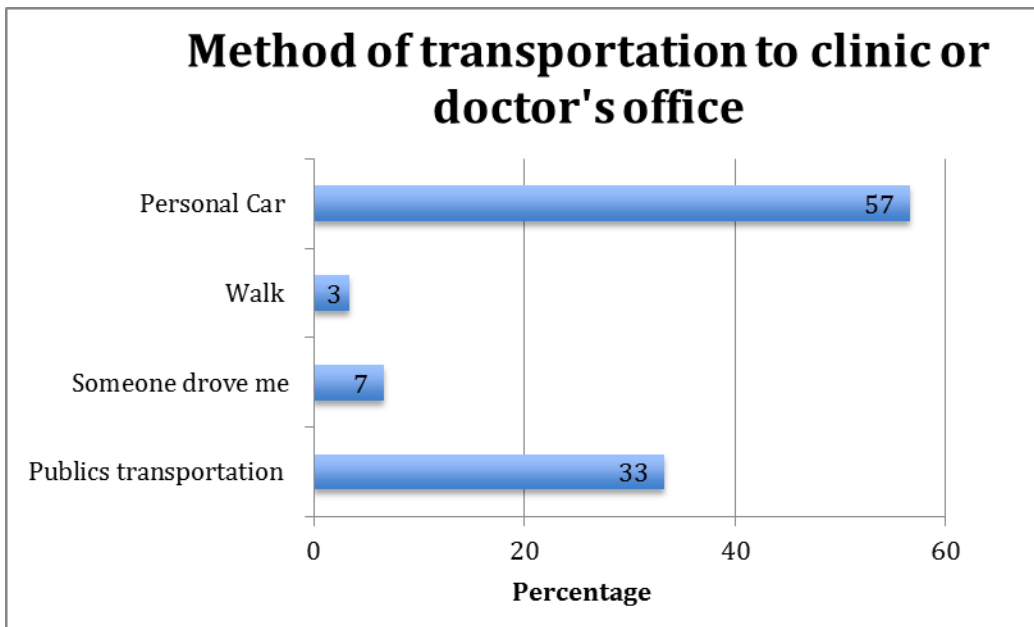
Characteristics	N (%)
Gender	
Female	20 (0.67)
Male	10 (0.33)
Marital Status	
Single	6 (0.2)
Married	22 (0.73)
Divorced	1 (0.03)
Unknown	1 (0.03)
Country of Origin	
Democratic Republic of Congo	4 (0.13)
Gambia	1 (0.03)
Kenya	3 (0.1)
Liberia	1 (0.03)
Nigeria	3 (0.1)
Sierra Leone	1(0.03)
Sudan	3 (0.1)
Zambia	14 (0.46)
Highest Education Level	
Less than High School	5 (0.16)
High School/GED	8 (0.26)
Some College	2 (0.06)
College	12 (0.4)
Post College	3 (0.1)
Employment Status	
Full Time	17 (0.56)
Part-Time	2 (0.06)
Unemployed	8 (0.26)
Student	1 (0.03)
Other	2 (0.06)
Languages Spoken Fluently	
Bemba	7 (0.23)
English	23 (0.76)
French	5 (0.16)
Nyanja	6 (0.2)
Lingala	5 (0.16)
Other	8 (0.26)

