COMPARING HEALTH INSURANCE STATUS OF CONGOLESE AND AFRICAN AMERICAN COMMUNITIES OF STONE CREEK CHURCH IN CHAMPAIGN-URBANA

BY

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THESIS

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ABSTRACT

When it comes to health insurance status in the U.S, minorities represent the largest uninsured group due to various factors such as unemployment status, lack of education, and poverty. The last recession has worsened the situation by increasing the number of uninsured across the country (KFF, 2012). Black communities of Champaign County in Illinois are not exempt from this alarming situation.

The purpose of this study is to compare the health insurance status of two different minority communities in the Champaign area. The research questions associated with this inquiry are twofold. The first question is: Is there a difference in health insurance status between Congolese and African Americans attending the same church in Urbana, Illinois? This question will examine the trends of health insurance status between these groups. The second question is: Are there barriers associated with the coverage of health insurance among these minority groups? A questionnaire was randomly distributed to participants after church services to ensure that they reported their health insurance status. A sample size of 109 people was obtained (55 Congolese with 30 males or 54.55% and 25 females or 45.5% participated in the study, 54 African Americans with 24 males or 44.4% and 30 females or 55.6% participated in the study).

The results of this study show that income variable is statistically significant to distinguish between having health insurance and not having health insurance for both African American and Congolese communities attending a local church in the Champaign area. For Congolese, the length of stay in the U.S. is statistically significant to distinguish between having health insurance and not having one. English proficiency, high premiums, and the lack of knowledge of health care system were identified as barriers to health care access among Congolese and African Americans.

To my parents: Sylvain M. Ilunga and Albertine M. Tshama

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CHAPTER 1

INTRODUCTION

1.1 PROBLEMS OF MINORITIES AND HEALTH INSURANCE IN THE U.S.

The distribution of health care has been hit by the economic crisis of 2008 in such a way that the number of uninsured increased due to factors such as unemployment, lack of education, and poverty. During that recession, people lost their jobs and health insurance, as well. Consequently, the number of unemployed and uninsured increased. In 2010, the number of people with no health insurance across the U.S. was estimated at 49,903,900 uninsured or 16% of the total population. Yet, in 2008, this number was approximately 47,000,000 uninsured across the country (Illinois Health Insurance Status, 2010). That is, two years later, that number increased by about 2,000,000 and minority groups continue to suffer from this. Thus, lack of health insurance is a growing concern in the U.S health care system, which must be addressed.

The Congolese population's knowledge and use of the American medical insurance system could be delineated by English proficiency. It would help Congolese to better communicate and understand the American health care culture which may be a new concept to them. However, the Congolese health care system has some flaws that make it inefficient and unsystematic, since this is one of the most corrupt countries in Africa (Kodi, 2007). Thus, the Congolese exposure to a well-organized health care system is perplexing. That is, the Congolese will be more likely to have challenges in understanding the U.S. health care system. In 1990s, the D.R. Congo became one of the worst places to live in Africa because of the mismanagement of the political system (Kodi, 2007). In 2009, the Congolese total expenditure of health per capita was $7, compared to $862 per capita in South Africa, $68 per capita in Kenya, $49 per capita in Burundi, $4,237 per capita in Belgium, and $7,410 per capita in the U.S. (WHO, 2011). The low

total expenditure of health per person identifies that the D.R. Congo has serious issues associated with management. However, in terms of natural resources, the D.R. Congo is one of the richest countries worldwide. The Congolese soil has copper, diamond, uranium, zinc, cobalt, and gold. This list is not exhaustive. The majority of Congolese land is cultivable naturally. The fauna and flora are diverse and have particular animal species such as okapi (a zebra-and-giraffe-look-like) and bonobo (a great apes that can stand upright like humans), which are found only in the D.R. Congo (Hart, 2007). Besides these tremendous natural resources, the D.R. Congo is one of the worst places to live with no exposure to a well-established health care system. With all of this, Congolese will be more likely to leave their country.

Similar to the Congolese, African Americans are one of the minority groups living in the U.S (CIA, 2011). However, compared to Congolese, African-Americans have a better socio-economic status. They are exposed to a well-established health care system with a defined role of government funded programs or health insurance firms. However, there are issues such as lack of health insurance associated with black people in the U.S. According to the 2009 census data, Champaign County has 20, 837 uninsured (all races), Peoria County has 19, 443 uninsured, and Kankakee County has 14, 200 uninsured. The number of these uninsured people is based on all income levels, both sex, and under 65 years (U.S Census Bureau, 2011). Uninsured people are more likely to live under the poverty level and rely on public funded programs for assistance (U.S Census Bureau, 2011). Living in poverty puts one at risk of developing some chronic diseases such as diabetes, heart-related diseases, and mental illnesses. Furthermore, health-related habits such as practicing safe sex, smoking cessation, and adequate physical activities are neglected sometimes due to poverty and lack of education.

The interaction of both Congolese and African Americans, as minority groups, with the health care system could be related to factors such as employment, education, and income. Due

to unemployment and lack of education, minorities may be more likely to rely on public funded programs for health insurance. Access to health care is an issue associated with uninsured people in the U.S. That is, people cannot afford paying premiums. Since 2008, there has been a change in insurance status due to recession in the U.S. However, the number of insured children has increased slightly in 2010 compared to 2007 due to the implementation of the new program covering all children in America (KFF, 2011).

In 2007, the uninsured rate for nonelderly adults and children in the U.S. was 19.1% and 10.9%, respectively. Three years later, the same rate was 22% and 10% for nonelderly adults and children, respectively (KFF, 2011). That is, there was a slightly decrease of the uninsured rate of children in the U.S.

1.2 RESEARCH QUESTIONS

       The research question associated with this study will be: is the health insurance status of African Americans and Congolese attending the same church in Champaign County different? Surveys were distributed to African Americans and Congolese of Stone Creek Church in Urbana asking questions related to their health insurance status. This will be a glimpse in terms of the number of insured and uninsured attending the same church in the Champaign area.

       As minority groups, Congolese and African Americans may or may not have the same challenges associated with health insurance coverage. That is why this study has three subsequent research questions to identify these barriers. The first question will be: what might be the barriers associated with the access to health care? The hypothesis associated with this question is: there is a difference in terms of health insurance status between Congolese and African Americans attending the same church located in Urbana, Illinois. The second question will be: What might be the barriers associated with the medical insurance status between Congolese and African Americans of Stone Creek Church in Urbana, Illinois? The identification of these barriers will help to address the issue associated with access. The question's hypothesis is: there are some barriers associated with the medical insurance status between Congolese and African Americans attending the same church in the Champaign area. The last research question is: are Congolese and African Americans aware of the health insurance types they have? This question's hypothesis will be that Congolese and African Americans attending Stone Creek Church in Urbana, Illinois, are aware of the health insurance types they have.

Significant Statement of the Study

      As the U.S health care system is complex to understand, a question arises about the health insurance status of the minority groups such as Congolese in the United States medical insurance system. This question is important because it could reveal whether immigrants with limited English proficiency understand the health care system. In fact, the misunderstanding of the medical insurance could be costly. Moreover, the misunderstanding of medical insurance plans could be one of the causes of poor medical practices by international people in the United States. Furthermore, this study would reveal the trends of health insurance status of African Americans and immigrant people such as Congolese living in the same area. This inquiry will shed the light on barriers associated with the access to health care among minorities. It will identify triggers such as employment, education, and income associated with these trends on the coverage of health insurance. The place and importance of health insurance among minorities will be revealed through this study by comparing two minority groups. This study will confirm or invalidate what is known about the health insurance status of minorities.

CHAPTER 2

LITERATURE REVIEW

2.1 REALITIES ASSOCIATED WITH CONGOLESE OF CHAMPAIGN COUNTY

Immigrants such as Congolese living in Champaign area encounter challenges associated with the American health care system. The U.S health care system is very difficult to understand for the Congolese community. In Congolese perspective, the challenge is twofold. The first is related to the language barrier. The second is attributable to unfamiliarity to the American health care culture. Coming from other continents to North America is one of the most interesting experiences that immigrant people encounter. The journey's experience of immigrants in the United States begins with searching for an employment or educational institution to obtain social integration. This is related to culture, values, and habits that pertain to a particular society living in the same area. Thus, immigrant people face different challenges on a daily basis in the United States. The challenge is more serious when one comes from a country where English is not their native languages. This is the case of Congolese people who come all the way from the D.R.Congo to the U.S. searching for a "better life" or "better education". These people face some social barriers which make their social integration a tremendous challenge. These barriers are associated with the knowledge of the U.S politic system, American culture, and the U.S. medical system in general.

- CONGOLESE SOCIO-ECONOMIC BACKGROUND

To understand how the Congolese will react towards the health care system, it is important to consider the Congolese social background associated with their experience to health care. Moreover, it is important to understand the economic background of the Congolese before they came to Champaign. According to Kodi (2007), "worse still, all the fraudulent and corrupt

activities in which people engaged to make ends meet were tolerated and accepted as a normal way of life." (p.4). The Congolese socio-economic background is tainted of corruption, impunity, and injustice. This is an inversion of values in the D.R. Congo. Indeed, this has been a legacy of the Mobutu regime which was characterized by impunity, injustice, and corruption. The legacy has led the country to pauperized situations such as higher rate of unemployment and outdated medical infrastructures (Kodi, 2007). In consequence, Congolese die of very curable diseases because of the mismanagement of the health care system. That is, Congolese have little, if not any, experience with a well-organized health care system. In terms of marital status, Congolese tend to value the role and importance of family (Personal Communication, G. Bokamba, Ph.D. January 3rd, 2012). That is, they believe that family is the bedrock of a society.

- THE REASONS OF CONGOLESE IMMIGRATION TO CHAMPAIGN

Historically, the Congolese started to live in the Champaign area in the late 1990s. Most of the Congolese came here because they won a green card lottery (or Diversity Visa program); therefore, they were invited by a friend who came earlier for study reasons (USDS, 2011). Those who came later started to play the green card lottery for their friends and relatives who were home because the D.R. Congo had poverty, injustice, and atrocities. In fact, the U.S through the Department of State/ Bureau of Consular Affairs organize annually an electronic green card lottery to give a chance to some people from countries around the world to immigrate permanently in the U.S (USDS, 2011). The D.R. Congo happens to be one of the countries in the list authorized to play the lottery green card. Some citizens from other countries who have a higher quota of people living permanently in the U.S cannot participate in the lottery green card. For instance, Indian people cannot participate in the lottery green card (USDS, 2011). The latter is like an ultimate solution for Congolese who feel hopeless living in their country.

"According to the Department of State (2011), the congressional mandated Diversity Immigrant Visa Program makes available up to 55,000 diversity visas (DVs) annually, drawn from random selection among all entries to persons who meet strict eligibility requirements from countries with the low rates of immigration to the United States. (p.2)"

However, the green card lottery is a brain drain for other countries around the world to the U.S. because having at least a high school diploma or 2 years work experience within the past five years in an occupation requiring at least two years' training or experience is the sine qua non requirement for participating in the lottery green card (U.S. Department of State, 2011). In addition, the participation in the green card lottery does randomly select people not accordingly. Quite often, the DV webpage is available in the last quarter of the year (from early October-November). The DV form asks demographic questions such as nationality, educational level, and marital status. When the online form has been submitted, the applicant receives a confirmation number which should be kept for verifying on May first of the following year whether or not the application has been randomly selected. The applicant can only submit one application during a fiscal year. In addition, the applicant should upload a passport photo along with the form. Family also can submit an application indicating the number of accompanying people along with their passport photos (USDS, 2011). Green card holders are entitled to receive social assistance such as Medicaid. After 5 years permanently living in the U.S, one will be allowed to apply for the U.S citizenship (USDS, 2011).