**Figure 1:** Percentage of visits to health clinic or doctor's office in past 3 months.



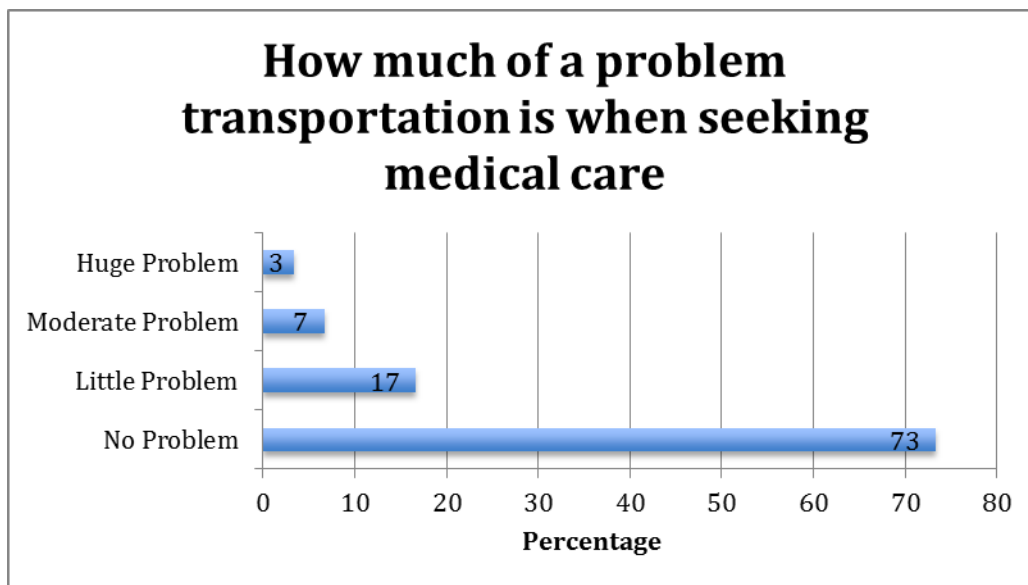
N=30

**Figure 2:** Method of transportation to clinic or doctor's office.



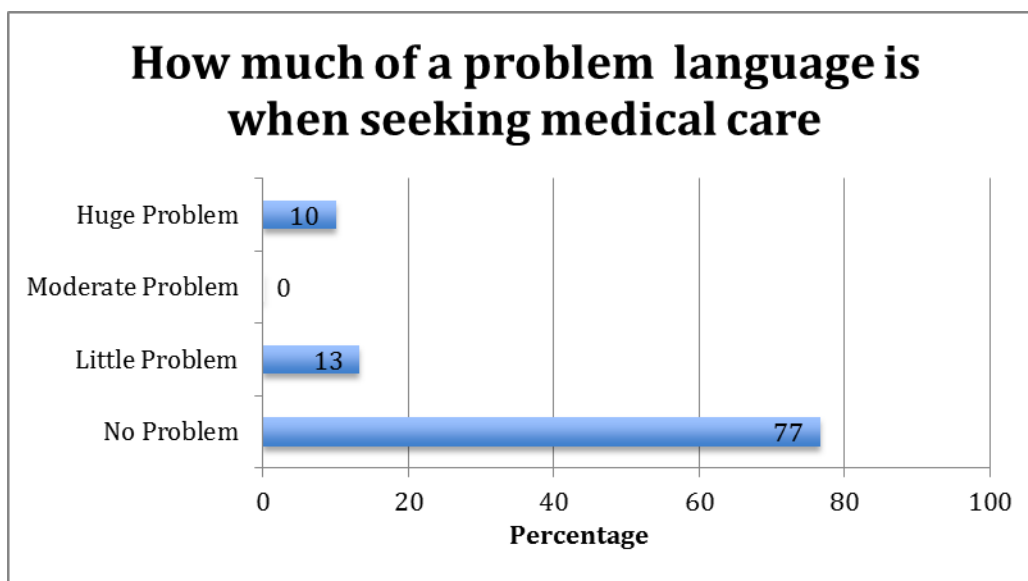
N=30

**Figure 3:** How much of a problem transportation is when seeking medical care.



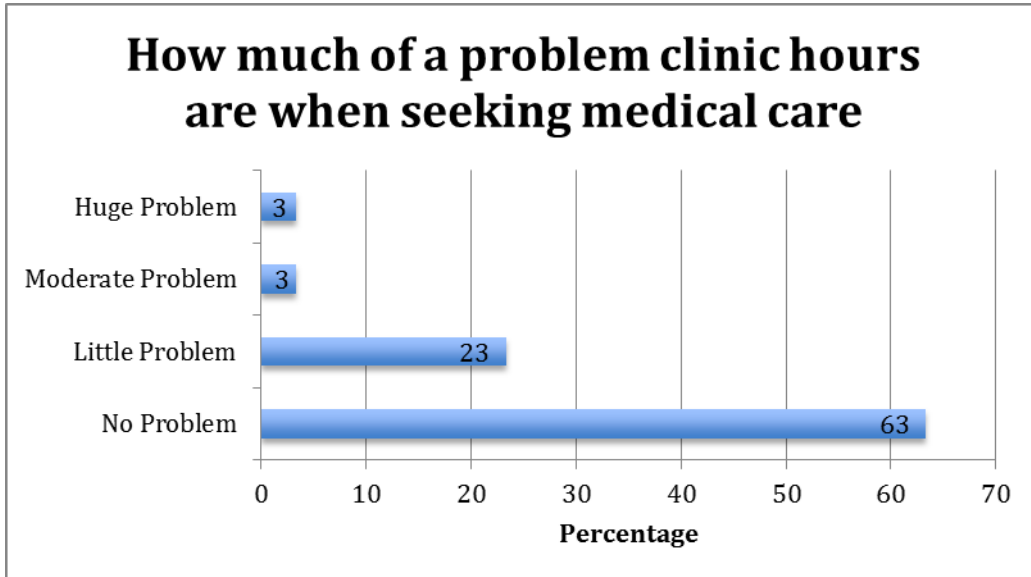
N=30

**Figure 4:** How much of a problem language is when seeking medical care.



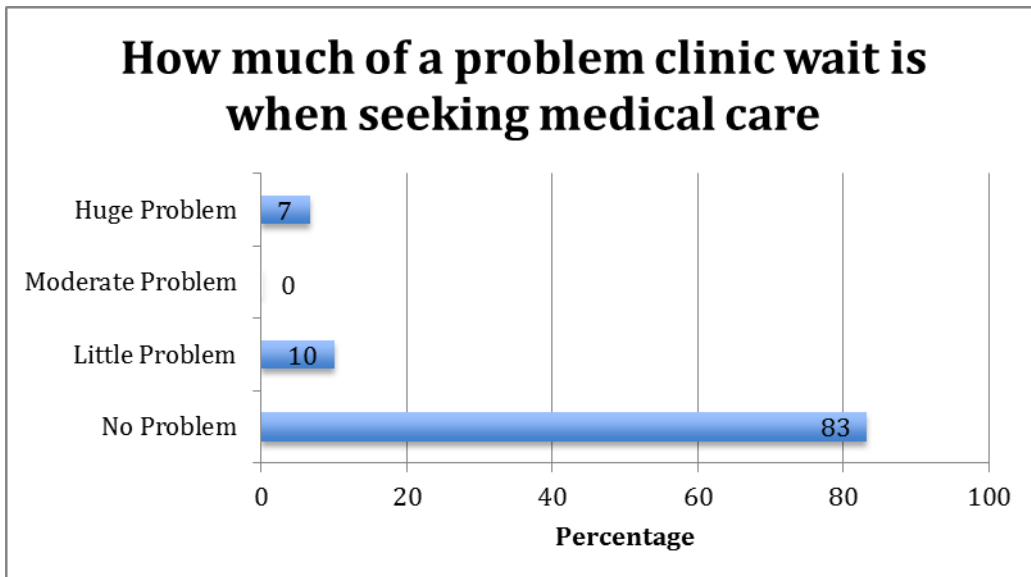
N=30

**Figure 5:** How much of a problem clinic hours are when seeking medical care.



N=30

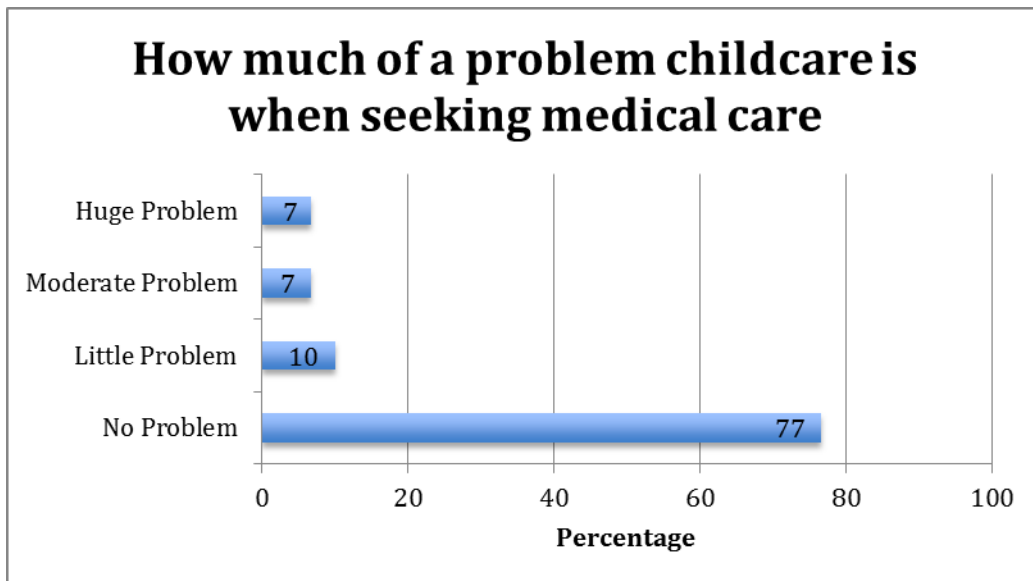
**Figure 6:** How much of a problem clinic wait is when seeking medical care.