Some Congolese came to the U.S. for a trip related to work and; due to the politics, security, and economic instability of the D.R. Congo they decided to seek asylum (Personal Communication, G. Bokamba, Ph.D. January 3rd, 2012). Most of the time, the request of asylum has been an advice of either a friend living in Champaign, or their own family back home. One will argue that having the chance to come to the U.S. for the first time does not guarantee a

second visa entry to the U.S. Furthermore, some Congolese come to Champaign because they have been granted with the Fulbright scholarship. Once, they done with their studies, they don't want to go back home because of the lack of employment and insecurity (Personal Communication, G. Bokamba, Ph.D. January 3rd, 2012). They search for a job in the U.S. or somewhere else around the world; and hopefully, the job can offer them the possibility to apply for green card or other possibilities.

- THE GROWTH OF THE CONGOLESE COMMUNITY OF CHAMPAIGN

Most of the Congolese immigrants who settled in the Champaign area were young people born during the dictatorship of Mobutu and they never experienced democracy in the D.R. Congo. For instance, most of them never voted at all because, during Mobutu's regime, there were no democratic elections. In fact, Mobutu was a dictator who organized a coup in November 1965 in the D.R. Congo. He ruled the country from that time thru 1997, when L.D Kabila ousted him from the D.R. Congo. In 1997, when Mobutu fled the country, he was accompanied by his staff. They fled the anger of the Congolese population who were made pauper and marginalized by their regime (Reno, 2006). Therefore, some of the Mobutu's staff sent their relatives to the U.S. Once in the U.S, some of them ended up living in Champaign because a friend or relative invited them. This is how the community of Congolese of Champaign came to settle in this area. Since then, their number has been growing and, as a result, they have organized themselves into a recognized community. Furthermore, there is a group of Congolese who live in other places in the U.S. and they are not happy in those places. Their friends or relatives invite them to come to Champaign. Thus, this led to the rapid growth of the Congolese community in Champaign (Personal Communication, G. Bokamba, Ph.D. January 3rd, 2012).

- THE ORGANIZATION OF CONGOLESE COMMUNITY OF CHAMPAIGN

The population of the D.R. Congo in Champaign organizes and participates in some leisure activities such as soccer, parties, and concerts. They even find a place where they can worship God freely, because many Congolese people are religious. The Congolese of Champaign also did their own census to estimate their number in the Champaign area. According to their census, they estimate the total population of Congolese living in Champaign in October 2011 was about 500 people (Congolese Community of Champaign County, 2011). This estimate is more likely to change on monthly basis due to the fact that the Congolese living in Champaign grows rapidly. Since this community is relatively young, they are of reproductive age. Moreover, Congolese still play the green card lottery for their friends and relatives back home and those relatives enter in the U.S at different times. The dream of the Congolese community in Champaign is to have a well-organized community with a hierarchy and to be recognized as such. In addition, they want to live the "American dream" but keep their values and traditions. They want to pass on their beliefs, values, and traditions to their offspring born here. They strongly believe in adopting multiculturalism between the American and Congolese cultures (Le, Lai, & Wallen, 2009).

Moreover, they have created a website where they present their organization called Communauté Congolaise de Champaign County (Congolese Community of Champaign County) or CCC by initials (CCC, 2011). Through the website, the Congolese community has provided the information about the availability of the free clinic located in Champaign County. Through this section, they encourage Congolese with limited English proficiency to utilize a service of translators they provide to ensure effective communication with health care providers. This indicates that health care is an important concern. Therefore, we can assume that access to health care is one of the major concerns for this immigrant community of the Champaign area.

- WARS AND ITS COLLATERAL DAMAGES IN THE D.R. CONGO

The D.R. Congo is a country under conflict with wars on the North-east of the country. Therefore, Congolese are more likely to seek asylum abroad since the armed conflicts have destroyed this central African country. The D.R. Congo has known different endless wars since 1996. The United Nations has declared that the Congolese Civil War is the worst conflict since the World War II. More than 5 million Congolese have been killed since 1996 (UN News Centre, 2011). Therefore, the economy and political system of this country is one of the most corrupt worldwide. The wars include different ethnic militia fighting against each other for the control of raw materials such as Coltan. This is one of the most important minerals in electronic devices such as cellphones, computers, or tablets (Mustapha, Mbuzukongira, & Mangala, 2007). That is, this ore is one of the most important worldwide. In the light of this, Congolese believe that these wars are orchestrated by the international community who want to take advantage by providing fire arms and money to those militia, and then they can exploit Coltan freely (Mustapha et al., 2007). Thus, they believe that the international community is involved because the militias do not have enough money to finance these wars for more than 5 years. According to Mustapha et al (2007), Coltan mining has given rise to a number of environmental and socio-political problems (p.2). Therefore, the destruction of fauna or flora could cause ecologic disequilibrium and produce environmental-related diseases. This is one of the most serious environmental concerns in the twenty first century. Some of Congolese's neighboring countries also are involved in these wars. These countries are: Rwanda, Uganda, and Burundi (Reno, 2006).

In these war zones (East side of the Congo); women are raped on a daily basis. Most of the raped women end up with unwanted pregnancies. Some women become HIV positive because they have been intentionally raped by HIV positive males (UN News Center, 2011). This could be the worst tragedy the world has ever known because people are dying of fire arms,

hunger, and diseases. Men are the first target of the armed forces in the North-East of the Democratic Republic of the Congo. The militias kill males in order to crush the resistance. In addition, they intentionally enroll children by force in the army (UN News Center, 2011). They give children drugs so they will be able to kill even their own parents. According to the recent Human Development Report (2011), "the D.R. Congo is the 187th out of 187 Countries in terms of Human Development Index (HDI). This program was introduced as an alternative to conventional measures of national development, such as level of income and the rate of economic growth (health and education)" (p.1). This is due to wars in the East side of the country, the lack of democratic institutions, and presence of corruption (Kodi, 2007). With all of this, Congolese are more likely to leave their country and find liberty, opportunity, education somewhere else around the world.

2.2 CONGOLESE HEALTH CARE SYSTEM

Originally, the Congolese health care system was well-organized in the central Africa depending on their territorial divisions. According to Baer, "D.R. Congo also has a well-defined health care system of 515 health zones, one-third of which are co-managed by faith-based organizations" (p.1). The Congolese health care system was created based on the socio-demographic division of this country. In the D.R. Congo, the health zones cover approximately 100, 000 people and one surgeon general, medical practitioner, nurses. Therefore, the health zones run the primary health care for the population in this country. The current Congolese health care system suffers of lack of materials, inaccessibility, and outdated equipment. This bad management has lasted for approximately three decades. Therefore, Congolese living in the Champaign area are not familiar with a well-structured health care system. The Congolese health care system is decentralized. The ministry of health oversees the health care system and has three hierarchy levels. The central level is constituted of: the minister of public health and his cabinet,

the general secretariat (with 1 general secretary, 13 districts, and 52 programs such as program against IST/AIDS, program against malaria, and program against tuberculosis). The intermediate level has eleven provincial health inspections, 52 health districts. The peripheral level has 515 health zones, 393 general hospitals of reference, 8,266 health centers (Baer, 2011).

In some cases, employers contract with different hospitals or clinics to ensure that their workers and families receive care when needed. On the other hand, the unemployed people, who constitute the majority of population, can access health care through out-of-pocket payments. Due to poverty, people cannot afford this even though the cost is not really high. The government owns some hospitals or clinics, so do private entities such as NGOs, churches, wealthier people (USAIDS, 2011). The Congolese National Institute of Social Security (Institut National de Securité Sociale, INSS), through its Action of Socio-Health (Action Sanitaire et Sociale, ASS) program is where the population receives health care coverage contracts with employers. The program owns a few health centers where their enrollees can receive care. These health centers also accept non-enrollees people with a small co-payment and give a discount for disabled people. However, these benefits are delayed sometimes due to different factors such as the lack of information, reduced number of the health centers, poverty, and mismanagement; Congolese are more likely to not use the national social security system (National Institute of Social Security, 2011).

The D.R. Congo also has the National Society of Insurance (Société Nationale d'Assurances, SONAS), which was created in 1966 under the Mobutu's regime (National Society of Insurance, 2011). Technically, the Congolese health insurance is mandatory and universal. However, the majority of the population is not covered due to the lack of information, corruption, and mismanagement that characterize the country. SONAS is a Congolese state enterprise with a partnership with western banks. This company also covers dental,

pharmaceutical drugs expenses, and transferring a patient from the D.R. Congo to another country for medical reasons. SONAS can deny coverage due to previous health-related conditions such as incurable diseases, blindness, abortion, and disease due to an accident (National Society of Insurance, 2011). The premiums which are based on the package can be paid individually (quarterly), through the employer (half-yearly), or yearly (National Society of Insurance, 2011). In addition, SONAS does not offer exclusively medical insurance; it also offers different services such as automobile, business, and home insurances (National Society of Insurance, 2011). This company is in charge of mainly insurance plans and this lead to its failure to cover all Congolese. Moreover, in terms of medical insurance, there are no penalties associated with not having health insurance in the D.R. Congo.

- CONGOLESE HEALTHY MIGRANTS

It is obvious that developed countries around the world won't accept immigrants who will become public charge or sources of infectious diseases when than migrate in their countries. That is why; some medical exams are required prior to immigration. This is the case of Congolese who plan to immigrate permanently in the U.S. They go through some medical exams such as HIV/AIDS, tuberculosis, and hepatitis tests. Furthermore, they are vaccinated against some preventable diseases such as poliomyelitis, cholera, and varicella (USDS, 2011). The purpose of immigration medical exams is to be proactive and selective for potential immigrants. As a result, the U.S ends up receiving relatively healthy migrants who can be productive in terms of work.

Hamilton and Hummer (2011) said, "Explanations based on cultural buffering suggest that health and mortality differences between immigrants and U.S.-born individuals may be explained by the relatively low tendency for immigrants to smoke, consume alcohol, use illicit drugs, or be overweight or obese when compared to similar members of the U.S.-born population." (p.1).