N=30

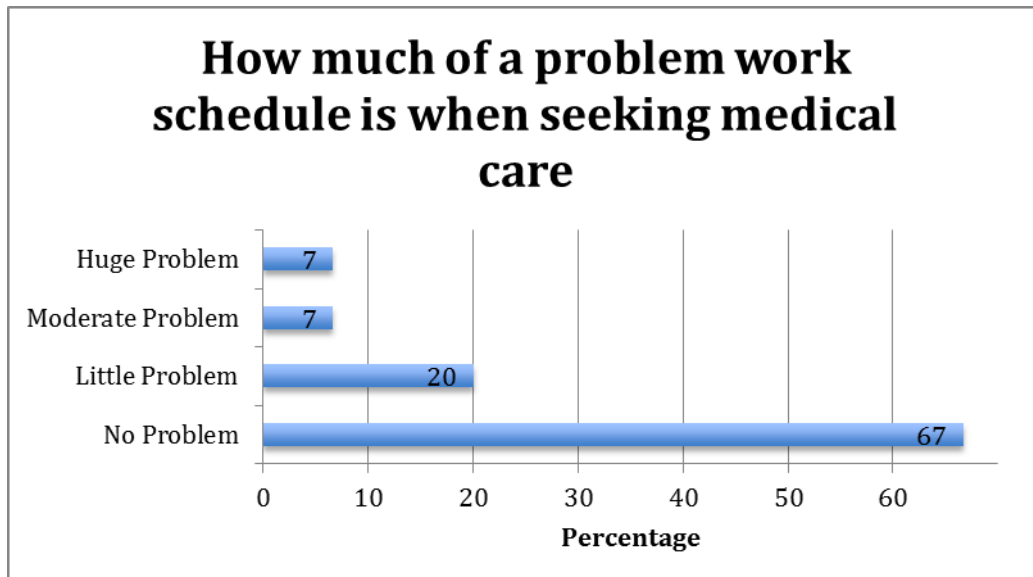


**Figure 7:** How much of a problem childcare is when seeking medical care.



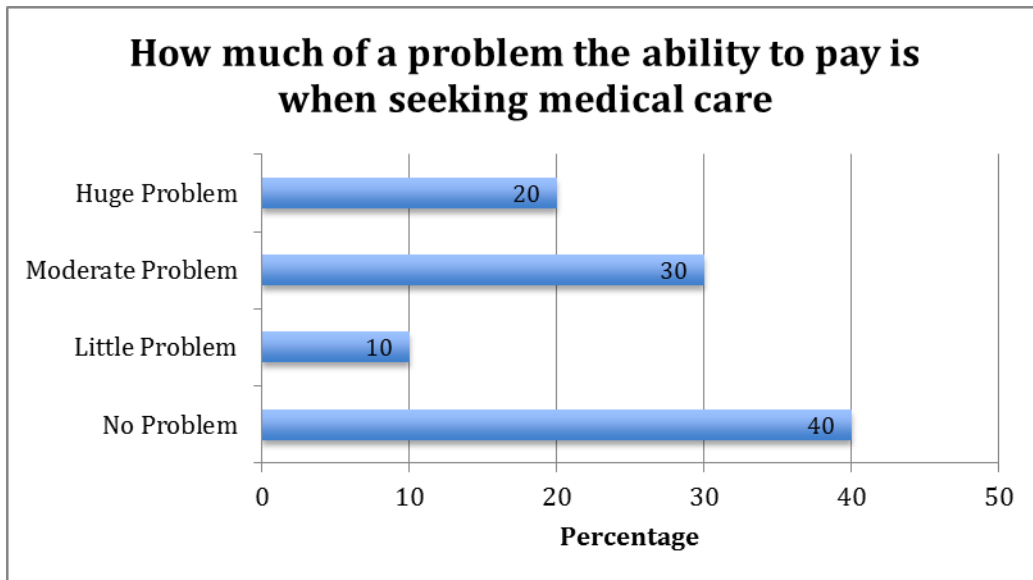
N=30

**Figure 8:** How much of a problem work schedule is when seeking medical care.



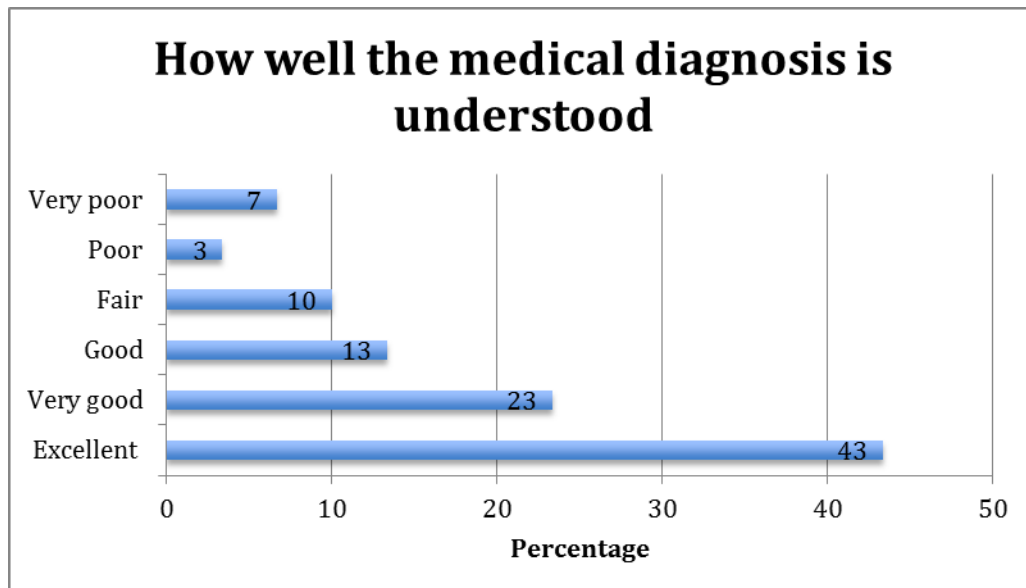