- STATISTICS ASSOCIATED WITH CONGOLESE

The age structure of the D.R. Congo is: 0-14 years (44.4%), 15-64 years (53%), 65 years and over (2.6%). The Congolese life expectancy is shortened due to poverty; they are dying from curable diseases, lack of medical resources, and lack of knowledge in preventive health. Life expectancy at birth associated with Congolese is 55.33 years (53.9 years for males, 56.8 years for females). This 2011 estimate shows that there is an improvement on female life expectancy rate which use to be lower than male due to pregnancy complications. The life expectancy rate is lower due to a poor quality of life Congolese live with. Most people are unemployed and cannot afford health care services. The lack of preventive medicine or health education could be a determinant factor associated with a lower life expectancy. For instance, for some Congolese; being overweight is a sign of wealth and opulence. Being thin is a sign of poverty and hunger (Holdsworth, et al, 2008). That is, the Congolese medical institution has failed to meet the expectation associated with the consequences of obesity. The literacy level associated with Congolese is 67.2% for total population (80.9% for male, 54.1% for female) (CIA, 2011). In D.R. Congo, women were considered to be housewives and were not encouraged to attend school. This was one of the negative sides of Congolese culture. However, with modernization, there has been an improvement because parents understand the importance for males and females to attend school. Therefore, parents send females and males to school and encourage them to find a relevant job.

- THE PLACE OF THE CONGOLESE CHURCH IN HEALTH CARE

Churches play an important role on the organization of the health care in the D.R. Congo, because some churches own hospitals or community health care centers in this country. From the Congolese perspective; churches assure the spiritual growth, and they provide social services as well. Those services can be the health care system, schooling, and counseling. Thus the church,

in the D.R. Congo plays a crucial role in the provision of the health care system. Congolese believe that all diseases are not curable by the modern medicine. There are diseases that are thought to be caused by witchcraft or curses. Consequently, those kinds of diseases should be treated through prayers and incantations. Thus, church in the D.R. Congo has multifaceted roles; assuring spiritual growth, providing education, and providing social services (USAIDS, 2011).

- THE PLACE OF ALTERNATIVE HEALTH CARE IN CONGOLESE PERSPECTIVE

Furthermore, there are traditional healers in the Democratic Republic of the Congo. Those healers are important because they claim to heal different diseases such as HIV/AIDS. The traditional healing is a holistic approach of the healing experience in Africa. The traditional healing is cheaper than the western medicine in the D.R. Congo because they don't use technology. Thus, this type of medicine is not modernized and they use spiritual approach to diagnose a disease. The traditional medicine is popular in the D.R. Congo because it is linked to the Congolese culture. According to anthropologists, there are different ways that one can become a traditional healer. The first way of becoming a traditional healer could be through the ancestral election. This means that one will be elected by ancestors. The other way of becoming a traditional healer could be through instruction. That is, shadowing a traditional healer who will teach and train a potential candidate on the values and pharmacology of various plants. The traditional healers use the roots of plants, leaves, and bark to prepare and create drugs. They have different ways of administration; by mouth and on the skin (UNAIDS, 2003).

2.3 REALITIES ASSOCIATED WITH AFRICAN AMERICANS OF CHAMPAIGN COUNTY

African Americans are one of the other minority groups using the United States health care system. This community has lived in the U.S for ages. Historically, because of slavery, the community of African descent was brought to the United States. Therefore, they would not have the same challenges than Congolese living in Champaign. Thus, unlike the Congolese, they have

a different experience of health care. Officially, they only have English as their main language. According to the CIA 2000 census, 82.1% of people speak English in the United States. That is, English is the main way of communication in the U.S.

- STATISTICS ASSOCIATED WITH AFRICAN AMERICAN COMMUNITY

African Americans are more likely to be underinsured or uninsured than Caucasians (Thomas & James, 2009). This may be due to the lack of employment and factors such as lack of education. The less educated people are more likely to overlook the importance of medical insurance, especially when they are young (Schwartz & Schwartz, 2008). In 2010, the state of Illinois has a total of 12, 830, 632 population. In the same year, Champaign County has 201, 081 people (all races included) (US Census Bureau, 2011). The state of Illinois is one of the largest states in the U.S in terms of the population of African Americans (US Census Bureau, 2011). That is, this state is ranked 7th across the country in terms of proportion of blacks in the community (US Census Bureau, 2011). According to the U.S census of 2010, the percentage of black people living in the United States was 13.5% (p.2). Furthermore, the percentage of black persons living in Champaign in 2010 was estimated to 12.4% (US Census Bureau, 2011). However, the percentage of black people comprises all black people living in the United States. That is, it is a heterogeneous group of black communities living in Champaign. Therefore, the exclusive rate of black Americans living in the United States could be lower. Religion also is important among Afro-American communities living in the U.S. According to the CIA 2007 estimate, the U.S has 51.3% of Protestant, 23.9% Roman Catholic, 1.7% Mormon, 1.6% other Christian, 1.7% Jewish, 0.7% Buddhist, 0.6% Muslim, 2.5% unspecified, 12.1% unaffiliated, 4% none (p.1). That is, people are more likely to be religious in the U.S. Therefore, some people would consider the spiritual approach to healing. According to Gillum and Griffith (2010), "among adults 18 years and over, 44.7% reported using prayer for their own health in the previous 12 months, including

36.5% of men and 52.6% of women. African Americans reported the greatest and European Americans the least use of prayer for health". (p.5). For instance, someone will be more likely to seek help in prayers than to go to healthcare providers, especially when it's serious diseases such as cancer.

- COMPARISON BETWEEN BLACK AND WHITE COMMUNITIES

When it comes to the comparison between the black community living in the U.S and the white community, there are disparities. According to the Commonwealth Fund, "the African American life expectancy is six years shorter than whites at birth, two years shorter at age 65(Collins, Tenney, & Hughes, 2002)". Furthermore, according to the Office of Minority Health, "in 2007, as compared to whites 25 years and over, a lower percentage blacks has earned at least a high school diploma (80% and 89% respectively)"(p.2). That is, African Americans are more likely to drop out of schools. There are some causing factors related to stopping school. Those factors could be poverty, living in dangerous neighborhood, and having parents who struggle with drugs. Still, education is an important factor for understanding healthcare. Moreover, more black women had earned a bachelor's degree than black men (DHHS, 2011). In terms of income, "the average of black family median income was $33,916 in 2007 compared to $54,920 white family in the U.S. Obviously, the black community income is lower, therefore, this community would be more likely to turn to the government to seek assistance such as Medicaid. Furthermore, "in 2007, 24.5% of black people were living at the poverty level compared to 8.2% of white people" (DHHS, 2011).

African Americans may not have access to healthy foods due to reasons such as high cost, lack of knowledge of nutritional facts, peer pressure. Some African Americans may experience food deserts, when they don't have access to the grocery stores in the neighborhood (Kelly, Flood & Yeatman, 2011). In consequence, they will be more likely to eat "junk foods".

In terms of dietary guidelines, it has been said that black people would benefit from further reducing sodium intake to 1,500 mg daily in the U.S (MMWR, 2011). This testifies that the dietary intake for African Americans could increase the frequency of some subsequent ailments in the U.S.

The unemployment rate of black people was 8% compared to 4% of white in 2007 (DHHS, 2011). This could be the consequence of being undereducated or uneducated. And when it comes to find a relevant job, the uneducated could struggle. Being unemployed, puts one at risk of being uninsured or underinsured because more people receive medical insurance through their employers (Stanton, 2004). According to Stanton (2004), "the U.S employed-based health insurance market provides insurance coverage to nearly two-thirds of the population under 65" (p.2). "In 2007, 49% of black people compared to 66% of non-Hispanic white utilized employer-sponsored health insurance" (DHHS, 2011). The smaller percentage of African Americans using employer-related health insurance could be due to the fact that some black people are unemployed or part-time with no health insurance benefits at work. In 2007 more African Americans in comparison to white people relied on public health insurance such as Medicaid and 23.8% were under these plans (DHHS, 2011). This may be due to the cost and accessibility of medical care. In fact, the cost of the U.S health care is skyrocket and people living at the poverty level such as black people could not afford it. "In 2007, 19.5% of black people compared to 10.4% of white people were uninsured in the U.S" (DHHS, 2011).

Some health conditions such as heart diseases, stroke, cancer, asthma, influenza, pneumonia, diabetes, HIV/AIDS, and homicide were higher among African Americans than whites in 2005 (DHHS, 2011). This may be due to factors such as eating habits, sedentary lifestyles, and health-related behaviors. Homicide rates in black communities may be high because of the increased stress level and poverty. However, some health-related behaviors have

been improved among African Americans in the U.S. According to Kahende et al (2011), "although smoking prevalence in recent decades has declined substantially among all racial/ethnic groups, disparities in smoking-related behaviors among racial/ethnic groups continue to exist" (p.2). This improvement could be due to well-established programs to ensure that smokers change their behavior. Thus, they commit themselves to change their behavior and improve their lifestyles.

The socio-related environmental factors intervene when it comes to these diseases. African Americans would be more likely to live in crowded and outdated apartments; in consequence, they may develop some chronic respiratory diseases such as asthma. Thus, this shows that the black community is in a worse condition in terms of health. In 2008, the Illinois Infant Mortality Rate of African Americans 13.9% in comparison with 5.8% of Caucasian communities (IDPH, 2009). This may be due to factors such as poverty, lack of education, and crime. In addition, the inaccessibility of health care could be a determining factor causing the infant mortality rate of black children to be high. There are different factors one should be considered to determine the role and importance of the U.S health care system. In 2009, the lead poisoning on children was 4% among African Americans in Illinois (IDPH, 2009). This is because some Illinoisans are living at the poverty level and are in apartments without lead based paints. In 2010, the Illinois tuberculosis cases in Champaign were 5 TB positive per 100 TB positive people in Illinois. In 2010, the tuberculosis cases by race ethnicity in Illinois are 24% for black people, 18% for white people, 31% for Hispanic communities, 27% for Asian communities (IDPH, 2011).

In terms of immunization, in 2006, African American aged 65 and older were 30% less likely to have received the influenza shot in the past 12 months in comparison to white people in the U.S (IDPH, 2009). In terms of the rates of health care expenditure, physician density, and

life expectancy at birth would give an overview of the U.S health care system. Thus, the health expenditure rate associated with GDP in the U.S is 16.2%, the largest one in the world (CIA, 2011). This shows that the health care system is not neglected in the United States and they coordinate efforts to improve people's lives by providing a better health care system.

- LIFESTYLES OF AFRICAN AMERICANS

The quality of life of African Americans still has some concerns which need to be discussed. African Americans are more likely to have chronic diseases due to the poor quality of life. There are disparities associated with the African American communities living in the United States. According to Keyes, Barnes and Bates (2011), living under the poverty level could be a determining factor causing stress or mental disorders. Therefore, we can assume that African Americans living under poverty level will be more likely exposed to stressful situations and develop some subsequent health-related situations such as mental diseases, suicidal attempts, and chronic diseases (Keyes et al., 2011)

It has been said that "22% of adult African Americans has considered hospital emergency rooms, clinics, or going nowhere as their primary care in comparison to 9% of whites in the United States"(Adashi, Geiger, & Fine, 2010). This is a twofold situation; in which we can assume that one don't understand the role and importance of primary care provider in the health care system. The primary care provider is the first place to go in case of any health-related issues. According to Adashi et al, "and yet this unique national asset constitutes a critical element on any reform intent of expanding access to health care through a primary care portal (p.2)". In the primary care settings, patients are more likely to establish a relationship with their providers; therefore, the expectation is that the relationship should be improved. The second reason for the high rate of use of hospital emergency room visits by black communities is that African Americans are more likely to be underinsured or uninsured; they will head directly to

emergency rooms or clinics for any disease. In addition, the role and importance of preventive care are misunderstood or overlooked. Yet, preventive care is crucial in one's health because it prevents some health-related situations to happen. Preventive care is not just the responsibility of individuals, but also the government plays a crucial role in encouraging individuals to change their health-related behaviors. For instance, the local public health department encourages any 40 or 45 years old black male to get screened for prostate cancer yearly. This aims to detect early the proliferation of cancer cells and to control them as well (IDPH, 2009).