N=30

**Figure 9:** How much of a problem ability to pay is when seeking medical care.



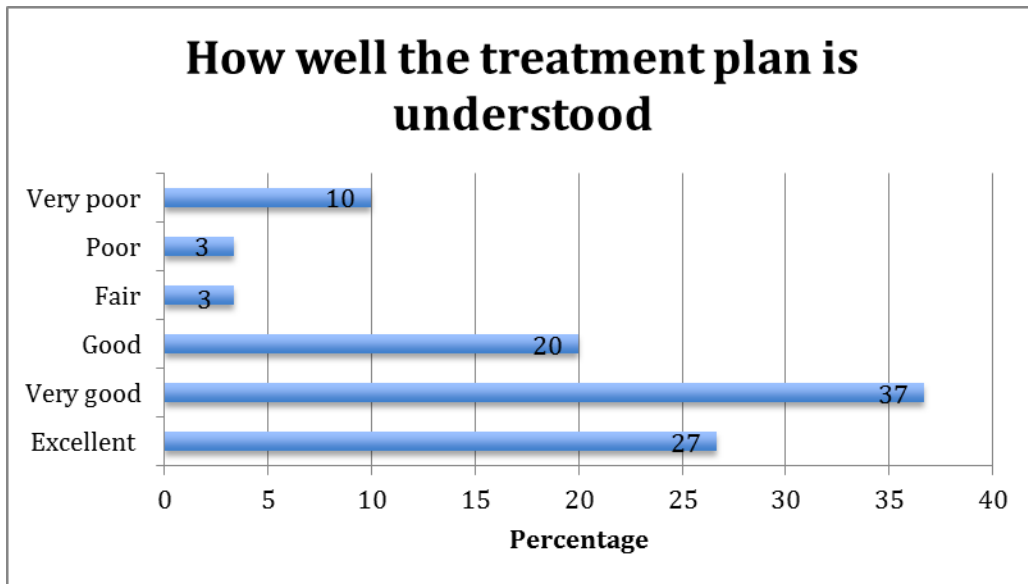
N=30

**Figure 10:** How well the medical diagnosis is understood.



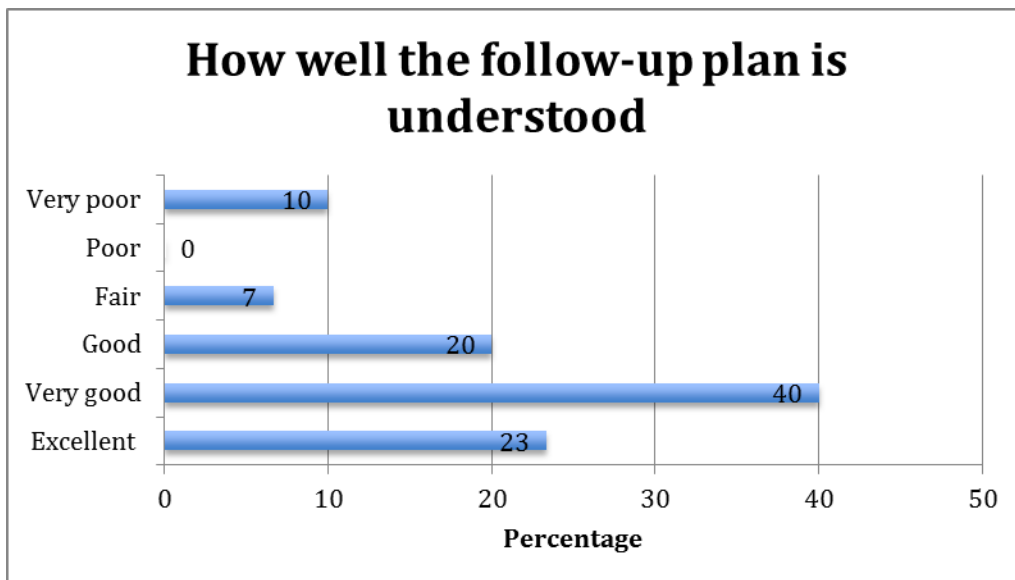
N=30