2.4 OVERVIEW OF THE US HEALTH CARE SYSTEM

Health care in the United States is a mosaic system with different components and users. People should know what health insurance plan they have before heading to a provider and understand what is covered or not covered through the health plan to avoid any unexpected out-of-pocket expenses. Thus, the provision of the health care can be complicated. That is, one can choose any health insurance plans, but the ultimate goal is to receive care when it comes to health-related issues. This is the magic of the U.S health care system. Despite the fact that the U.S health care system is highly ranked in terms of the quality, there are many questions surrounding this system (Orszag & Emanuel, 2010).

For instance, Medicaid is one of the components of the United States health system. This component is complex in terms of the provision, payment, and policies. Medicaid is the largest source of funding for medical and health-related services for America's poorest people and has had many successes throughout its history. Medicaid provides supplemental health coverage for the country's people in need. This policy has considerable flexibility within the states' Medicaid plans. However, some federal requirements are mandatory if federal matching funds are to be received.

Nowadays, the cost of health care in the United States is a major concern because many people are not able to afford medical care. A study by Orszag and Emmanuel (2010) says, "Projections suggest that with reform, total health care expenditures as a percentage of the gross domestic product will be 0.5% lower in 2030 than they would otherwise have been"(p.1). The new health care reform focuses primarily on the reduction of cost and increase the number of health care users in the United States. Cutler (2010) says, "If reform can successfully bend the cost curve over the longer term, coverage will be affordable and the federal budget will be close to balanced" (p.1). Moreover, insurance companies are one of the major key players in health care in the U.S. They make the cost higher because they are profitable organizations.

The complexity of insurance plans could be associated with higher cost since people do not use the plan effectively. Therefore, some users are uninsured or underinsured due to their inability to afford the health care. In consequence, a higher cost is raising the question of accessibility of the U.S health care system. The last attempt of Obama's health care proposal was intended to address precisely those problems (Orszag & Emanuel, 2010). Among the users, the minority groups living in the United States struggle to have access to the health care system due to different factors such as unemployment or poverty. That is, accessibility to the U.S health care system is an important aspect to consider for determining the coverage. In addition, the question is: is the health care language comprehensible to the minority groups since they are more likely to be uninsured? African Americans and Congolese living in Champaign are the minority groups in terms of population proportion (DHHS, 2010). They are more likely to be uninsured compared to the majority groups such as white people. Unlike other industrialized countries around the world, the provision of health care in the U.S is through employer (Stanton, 2004). That's why unemployed people are more likely to be uninsured.

2.5 INTERACTION OF CONGOLESE AND AFRICAN AMERICANS WITH HEALTH CARE

The trend associated with the use of the medical insurance by Congolese should be evaluated to ensure that these people use effectively the U.S medical insurance. An article from the Kaiser Family Foundation says, "In contrast, with the exception of Asians, roughly 1 in 4 persons of each population of color receives coverage through Medicaid or other public programs" (Thomas & James, 2009). This excerpt shows that the U.S public programs offering health insurance are the main providers of people of color. Congolese are among communities of color living in the United States. Therefore by extrapolation, Congolese living in Champaign-Urbana would be more likely to receive their health insurance through public programs such as Medicaid. In fact, the new Patient Protection and Affordable Care Act would play a crucial role among communities of color because these people are more likely to be uninsured compared to white people. In addition, the Kaiser Family Foundation testifies that "by 2045, more than half of the population in the U.S. will be a person of color. In general, people of color continue to experience worse access to health care and worse health outcomes than their white counterparts"(KFF, 2010). This excerpt says that the percentage of people of color, black people included, in the United States would increase in the future. However, these people experience worse health care coverage and outcomes compared to white people. Therefore, this shows that something should be done to improve the access to the health care system for people of color. That's why the Obama health care reform focuses on the reduction of the uninsured population and improves the experiences related to medical insurance plans in the Unites States (Adashi, Geiger, & Fine, 2010).

In addition, some users of health care encounter difficulties in understanding the language used by health providers and the system in general. That is, jargon used in health care

could be misunderstood by some users. Especially when English is not the native language, communication becomes a challenge. A study by Ishikawa and Yano (2008) said, "Also for individuals whose native language is not the national language where they live, health literacy is affected not only by their literacy in the national language, but also by their literacy and health literacy in their native language, which makes the relationship between literacy and health literacy further complex" (p.1). The basic knowledge of the medical insurance plan is crucial for users as it emphasizes on the effectiveness of utilization. Nevertheless, Congolese are more likely to encounter the challenge associated with limited health literacy.

African Americans are not exempt of a limited knowledge of health literacy because of medical jargon. According to the WHO, "Health literacy is the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand, and use information in ways which promote and maintain good health" (WHO, 2009). This highlights the role and knowledge on medical jargon. The effectiveness of knowledge of medical insurance by international people and U.S citizens is important. That is, every health consumer should be able to understand the language used to clarify his or her health care plans. There are various factors associated with the uninsured or underinsured, culture could be one of them.

In fact, cultural adherence could be a barrier for preventing access to health care. This might be the case of African Americans living in Champaign. The culture encompasses various factors such as communication, eating habits, and the values of life. That is, the African American communities have their own set of values related to their perception of life. Moreover, the role and importance of friendship could be a trigger in boosting one's behavior of understanding the health care. According to the National Minority of AIDS education, "the mistrust that African Americans have for the medical community is reflected in the disparities seen in HIV research between the participation of African-American and white patients"

(McNeil et al, 2002). That is, there is a gap between health care providers and African American communities. This gap could be the reason why black communities are more likely to be uninsured or underinsured in the U.S. The quality of the relationship between health care providers and users is important because it establishes confidence between both sides. That is, they both need well-established relationship to improve the quality of services. In addition, Dorell et al (2011) testify, "limited health care access and missed opportunities for HIV and other sexually transmitted infection (STI) education and testing in health care settings may contribute to the risk of HIV infection"(p.2). Some African Americans don't have the information about sexual education; consequently, they are more likely to be exposed to STI (Sexually Transmitted Infection). This also is due to the inaccessibility to the U.S health care. There are reasons such as negligence or not spreading the information could lead one to miss opportunities for HIV and sexually transmitted infection.

With the last debate of the health care reform in the U.S, a question related to the quality of health care has been addressed to ensure that the U.S health care quality is not reduced due to the consideration of disparities. In fact, health disparities have been an important issue in this country which needs to be addressed to ensure that the minority groups have full access to health care. According to Weinick & Hasnain-Wynia (2011), "As the nation focuses on the practical realities of implementing health care reform and concurrent quality improvement provisions under the Affordable Care Act 2010, it is important to recognize that overall improvements in the U.S health care system might not automatically benefit all segments of the population equally"(p.1). Providing the universal health care in the U.S could threaten the quality of care due to the increase number of patients to be covered. This is quite a dilemma in the U.S because the limited access to health care could worsen one's health and at the same time the quality of the health care services should be maintained high.

CHAPTER 3

RESEARCH METHODS

3.1 PURPOSE OF THE RESEARCH

This study aimed at comparing medical insurance status between Congolese and African American communities attending the same local church in located in Urbana, Illinois. In addition, the purpose of this inquiry was to identify barriers associated with the coverage of medical insurance and knowledge of type of health insurance between these users, known as minorities. Therefore, a survey was distributed to Congolese and African American communities attending Stone Creek church asking questions about their insurance status, demographic status, and knowledge of their medical insurance plans. Research questions have been developed to ensure that the result is accurate and relevant. This study was reviewed and approved by the Institutional Review Board/UIUC with an IRB protocol numbered 12287.

Research Questions

A. Is there any difference of medical insurance status between Congolese and African Americans attending the same local church in Champaign? If there is a difference, in what aspects will the difference be?

B. What might be the barriers associated with the medical insurance status between Congolese and African Americans of Stone Creek church in Champaign County?

C. Do Congolese and African Americans know what types of health insurance plans they have?

Hypotheses

A. H_1: There is a difference of medical insurance status between Congolese and African

   Americans attending Stone Creek church in Champaign.

   H_o: There is not a difference of medical insurance status between Congolese and African

   Americans attending Stone Creek church in Champaign.

B. H_1: There are barriers associated with the medical insurance status between Congolese

   and African Americans of Stone Creek church.

   H_o: There are not barriers associated with the medical insurance status between

   Congolese and African Americans of Stone Creek church.

C. H_1: Congolese and African Americans attending Stone Creek church know the types of

   health insurance plans they have.

   H_o: Congolese and African Americans attending Stone Creek church do not know the

   types of health insurance plans they have.

3.2 RESEARCH METHODOLOGY

Data Collection

Surveys were distributed to participants to fill out the demographic questions. There were

a total of 55 Congolese (30 male and 25 female) and 54 African Americans (24 male and 30

female) attending Stone Creek church located in the Champaign-Urbana area. Subjects lived in

the United States for at least one year. Participants also answered questions related to their

knowledge and use of medical insurance plans. Questions such as education level, marital status,

and having medical insurance were asked to subjects. The data was aggregated with no personal

identification of participants. Subjects were between 20 and 60 years of age to participate in this

inquiry. The survey took approximately five minutes to complete. There were two versions of the

survey, English and French (since Congolese are native French speakers). The participation in the survey was completely voluntary and the answers were confidential. The surveys were distributed and collected by research staff. People on Medicaid participated in this inquiry.

Data Analysis

This study was based on a self-reported survey which had some demographic information such as age, gender, education level, and medical insurance coverage. Some statistical measures were computed by using the Statistical Package for the Social Sciences (PASW/SPSS) version 18.0 to evaluate the trends of participants towards the medical insurance status and the knowledge of health insurance plans. The frequency table was used for variables such as age, marital status, and gender to present data in terms of percentage. In the survey, age was categorized into two categories: 20-40 years; 41-60 years. The variable gender also had two categories: female and male. The marital status variable had two categories, as well; single (include widowed, separated, and never been married) and married. The chi-square analysis was used for comparing Congolese and African Americans health insurance status and knowledge of medical plans. Based on the questionnaires, the independent variables were: income, education level, time spent in the U.S. (applicable to Congolese only) and employment status, whereas the dependent variable was medical insurance status. The income level was categorized into two groups: less than $25,000; and more than $26,000 categories. Highest level of education attained was categorized into four groups: less than high school diploma, high school diploma or GED, college degree or vocational degree, and graduate studies. The SPSS/PASW created the dummy variables for the education level variable since it had more than 2 categories. Different comparison tables between Congolese and African Americans were made for presenting the difference in terms of the medical insurance status and demographic data.

The first set of variables was demographic variables with place of birth (the U.S or Congo), gender (female or male), age range (20-40 or 41-60 years), marital status (single or married), the length of stay in the U.S (applicable to Congolese only), immigration reasons (applicable to Congolese only), heaving children (yes or no), and education level (less than high school, high school, undergraduate, and graduate). The second set of variables was employment status (full or part time), type of work (professional or manual), income level (less than $25,000 or $26,000 or more), health insurance through employer, and family health insurance coverage (yes or no). The third set of variables was associated to the type of health insurance Congolese and African Americans (Medicaid, PPO, fee for service, HMO, POS, and don't know what type). The fourth set of variables was associated to reasons of not having health insurance among Congolese and African Americans. Those variables were: higher premiums (yes or no), unnecessary (yes or no), coverage denied (yes or no), employer doesn't offer (yes or no), and don't understand the system (yes or no). The last set of variables was associated to medical service providers such as Carle (yes or no), Provena Covenant Medical Center (yes or no), Christie Clinic (yes or no), McKinley Health Center (yes or no), emergency room (yes or no), Frances Nelson Medical Center (yes or no), Champaign County Christian Health Center (yes or no), Champaign Urbana Public Health District (yes or no), and don't use service (yes or no).

CHAPTER 4

RESULTS

Analyses were conducted to obtain information on the number of Congolese and African Americans with health insurance (having health insurance and not having one). Various frequency tables were used to present the percentage of Congolese and African Americans in relation to health insurance status. That is, comparison tables were made to present difference between Congolese and African Americans on health insurance status attending the same church located in the Champaign area. Pearson chi-squares were calculated for chi-square analyses.

Table 1 displays the demographic comparison between Congolese and African Americans attending Stone Creek church in Champaign on demographic data such as place of birth, gender, age range, marital status, length of stay in the U.S (this variable is applicable to Congolese only), immigration reasons (applicable to Congolese only), having children, and education level (dummy variables: less than high school, high school, undergraduate, and graduate). According to the results displayed on Table 1, the study had 30 male (or 54.5%) and 25 female (or 45.5%) Congolese. On the other hand, the study had 24 male (44.4%) and 30 female (55.6%) African Americans. The percentage of married couples between Congolese and African Americans was totally different, 63.6% and 37.0%, respectively with a Pearson chi-square of 7.71 and a p value of 0.007. This shows that marital status variable between Congolese and African Americans is statistically significant. Additionally, the percentage of Congolese and African Americans having children was 61.8% and 64.8%, respectively with a Pearson chi-square of 0.11 and a p value of 0.843. In terms of education level, Congolese had 7.3% of people with less than high school diploma compared to 3.7% of African Americans. Congolese had 30.9% of people with high school diploma compared to 38.9% of their counterparts, African Americans. Congolese had 60% of people with an undergraduate degree compared to 38.9% of

African Americans. Congolese had 1.8% of people with master or doctorate degree compared to 18.9% of African Americans.

Table 2 displays the comparison between Congolese and African Americans on work status, income, and insurance health status. The results show that Congolese (81.8%) were more likely to work full time than African Americans (68.5%), but this was not statistically significant with Pearson chi-square of 2.59 and a p value of 0.125. African Americans (51.9%) were more likely to earn $26,000 or more annually than Congolese (18.2%), which was statistically significant with Pearson chi-square of 13.60 and a p value of less than 0.001. Congolese (60.0%) were more likely to have health insurance through employer than African Americans (37.0%), which was statistically significant with a Pearson chi-square of 5.75 and a p value of 0.022. In terms of family health insurance coverage, 25.5% of Congolese families had coverage whereas 42.6% of African Americans families had coverage.

Table 3 displays data of health insurance types between Congolese and African Americans. In terms of number of participants with Medicaid, 20% of Congolese responded yes whereas 13% of African Americans responded yes, with a Pearson chi-square equaled 0.98 and a p value of 0.440, which is not statistically significant. The PPO variable was not statistically significant since its p value was 0.556 with a Pearson chi-square of 0.42. That is, 9.1% of Congolese agreed having PPO whereas 13% of African Americans agreed having PPO. In terms of fee for service, 7.3% of Congolese responded yes whereas 3.7% of African Americans responded yes with a Pearson chi-square of 0.67 and a p value of 0.679, which is not statistically significant. In terms of HMO, 7.3% of Congolese responded yes whereas 40.7% of African Americans responded yes with a Pearson chi-square of 16.8 and a p value of 0.001, which is statistically significant. For POS, no Congolese responded yes whereas 5.6% African Americans responded yes with a Pearson chi-square of 3.11 and a p value of 0.118, which is not statistically

significant. In terms of the "don't know" variable, 18.2% of Congolese said that they have health insurance but they don't what type whereas 9.3% of African Americans said the same with a Pearson chi-square of 0.176 and a p value of 0.266, which is not statistically significant.

Table 4 displays the reasons for not having health insurance between Congolese and African Americans. Congolese (43.6%) were less likely to report that higher premium is one of the reasons for not having health insurance whereas African Americans (85.2%) reported the same. That is, the higher premium was statistically significant with a Pearson chi-square of 20.47 and a p value of less than 0.001. No Congolese said that health insurance was unnecessary, whereas 3.7% of African Americans said the contrary with a Pearson chi-square of 2.08 and a p value of 0.243, which was not statistically significant. No participants reported that coverage was denied for any reasons. In terms of employer offering health insurance, 20% of Congolese reported that whereas 11.1% of African Americans reported the same with a Pearson chi-square of 1.64 and a p value of 0.291, which was not statistically significant. No African Americans reported that they don't understand the system whereas 30.9% of Congolese reported the contrary, with a Pearson chi-square of 19.78 and a p value of less than 0.001, which was statistically significant.

Table 5 displays the comparison analysis between Congolese and African Americans on medical service providers. The findings were that 56.4% of Congolese were going to Carle whereas 57.4% of African Americans were going there, with a Pearson chi-square of 0.01 and a p value of 1.000, which was not statistically significant. For Provena Covenant Medical Center, 14.5% of Congolese reported going there whereas 33.3% of African Americans reported the same, with a Pearson chi-square of 5.30 and a p value of 0.026, which was statistically significant. For Christie Clinic, 23.6% of Congolese were going there whereas 44.4% of African Americans where going there with a Pearson chi-square of 5.26 and a p value of 0.027, which

was statistically significant. For McKinley Health Center, no Congolese reported going there whereas 5.6% of African Americans reported going there with a Pearson chi-square of 3.14 and a p value of 0.112, which was not statistically significant. Some Congolese (5.5%) reported going to Frances Nelson Medical Center whereas African Americans (1.9%) reported going there with a Pearson chi-square of 1.33 and a p value of 0.513, which was not statistically significant. For Champaign County Christian Health Center or free clinic, 3.6% of Congolese reported going there for medical care whereas 7.4% of African Americans reported going there for care with a Pearson chi-square of 0.75 and a p value of 0.438, which was not statistically significant. For the Champaign Urbana Public Health Department, 3.6% Congolese go there whereas 3.7% of African Americans go there with a Pearson chi-square of 1.156 and a p value of .354, which is not statistically significant. Some Congolese (21.8%) reported that they don't use medical service whereas African Americans (1.9%) reported the same with a Pearson chi-square of 10.34 and a p value of 0.002, which was statistically significant.

Table 6 displays the Congolese health insurance status versus length of stay in the U.S. The Pearson chi-square associated to these variables was 6.11 with a p value of 0.028, which is statistically significant.

Table 1 Comparison table between Congolese and African Americans on demographic data.

	Congolese N (%)	African Americans N (%)	Pearson χ^2	p
Total	55 (100%)	54 (100%)		
Gender			1.11	0.340
Male	30 (54.5%)	24 (44.4%)		
Female	25 (45.5%)	30 (55.6%)		
Age range			3.04	0.095
20-40 years	43 (78.2%)	34 (63.0%)		
41-60 years	12 (21.8%)	20 (37.0%)		
Marital status			7.71	0.007***
Single	20 (36.4%)	34 (63.0%)		
Married	35 (63.6%)	20 (37.0%)		
[1]Length of stay in the U.S				
0-5 years	40 (72.7%)			
6-more years	15 (27.3%)			
[1]Immigration reasons				
Better education	32 (58.2%)			
Living better	23 (41.8%)			
Having children			.11	0.843
Yes	34 (61.8%)	35 (64.8%)		
No	21 (38.2%)	19 (35.2%)		
Education level			11.11	0.011**
Less than HS	4 (7.3%)	2 (3.7%)		
High school	17 (30.9%)	21 (38.9%)		
Undergrad	33 (60.0%)	21 (38.9%)		
Graduate studies	1 (1.8%)	10 (18.5%)		

Note. [1]No African Americans responded to the questions related to the length of stay in the U.S and immigration reasons variables. ***p<0.01, **p<0.05

The Pearson chi-square associated with the working status is 2.59 with p value equals .125, which is not statistically significant. African Americans (63.0%) were more likely to have professional job type than Congolese (5.5%) with Pearson chi-square equals 40.2 and *p* value less than 0.001, which is statistically significant. In terms of the income level, Congolese had 81.8% of income of less than $25,000 whereas African Americans had 48.1% of the same income level. African Americans (51.9%) were more likely to have an income of $26,000 or more than Congolese (18.2%) with a Pearson chi-square equals 13.6 with *p* value less than

0.001. That is, the income level is statistically significant. The Pearson chi-square associated

with health insurance through employer variable was 5.75 with *p* value of 0.022. That is, the

health insurance through employer variable was statistically significant for Congolese (60%) and

African Americans (37%). In terms of family covered through health insurance, Congolese had

25.5%, whereas African Americans had 42.6% with a Pearson chi-square of 3.57 and a *p* value

of 0.070 which is not statistically significant.

Table 2 Comparison table between Congolese and African Americans on working status, income, and health insurance status.

	Congolese N (%)	African Americans N (%)	Pearson χ^2	*p*
Working currently			2.59	0.125
Full time	45 (81.8%)	37 (68.5%)		
Part time	10 (18.2%)	17 (31.5%)		
Type of work			40.19	<0.001***
[1]Professional	3 (5.5%)	34 (63.0%)		
[1]Manual	52 (94.5%)	20 (37.0%)		
Income level			13.60	<0.001***
Less than $25,000	45 (81.8%)	26 (48.1%)		
$26,000-more	10 (18.2%)	28 (51.9%)		
Health insurance			5.75	0.022**
Through employer				
Yes	33 (60.0%)	20 (37.0%)		
No	22 (40.0%)	34 (63.0%)		
Family coverage			3.57	0.070
Yes	14 (25.5%)	23 (42.6%)		
No	41 (74.5%)	31 (57.4%)		

Note. [1]Professional jobs referred to working in education, engineering, and healthcare whereas manual jobs were related to warehouse, manufacture, and daycare. ***p<0.001, **p<0.05

Table 3 displays the frequency of Congolese and African Americans about the trends of

health insurance status. Based on the results, Congolese and African Americans could have some

problems understanding the health insurance types because most of them respond that they don't

have PPO as their health insurance type, while this is the current trend of health insurance type in

the U.S (KFF, 2011). Congolese had 20% of people with Medicaid whereas 13% of African

Americans had Medicaid with a Pearson chi-square of .98 and a *p* value of 0.440, which is not

statistically significant. In terms of PPO, 9.1% reported having this type of health insurance

whereas 13% of African Americans reported having it, with a Pearson chi-square of .42 and a *p*

value 0.556, which is not statistically significant. Congolese had 7.3% of people having fee for

service whereas 3.7% of African Americans have fee for service with a Pearson chi-square of .67

and *p* value of 0.679, which is not statistically significant. In terms of HMO, 7.3% of Congolese

had HMO whereas 40.7% of African Americans had HMO with a Pearson chi-square of 16.8 and

p value of less than 0.001, which is statistically significant.