**Figure 11:** How well the treatment plan is understood.



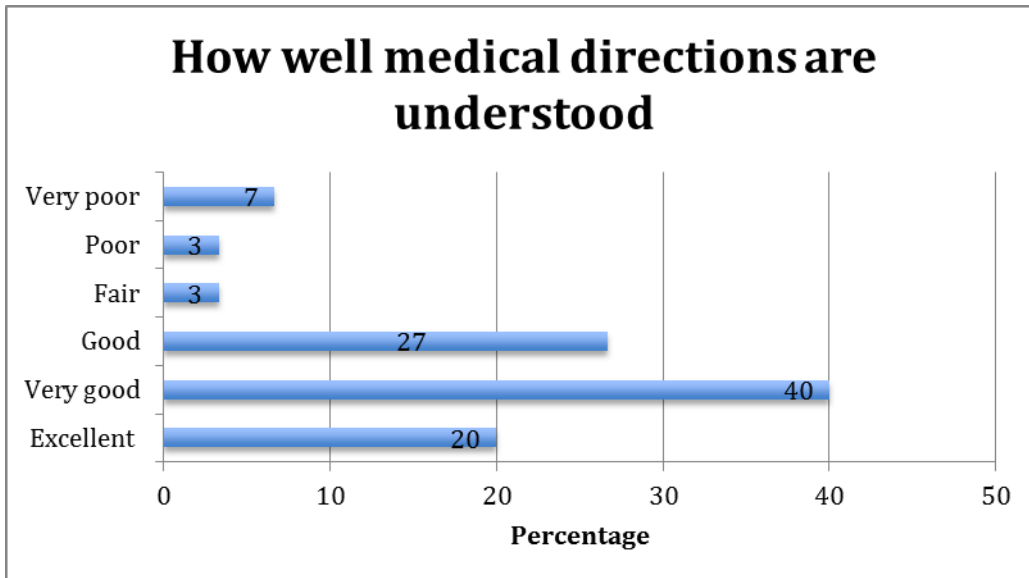
N=30

**Figure 12:** How well the follow-up plan is understood.



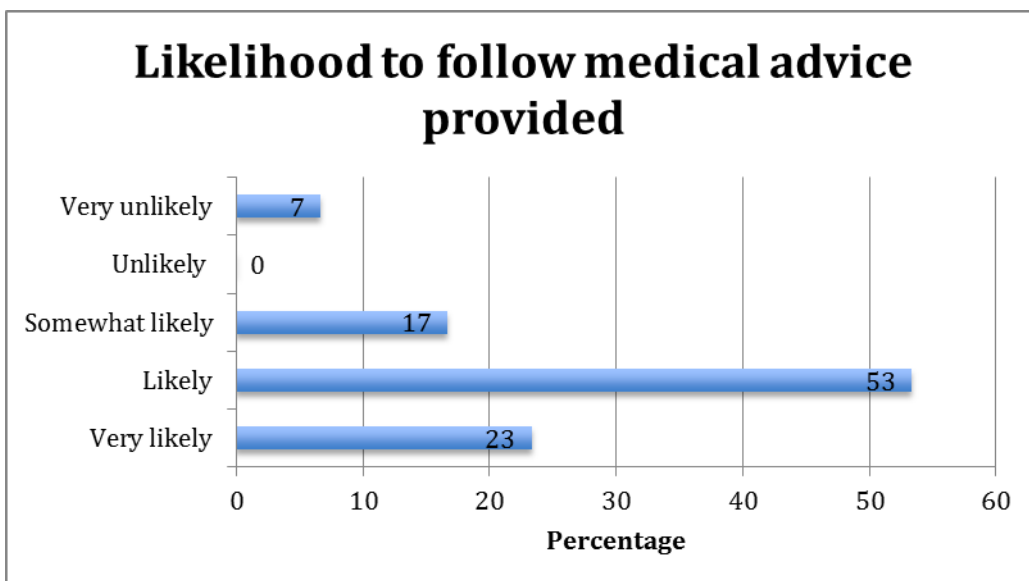
N=30

**Figure 13:** How well medical directions are understood.



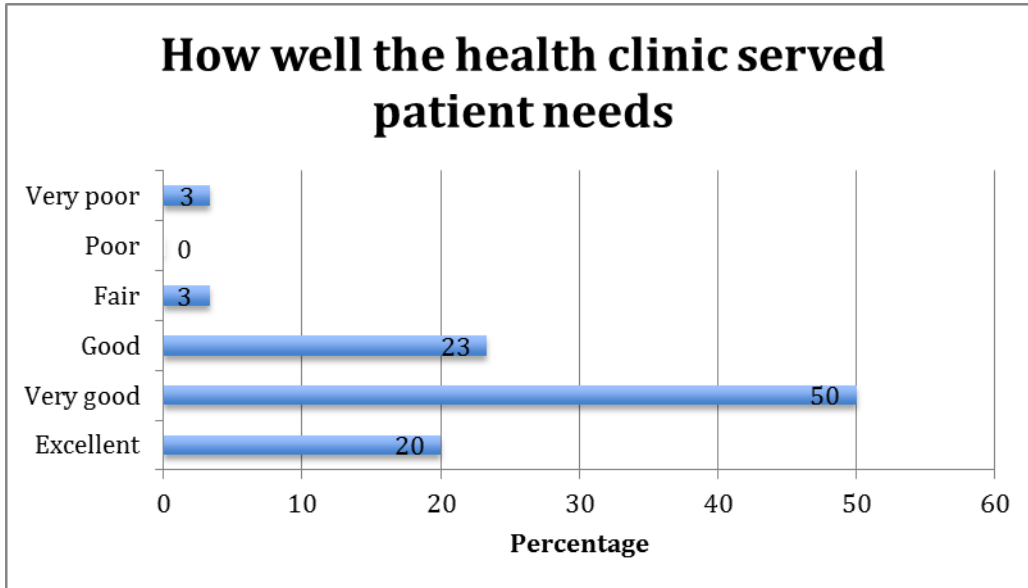
N=30

**Figure 14:** Likelihood to follow medical advice provided.



N=30

**Figure 15:** How well the health clinic or doctor's office served patient needs.



N=30

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## **APPENDIX A**