Table 3 Comparison table between Congolese and African Americans on health insurance types.

Types of health insurance	Congolese N (%)	African Americans N (%)	Pearson χ^2	*p*
Medicaid			.98	0.440
Yes	11 (20.0%)	7 (13.0%)		
No	44 (80.0%)	47 (87.0%)		
PPO			.42	0.556
Yes	5 (9.1%)	7 (13.0%)		
No	50 (90.9%)	47 (87.0%)		
Fee for service			.68	0.679
Yes	4 (7.3%)	2 (3.7%)		
No	51 (92.7%)	52 (96.3%)		
HMO			16.80	<0.001***
Yes	4 (7.3%)	22 (40.7%)		
No	51 (92.7%)	32 (59.3%)		
POS			3.14	0.118
[1]Yes		3 (5.6%)		
No	55 (100%)	51 (94.4%)		
Don't know			1.83	0.266
Yes	10 (18.2%)	5 (9.3%)		
No	45 (81.8%)	49 (90.7%)		

Note. [1]No Congolese responded yes to the POS variable. ***p<0.001

In terms of the reasons for not having health insurance, Congolese (43.6%) reported higher

premiums whereas African Americans (85.2%) reported higher premiums with a Pearson chi-

square of 20.47 and a *p* value of less than 0.001, which is statistically significant. No Congolese

reported health insurance as unnecessary whereas 3.7% African Americans reported health

insurance as unnecessary with a Pearson chi-square of 2.08 and *p* value of 0.243, which is not

statistically significant. No participants reported coverage denied. In terms of employer doesn't

offer health insurance, 20% Congolese agreed that this is their case whereas 11.1% African

Americans reported it with a Pearson chi-square of .20 and *p* value of 0.291, which is not

statistically significant. Some Congolese (30.9%) reported that they don't understand the U.S

health care system with a Pearson chi-square of 19.8 and *p* value of less than 0.001.

Table 4 Comparison table between Congolese and African Americans on the reasons of not
having health insurance.

Reasons for not having health insurance	Congolese N (%)	African Americans N (%)	Pearson χ^2	*p*
Higher premium			20.47	<0.001***
Yes	24 (43.6%)	46 (85.2%)		
No	31 (56.4%)	8 (14.8%)		
Unnecessary			2.08	0.243
[1]Yes		2 (3.7%)		
No	55 (100%)	52 (96.3%)		
Coverage denied				
[1]Yes				
No	55 (100%)	54 (100%)		
Employer doesn't offer			1.64	0.291
Yes	11 (20.0%)	6 (11.1%)		
No	44 (80.0%)	48 (88.9%)		
Don't understand the system			19.78	<0.001***
[2]Yes	17 (30.9%)			
No	38 (69.1%)	54 (100%)		

Note. [1]No Congolese responded yes to the "unnecessary" variable. Neither Congolese nor
African Americans responded yes to "coverage denied". [2]No African Americans responded yes
to "don't understand health care system" variable. ***$p<0.001$

Table 5 displays data on medical service providers for Congolese and African Americans

attending the same church in Urbana, Illinois. Both Congolese and African Americans were

more likely to go to Carle Hospital and Clinic for medical service, 56.4% and 57.4% respectively with Pearson chi-square of 0.01 and p value of 1.000, which is not statistically significant. For Provena Covenant Medical Center, 14.5% Congolese reported going there whereas 33.3% of African Americans reported going there with Pearson chi-square of 5.30 and p value 0.026, which is statistically significant. Congolese (23.6%) were less likely to go to Christie Clinic compared to African Americans (44.4%) with Pearson chi-square of 5.26 and p value of 0.027, statistically significant. For McKinley Health Center, 5.6% of African Americans were going there whereas no Congolese go there with a Pearson chi-square of 3.14 and a p value of 0.118, which was not statistically significant. Congolese (9.1%) were less likely to go the emergency room than African Americans (20.4%) with Pearson chi-square of 2.77 and p value of 0.112, which is not statistically significant. Frances Nelson Medical Center was another place where Congolese (5.5%) and African Americans (1.9%) were less likely to go to, with a Pearson chi-square of 1.33 and p value of 0.513, which is not statistically significant. Moreover, both Congolese and African Americans were less likely to go to the Champaign County Christian Health Center (free clinic) with a Pearson chi-square of 0.745 and a p value of 0.438, which is not statistically significant. For Champaign Urbana Public Health District, the percentage of participants going there was about the same for Congolese and African Americans, 3.6% and 3.7% respectively with a Pearson chi-square of 1.156 and a p value of 0.354. In terms of don't use service, Congolese (21.8%) were more likely to report that compared to African Americans (1.9%), with a Pearson chi-square of 10.34 and p value of 0.002, which is statistically significant.

Table 5 Comparison table between Congolese and African Americans on medical service providers.

Medical service providers	Congolese N (%)	African Americans N (%)	Pearson χ^2	p
Carle			0.01	1.000
Yes	31 (56.4%)	31 (57.4%)		
No	24 (43.6%)	23 (42.6%)		
Provena Covenant			5.30	0.026**
Medical Center				
Yes	8 (14.5%)	18 (33.3%)		
No	47 (85.5%)	36 (66.7%)		
Christie Clinic			5.26	0.027**
Yes	13 (23.6%)	24 (44.4%)		
No	42 (76.4%)	30 (54.6%)		
McKinley Health Center			3.14	0.118
*Yes		3 (5.6%)		
No	55 (100%)	51 (94.4%)		
Emergency room			2.77	0.112
Yes	5 (9.1%)	11 (20.4%)		
No	50 (90.9%)	43 (79.6%)		
Frances Nelson			1.33	0.513
Medical Center				
Yes	3 (5.5%)	1 (1.9%)		
No	52 (94.5%)	53 (98.1%)		
CCCHC (Free clinic)			0.75	0.438
Yes	2 (3.6%)	4 (7.4%)		
No	53 (96.4%)	50 (92.6%)		
CUPHD			1.156	.354
Yes	2 (3.6%)	2 (3.7%)		
No	53 (96.4%)	52 (96.3%)		
Don't use service			10.34	0.002***
Yes	12 (21.8%)	1 (1.9%)		
No	43 (78.2%)	53 (98.1%)		

Note. [1]No Congolese responded using McKinley health center. ***$p<0.01$, **$p<0.05$

The analysis health insurance status versus length of stay in the U.S. of Congolese is displayed in Table 6. Congolese who spent less than 5 years in the U.S. were more likely to have health insurance than those who spent more than 5 years in the U.S. with a Pearson chi-square of 6.11 and a p value of 0.028 which was statistically significant.

Table 6 Congolese health insurance status versus length of stay in the U.S. variable.

	Health insurance through employer		Pearson χ^2	p
	Yes (%)	No (%)		
¹Length of stay in the U.S.			6.11	0.028**
0-5 years	28(70.0%)	12 (30.0%)		
6 or more years	5 (33.3%)	10 (66.7%)		

Note. ¹The length of stay in the U.S. variable was only applicable to Congolese since they were born outside of the U.S. **$p<0.05$

CHAPTER 5

DISCUSSION

The purpose of this study was to compare the medical insurance status between Congolese and African Americans attending the same church in the Champaign area. A questionnaire was distributed to participants. A subsequent inquiry utilizing PASW/SPSS was conducted to understand the trends associated with the medical insurance status of Congolese and African Americans.

Research Questions

1. Is there any difference of medical insurance status between Congolese and African Americans attending the same local church in Champaign? If there is a difference, in what aspects will the difference be?

2. What might be the barriers associated with the medical insurance status between Congolese and African Americans of Stone Creek Church in Champaign County?

3. Do Congolese and African Americans know what types of health insurance plans they have?

5.1 FINDINGS

According to the results, there is a difference in medical insurance status between Congolese and African Americans attending Stone Creek church in the Champaign area. The frequency table shows that 60% of Congolese have health insurance through their employers, whereas 37% of African Americans have health insurance through employers with a Pearson chi-square of 5.75 and a p value of 0.022, which was statistically significant. Congolese were more likely to subscribe for health insurance through employers than African Americans because they have not been exposed to a systematic and qualified health care system throughout their lives.

Therefore, this will be a great opportunity to see how health care works. Another reason could be that 68.5% of African Americans work full time whereas 81.8% of Congolese work full time with a Pearson chi-square of 2.59 and a *p* value of 0.125, which was not statistically significant. Thus, with all the previous unmet health-related needs, these Congolese will be more likely to subscribe for health insurance through employers. Moreover, 9.1% of Congolese go to the emergency room for care whereas 20.4% African Americans go there with a Pearson chi-square of 2.77 and a *p* value of 0.112, which was not statistically significant. That is, compared to African Americans, a little percentage of people goes to the emergency room could be attributable to the bills they end up paying afterwards. Therefore, they decided to avoid the emergency room. Furthermore, Congolese had 3.6% of visit to free clinic (CCCHC) whereas African Americans had 7.4% with a Pearson chi-square of 0.745 and a *p* value of 0.438. This was not statistically significant. A small percentage of both Congolese and African Americans go to free clinic and this could be due to the fact that the free clinic operates few days a week in the evening when most of the Congolese are at work. Carle is the place where most of the Congolese and African Americans go for medical services, 56.4% and 57.4% respectively, with a Pearson chi-square of 0.012 and a *p* value of 1.000. No Congolese used using McKinley Health Center whereas 5.6% of African Americans responded the contrary with a Pearson chi-square of 3.14 and a *p* value of 0.118, which was not statistically significant. Congolese did not report going to McKinley Health Center because the majority of Congolese are Parkland's students.

- DIFFERENCE IN TYPE OF WORKS BETWEEN THESE GROUPS

Congolese (5.5%) were less likely to work in professional type of job than African Americans (63%) with a Pearson chi-square of 40.19 and a *p* value of less than 0.001. However, the majority of Congolese were working in manual jobs than African Americans (94.5% and 37%, respectively with Pearson chi-square of 40.19 and *p* value less than 0.001). Since

Congolese have some language barrier, they will be more likely to work in manufacturing industry. That is, Congolese working in the manufacture settings will make less money than people working on professional setting jobs. However, they do subscribe for health insurance deductions because having health insurance is a necessity in Congolese's perspective. That is; no Congolese responded that health insurance is unnecessary compared to 3.7% of African Americans who responded the contrary with a Pearson chi-square of 2.08 and a p value of 0.243, which was not statistically significant.

- DIFFERENCE IN INCOME BETWEEN THESE GROUPS

In terms of the income level, 81.8% of Congolese making less than $25,000 annually compared to 48.1% of African Americans with a Pearson chi-square of 13.60 and a p value of less than 0.001. On the other hand, 18.2% of Congolese making $26,000 or more annually whereas 51.9% of African Americans making $26,000 or more with a Pearson chi-square of 13.60 and a p value less than 0.001. Congolese make less money than African Americans because they are more likely to have manual jobs. However, this does not prevent them for having health insurance through employers because they want to try the system. In Congolese's perspective, having health insurance could be something to be pride of since they did not get so much exposure in D.R. Congo. In terms of the length of stay in the U.S, 72.7% Congolese who have been here less than 5 years were more likely to have health insurance compared to 27.3% Congolese who spent 6 years or more with a Pearson chi-square of 6.11 and a p value of 0.028, which is statistically significant. These people who have been in the U.S. for a shorter period of time would be more likely to subscribe for health insurance once they have a job regardless of their income level due to their unmet health-related needs in the D.R. Congo. A few proportions of Congolese, who have been here for more than 6 years, with health insurance may be due to the fact that some of them work part time with no benefits since they attend online or on campus full

time classes. That is, 81.8% of Congolese work full time whereas 18.2% of Congolese work part time with a Pearson chi-square of 2.59 and a *p* value of 0.125.

- DIFFERENCE IN MARRIAGE BETWEEN THESE GROUPS

In terms of marriage of both Congolese and African Americans attending Stone Creek church, 63.6% of Congolese are married, whereas 37% of African Americans are married with a Pearson chi-square of 7.71 and a *p* value of less than 0.001(see Table 1). In Congolese's perspective, marriage is an important concept (Personal Communication, G. Bokamba, Ph.D. January 3rd, 2012). The percentage of both Congolese and African Americans' couples with children is 61.8% and 64.8%, respectively, with a Pearson chi-square of 0.11 and a *p* value of 0.843, which was not statistically significant. In addition, 25.5% of Congolese families were insured whereas 42.6% of African Americans families do have health insurance with a Pearson chi-square of 3.57 and a *p* value of 0.070, which was not statistically significant. The difference of family coverage between Congolese and African Americans could be attributable to the unwillingness of Congolese parents to see their premiums going up because of dependents.

- EDUCATION DIFFERENCE BETWEEN CONGOLESE AND AFRICAN
  AMERICANS

The education level was statistically different between both groups with a Pearson chi-square of 11.11 and a *p* value of 0.011. That is, 7.3% of Congolese had less than high school compared to 3.7% of African Americans with less than high school. For high school diploma, 30.9% of Congolese had it whereas 38.9% of African Americans had it. For undergraduate, 60% of Congolese had some undergraduate experiences whereas 38.9% of African Americans had the same experiences. Finally, 1.8% of Congolese had graduate degrees whereas 18.5% of African Americans had graduate degrees. The Congolese of Champaign have a higher percentage of undergraduate degrees than African Americans because the U.S green card lottery requires that

one should have at least high school diploma or higher to participate in the lottery (USDS, 2011).
Since the unemployment rate is so high in the D.R. Congo, most of the educated people are more likely to immigrate for better life.

The second research question is whether there were barriers associated with the medical insurance status between Congolese and African Americans attending the same church? Cost is one of the barriers, since 85.2% of African Americans think that the reason for not having health insurance is cost, whereas 43.6% of Congolese think so with a Pearson chi-square of 20.4 and a p value of less than 0.001. That is, a small percentage of Congolese think that higher premium is a barrier to health care access because they have never been exposed to a systematic health insurance in D.R. Congo. Therefore, they do not know how much the premium should be (USAIDS, 2011). Another barrier is the misunderstanding of the U.S health care system, 30.9% of Congolese don't understand the system compared to African Americans who do understand the system with a Pearson chi-square of 19.8 and a p value less than 0.001. This may be due to the fact that Congolese have never been exposed to a systematic health care industry previously. Furthermore, 21.8% of Congolese reported don't use medical service whereas 1.9% of African Americans reported the same with a Pearson chi-square of 10.34 and a p value of 0.002, which is statistically significant. This may be due to the healthy migrant effect, in which young Congolese will be more likely to overlook health insurance and don't go anywhere for medical services (Hamilton and Hummer, 2011).

The last research question focuses on the trends of medical insurance plans and knowledge of medical insurance plans between Congolese and African Americans. In terms of health insurance plans, 20% of Congolese (women) have Medicaid, whereas 13% of African Americans have Medicaid with a Pearson chi-square of 0.98 and a p value of 0.440, which is not statistically significant. In addition, more Congolese (18.2%) have health insurance but they

don't know what types of health insurance plans they have, whereas 9.3% of African Americans have health insurance but they don't know what plans, this was not statistically significant (Pearson chi-square= 0.176 and p value= 0.266). A few proportions of Congolese and African Americans reported having PPO as their health insurance type, 9.1% and 13.0% respectively, with a Pearson chi-square of 0.42 and a p value of 0.556, which was not statistically significant. Yet, this insurance plan is one of the most popular nowadays (KFF, 2011). So, a question arises of whether or not study's participants understood the health care system. Based on the findings, HMO was the most used among African Americans with 40.7% of people having this type of health insurance compared to 7.3% of African Americans with a Pearson chi-square of 16.8 and a p value less than 0.001, which was statistically significant.

5.2 LIMITATIONS

This study is not without limitations. One of the flaws associated with this study is that the African American community attending Stone Creek Church in Urbana, Illinois, is not a representative group of all African Americans living in the Champaign area. That is, the African American community of Stone Creek church is more likely to be mixed and fairly educated. Additionally, some questions were exclusively applicable to one particular group participating in the study. For instance, question such as "time spent in the U.S", for Congolese was not applicable to African Americans.

According to the results, some participants had issues to report their current type of health insurance which consisted of PPO, HMO, POS, Fee for service, and others. Based on the current trend of health insurance types, PPO is the most used (KFF, 2011). However, according to the results, this is not the case. Additionally, the study was self-reported with the possibility of not reporting the reality intentionally or unintentionally (bias). There were some outliers

associated with the "family size" question for Congolese. Some of them mistakenly thought the question was related to the number of people in their extended family.

The sample size was relatively small, but it is a representation of the minority people living in the Champaign area. There was a not boundary limiting couples to fill out the survey. That is, husband and wife could fill out the survey separately as they were employed.

Conclusion

This study compares the health insurance status between two minority groups of the Champaign area attending the same church. The null hypothesis of the difference between the two groups was rejected. That is, the alternative hypothesis was accepted. There is a difference in terms of health insurance status between Congolese and African Americans attending the same church in the Champaign area.

A chi-square analysis, through PASW/SPSS, was conducted for comparing the medical insurance status between Congolese and African Americans. The independent variables were: education level, time spent in the U.S, and income. The time spent in the U.S variable was not applicable to African Americans. The dependent variable was: having health insurance or not having one.

This study sheds the light on the access of health care between two minority groups attending the same local church. The study confirms that minorities are more likely to be uninsured. The identification of barriers (people with health insurance don't know what type of health insurance they have) will help future studies to overcome these barriers in order to ensure that minorities have access to health care. Cost and understanding the medical insurance system are the barriers associated with the access to health care. The identification of these barriers will help future researches to increase knowledge of health care system among minorities for an effective use.

REFERENCES

Adashi, E. Y., Geiger, H. J., & Fine, M. D. (2010). Health care reform and primary care - the growing importance of the community health center. *New England Journal of Medicine, 362*(22), 2047-2050. doi:10.1056/NEJMp1003729

Baer, F. *Connecting good laptops and good health in DR Congo*. Retrieved from http://www.laptopsforhealth.org

Centers for Disease Control and Prevention (CDC). (2011). Usual sodium intakes compared with current dietary guidelines --- united states, 2005-2008. *MMWR.Morbidity and Mortality Weekly Report,60*(41), 1413-1417.

Central Intelligence Agency. (2011). The World Factbook. Retrieved from www.cia.go/library/publications/ the-world-factbook/geos/cg.html.

Collins, S.K., Tenney, K., & Hughes, L.D. (2002). Quality of Healthcare for African Americans: A Fact Sheet. *The Commonwealth Fund, 524.*

Congolese Community of Champaign County. (2011). Retrieved from http://congolesechampaign.org/

Coogan, P. F., White, L. F., Evans, S. R., Adler, T. J., Hathaway, K. M., Palmer, J. R., & Rosenberg, L. (2011). Longitudinal assessment of urban form and weight gain in african-american women. *American Journal of Preventive Medicine, 40*(4), 411-418. doi:10.1016/j.amepre.2010.12.013

Cutler, D. (2010). Analysis & Commentary How Health Care Reform must bend the Cost Curve. *Health Affairs, 29*(6), 1131-1135.

Dorell, C. G., Sutton, M. Y., Oster, A. M., Hardnett, F., Thomas, P. E., Gaul, Z. J., . . . Heffelfinger, J. D. (2011). Missed opportunities for HIV testing in health care settings among young african american men who have sex with men: Implications for the HIV epidemic. *AIDS Patient Care and STDs, 25*(11), 657-664. doi:10.1089/apc.2011.0203

Fitzgibbon, M. L., Stolley, M. R., Schiffer, L. A., Braunschweig, C. L., Gomez, S. L., Van Horn, L., & Dyer, A. R. (2011). Hip-hop to health jr. obesity prevention effectiveness trial: Postintervention results.*Obesity, 19*(5), 994-1003. doi:10.1038/oby.2010.314

Gillum, F., & Griffith, D. M. (2010). Prayer and spiritual practices for health reasons among american adults: The role of race and ethnicity. *Journal of Religion & Health, 49*(3), 283-295. doi:10.1007/s10943-009-9249-7

Griffith, D. M., Johnson, J. L., Zhang, R., Neighbors, H. W., & Jackson, J. S. (2011). Ethnicity, nativity, and the health of american blacks. *Journal of Health Care for the Poor and Underserved, 22*(1), 142-156.

Grossman, E., Legedza, A., & Wee, C. (2005). *Primary care for low-income populations: A comparison of healthcare delivery systems.* Malden, MA: Blackwell Science.

Hamilton, T. G., & Hummer, R. A. (2011). Immigration and the health of U.S. black adults: Does country of origin matter? *Social Science & Medicine, 73*(10), 1551-1560. doi:10.1016/j.socscimed.2011.07.026

Holdsworth, M., Hovette, P., Eymard-Duvernay, S., & Delpeuch, F. (2008). Perceptions of
Congolese Urban Men and Woment of Healthy and Desirable Body Sizes. *Proceedings
of the Nutrition Society, 67.* Doi: 10.1017/Soo29665108009968

Illinois Department of Public Health. (2009). *Health Statistics.* Retrieved from
www.idph.state.il.us.

Illinois: Health Insurance Status (2010). States Health Facts. Retrieved from
www.stateshealthfacts.org

Ilunga Tshiswaka, D. (interviewer) & Bokamba, G. (interviewee). (2012). The Reasons of
Congolese's Immigration to Champaign [Interview audio file].

Ishikawa, H., & Yano, E. (2008). Patient Health Literacy and Participation in the Health Care
Process. *Health Expectations, 11*(2), 113-122.

Kahende, J. W., Malarcher, A. M., Teplinskaya, A., & Asman, K. J. (2011). Quit attempt
correlates among smokers by Race/Ethnicity. *International Journal of Environmental
Research and Public Health, 8*(10), 3871-3888. doi:10.3390/ijerph8103871

Kaiser Family Foundation. (2012). Changes in Uninsured Rate for Nonelderly Adults and
Children, 2007-2010. Retrieved from www.facts.kff.org/chart

Kelly, B., Flood, V. M., & Yeatman, H. (2011). Measuring local food environments: An
overview of available methods and measures. *Health & Place, 17*(6), 1284-1293.
doi:10.1016/j.healthplace.2011.08.014

Keyes, K. M., Barnes, D. M., & Bates, L. M. (2011). Stress, coping, and depression: Testing a

new hypothesis in a prospectively studied general population sample of U.S.-born whites

and blacks. *Social Science & Medicine, 72*(5), 650-659.

doi:10.1016/j.socscimed.2010.12.005

Kodi, W. M. (2007). Anti-Corruption Challenge in Post-Election Democratic Republic of Congo.

Chatam House. Retrieved from www.chathamhouse.org.uk.

Le, T. N., Lai, M. H., & Wallen, J. (2009). Multiculturalism and subjective happiness as

mediated by cultural and relational variables. *Cultural Diversity & Ethnic Minority*

Psychology, 15(3), 303-313. doi:10.1037/a0015507

Levine, D. A., Lewis, C. E., Williams, O. D., Safford, M. M., Liu, K., Calhoun, D. A., . . . Kiefe,

C. I. (2011). Geographic and demographic variability in 20-year hypertension incidence

the CARDIA study.*Hypertension, 57*(1), 39-U158.

doi:10.1161/HYPERTENSIONAHA.110.160341

McNeil, J., Campinha-Bacote, J., Tapscott, E., & Vample, G. (2002). Be Safe: A Cultural

Competency Model for African Americans. *National Minority AIDS Education and*

Training Center. Retrieved from http://www.aids-ed.org/pdf/p02-et/et-17-00/be_safe.pdf

Mustapha, O.A., Mbuzukongira, P., & Mangala, M.J. (2007). Occupational Radiation Exposures

of Artisans Mining Columbite-Tantalite in the Eastern Democratic Republic of Congo.

Journal of Radiology Protection, 27(2), 187. Doi:10.1088/0952-4746/27/2/005

National Institute of Social Security. 2011. Action of Socio-Health. [Institut National de Securité

Sociale. Action Sanitaire et Sociale]. French Retrieved from www.inss.cd

National Society of Insurances. 2011. Catalogue of the Insurance's Products. [Société National d'Assurances. Catalogue de Produits d'Assurance]. French Retrieved from www.sonasrdc.com

Orszag, R.P., Emanuel, J.E. (2010). Health Care Reform and Cost Control. *The New England Journal of Medicine, 363*(7), 601-603.

O'Toole, P.T., Arbelaez, J.J., & Dixon, W.B. (2004). Full Disclosure of Financial Costs and Options to Patients: the Roles of Race, Age, Health Insurance, and Usual Source for Care. *Journal of health care for the Poor and Underserved, 15* (1), 52-62.

Reno, W. (2006). Congo: From State Collapse to 'Absolutism', to state failure. *Third World Quartely, 27*(1), 43-56.

Schoen, C., Osborn, R., Squires, D., Doty, M., Pierson, R., & Applebaum, S. (2010). How Health Insurance Design Affects Access to Care and Costs, by Income, in Eleven Countries. *Health Affairs, 29*(12), 2323-2334.

Schwartz, K., & Schwartz, T. (2008). Uninsured Young Adults: A Profile and Overview of Coverage Options. Kaiser Commission on Medicaid and the Uninsured. Retrieved from www.kff.org/uninsured.

Seidel, V.J. (1998). Qualitative Data Analysis. Retrieved from www.qualisresearch.com/pub/qda.pdf.

Stanton, W.M. (2004). Employer-Sponsored Health Insurance: Trends in Cost and Access. *Agency for Healthcare Research and Quality*. Retrieved from http://www.ahrq.gov/research/empspria/empspria.htm

Sumata, C. (2002). Migradollars and Poverty Alleviation Strategy Issues in Congo (DRC). *Review of African Political Economy, 29* (93), 619-628.

T. Hart. (2007, May). Searching for Bonobo in Congo. [Web log comment]. Retrieved from http://www.bonoboincongo.com.

Thomas, M., & James, C. (2009). The Role of Health Coverage for Communities of Color. *Race, Ethnicity Health Care, 8017*. Retrieved from http:www.kff.org/healthreform.

Tyler, J. (2011, October 16). Congo week raises awareness of humanitarian crisis. *Daily Illini,* p.1.

United Nations AIDS. (2003). *Ancient Remedies for a new disease: the integration of traditional healers in the fight against AIDS increases access to care and prevention in East Africa. [Des Remedes Ancestraux pour une Maladie Nouvelle : L'Integration des Guerisseurs Traditionnels a la Lutte contre le Sida accroit l'Acces aux Soins et a la Prevention en Afrique de l'Est]*. Onusida. Retrieved from www.data.unaids.org

United Nations Development Programme. (2011). Country Profile: Human Development Indicators. Retrieved from www.hdrstats.undp.org/en/countries/profiles/COD.html

United Nations News Centre. (2011). Mass Rapes in DR Congo could be Crimes against Humanity—UN Report. Retrieved from www.un.org/apps/news/story.asp

United States AIDS. (2011). National Health Accounts 2008-2009 Executive Summary. Retrieved from www.who.int/nha/country/cod/drc_nha_2008-2009-eng.pdf

United States Census Bureau. (2011). State & County Quickfacts: Champaign County, Illinois.

   Retrieved from www.quickfacts.census.gov/qfd.

United States Department of Health and Human Services. (2010). The Office of Minority Health.

   Retrieved from www.minorityhealth.hhs.gov

United States Department of State. (2011). A Service of the Bureau of Consular Affairs.

   Retrieved from www.travel.state.gov/visa/

Weinick, R. M., & Hasnain-Wynia, R. (2011). ANALYSIS & COMMENTARY quality

   improvement efforts under health reform: How to ensure that they help reduce

   disparities-not increase them. *Health Affairs, 30*(10), 1837-1843.

   doi:10.1377/hlthaff.2011.0617

World Health Organization. (2009). *Track 2: Health Literacy and Health Behavior. 7th Global

   Conference on Health Promotion* [track themes]. Retrieved from

   http://who.int/healthpromotion/conferences.

Survey of Comparing Health Insurance Status of African Americans and Congolese Communities Living in the Champaign-Urbana Area

1. Gender:_____Male _____Female
2. Age range: ____20-30 years
   ____31-40 years
   ____41-50 years
   ____51-60 years
3. Marital Status: _____Widowed
   _____Single (never been married)
   _____Married
   _____Separated (divorce)
4. Where were you born?
   _____In the United States (go to question 7)
   _____In Congo (DRC)
5. *Answer this question, if you are not originally from the U.S.* How long have you been in the United States?
   ____0-2 years
   ____3-5 years
   ____6-8 years
   ____9-11 years
   ____12-more
6. *Answer this question if you are not originally from the U.S.* What made you come to the United States?
   ____For better education
   ____For business reasons
   ____To work
   ____For political reasons (asylum)
   ____Family reunion
   ____Don't know
7. Do you have children?
   ____Yes
   ____No
8. How many people are in your family (including yourself)?

   _____
9. What is your highest level of education?
   ____Elementary
   ____Middle School
   ____GED
   ____High school diploma
   ____ Associate degree
   ____Vocational degree
   ____Bachelor degree
   ____Master degree
   ____Doctorate/PhD
10. Are you currently employed?
    _____Full time job
    _____Part time job
    _____Unemployed (go to question 14)
11. What's type of work do you currently have?
    ____Factory (warehouse)
    ____Office
    ____Construction
    ____Daycare
    ____Driver
    ____Restaurant
    _____other (please specified)

12. What is your income level range?

_____less than $15,000

_____$15,000-25,000

_____$26,000-39,000

_____$40,000-more

13. Do you have health insurance through your employer?

___Yes

___No

14. Is your family covered through your health insurance

_____Yes

_____No

15. What types of health insurance you have?

_____Medicaid

_____PPO

_____Fee for service

_____HMO

_____POS

_____Don't know (you have health insurance, but you don't know what type)

_____Don't have any

16. *Answer this question, if you don't have health insurance*. What might be the reasons of not having health insurance?

_____Premium too high

_____Unnecessary (feel like you don't need it)

_____ Coverage denied (due to preexisting medical conditions)

_____ Employer doesn't offer health insurance

_____ Don't understand the system

17. Where do you go for medical services? *Mark all that apply*

_____Carle Foundation Hospital and Clinic

_____Provena Covenant Medical Center

_____Christie Clinic

_____McKinley Health Center

_____Emergency room

_____Frances Nelson Medical Center

_____Champaign County Christian Health Center (Free clinic)

_____Champaign-Urbana Public Health District

_____Don't use service

Appendix B

Informed Consent form of Comparing Health Insurance Status of African American and Congolese Communities living in the Champaign-Urbana Area.

Comparing Health Insurance Status of African American and Congolese Communities Living in the Champaign-Urbana Area.

You are invited to participate in a research being conducted by Susan Farner, PhD in the department of Kinesiology and Community Health at the University of Illinois at Urbana-Champaign. The purpose of the research is to evaluate your insurance status and your knowledge of health insurance. Your identification will not be used. The data will be aggregated without identification.

You are asked to complete a survey. You must be between 20 and 60 years of age to participate in this research. The survey will take approximately 15 minutes to complete. You may skip any questions you are not comfortable answering. There is a coversheet for the survey so your results will not be visible to anyone. Your participation in the research is completely voluntary. The surveys will be distributed and collected by research staff. The results of this research will be reported in Master Thesis projects, in journal articles and conference presentations.

The risks associated with this project not more than those of daily life. The benefits to this project will be to determine the barriers that might exist for you to obtain health insurance. You will be given a copy of the consent form for your records.

If any time, you have questions about this research project, please feel free to contact the principal investigator, Susan Farner, PhD, Department of Kinesiology and Community Health, 129 Huff Hall, 333-6876, sfarner@illinois.edu. You are welcome to call collect if you identify yourself as a research participant.

 If you have any questions about your rights as a participant in research involving human subjects, please contact the University of Illinois Institutional Review Board (IRB) office at 217-333-2670 (collect calls accepted if you identify yourself as a research participant) or via email at irb@illinois.edu.

I certify that I am between 20 and 60 years of age.
I have read and understand the above consent form and voluntarily agree to participate in this study.

Appendix C

Script of Comparing Health Insurance Status of African American and Congolese Communities living in the Champaign-Urbana area

Comparing Health Insurance Status of African American and Congolese Communities Living in Champaign-Urbana Area.

A professor from the department of Kinesiology and Community Health of the University of Illinois at Urbana-Champaign is conducting a study aimed at evaluating the insurance status and the knowledge of health insurance among African American and Congolese attending this church (Stone Creek Church). You must be African American or Congolese aged 20 thru 60 to participate in this study. If you are interested in participating, please stay in the sanctuary and a short survey will be handed out to you. This study is completely anonymous. The survey will take approximately 15 minutes to complete. You may skip any questions you are not comfortable answering.