

UNDERSTANDING AFRICAN IMMIGRANT HEALTH IN THE UNITED STATES: AN
EXPLORATORY STUDY OF THE NIGERIAN IMMIGRANT
HEALTHCARE EXPERIENCE

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DEDICATION

To:

Papa – I du ike, Nwa Uzo!

Amarachi – One day you will comprehend how the sacrifices you were not even aware you were making, helped make this possible.

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Ogbonnaya Isaac Omenka

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Introduction:

In the United States, there is very little knowledge about the health of African immigrants. Although their population exceeds 2 million and still on the rise exponentially, a big gap exists regarding knowledge about health care access and outcomes for this population. Before relocating to the US, many African immigrants face health-threatening conditions, including civil wars and poverty, which are exacerbated by the lack of understanding and attention to their health care needs in the US.

Methods:

To examine the health care experiences of African immigrants in the US, two distinct studies were conducted. A scoping review examined literature between 1980 and 2016 using four databases, to identify knowledge-gaps concerning African immigrant in the US. A qualitative study comprising 33 semi-structured (one-on-one) interviews and 4 focus groups was conducted using Nigerian immigrant participants in Indianapolis, to assess how discrimination affects their health care experiences and quality of care, and the factors their influence their health care meanings, respectively.

Results:

For the scoping review, 14 articles were included. All the studies were focused on barriers to the health care access of African immigrants in the US. Along with religion and culture, lack of culturally-competent healthcare and distrust of the US health system, were identified as the major barriers. Both the one-on-one interviews and focus groups revealed provider attitudes, through implicit and open biases, were a key contributing factor to the participants' health care meanings and healthcare utilization. Additionally, results showed an important intersectionality within the healthcare experiences of the participants, as a result of their perception as "black," along with African Americans and other physically-related groups.

Conclusion:

African immigrants in the US grapple with the critical process of reconciling their original identities with their emerging realities, including negative provider attitudes and discrimination, and lack of identify in the US health system. This study highlights the importance of understanding African immigrant health in the US, through the examination of the role of the African framewok of understanding of their health in their approaches to healthcare and well-being.

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CHAPTER 1

Introduction

There is paucity of research on the healthcare experiences and healthcare needs of African immigrants in the United States. With a population of more than two million, nothing is known about healthcare access and outcomes for this population.¹⁻³ For many African immigrants in the United States, the driving force for relocating was economic prosperity, and for many others, repression and political turmoil, resulting in wars, were behind their immigration.⁴ Other reasons for moving to the US by African immigrants include family reunification, the diversity lottery program, and brain drain (migration of professionals to wealthier countries for socioeconomic benefits).⁵⁻⁷ More than 36% of the US African immigrants are from West Africa, followed by Eastern (29%) and Northern Africa (17%). Of these African immigrants, the largest number (more than 14%) come from Nigeria, followed by 10% from Ethiopia.² Between 2000 and 2013, the population of African immigrants went up by 41%, representing the largest population growth rate out of all US immigrant groups.¹ Most of US African immigrants are from the English- and French-speaking sub-Saharan countries such as Nigeria, Ghana, Senegal, and Ivory Coast.⁸

Traditionally, Africans view life in general as a mesh of physical and spiritual influences, whereby the supernatural wields an overriding impact on the physical. In their understanding of health and well-being, Africans' primary assessment of any health condition is largely predicated on the determination of its connection to any spiritual factors. Whether through the lenses of culture or religion, this view of well-being is still key.^{9,10} Although they recognize the human input to health outcomes, the traditional African perception of well-being is based on its ultimate predication on spiritual factors.¹¹ From the traditional perspective, Africans often consult oracles regarding their illnesses. Also based on their religious beliefs, Africans address illnesses with prayer and faith in God's healing powers. It is common for many Africans to utilize both oracle consultation and prayers with faith, to feel more assured of their protection.^{9,11,12} In dealing with illnesses and other issues related to well-being, the

African understanding of causality is divided into the immediate and the ultimate. This means that despite the identification of present responsible factors for an individual's health outcomes, they will still want to understand the reasons why those initial factors affected that individual and not someone else. This may lead to the identification of the ultimate spiritual determining factors.¹³ According to this perception of well-being, the relationship between the physical and spirituals aspects is a continuum.¹⁴ The health experiences and healthcare needs of African immigrants are a significant challenge for US healthcare professionals. Failing to understand this issue can lead to the delivery of culturally incompetent care, and poor health outcomes or disparities. This is why it is necessary for US providers to include in their assessments, African immigrants' cultural and spiritual understanding of their own health and healthcare needs.

Prior to arriving in the United States, many African immigrants deal with adverse conditions that pose high threat to health, including poverty, family separation, and mental health challenges, in their home countries. Consequently, many of them already carry significant health vulnerabilities upon arrival in the United States. Despite these susceptibilities, African immigrants have not been included in US healthcare studies, especially regarding immigrant health and the impact of culture on healthcare experiences. So far, immigrant health research in the United States has focused on the Hispanic and Asian populations.^{15,16} It is incorrect to assume findings from those studies will apply to African immigrants because health experiences and meanings vary across populations. For instance, African immigrants regard a lean physical appearance as unhealthy, and a big body-type as an indicator of well-being. This stands in contrast to the western view, which equates health with lower body fat.¹⁷ Even when African immigrants are included in studies, they are often misrepresented as "black," along with African Americans and Caribbean immigrants, making it difficult to identify them in databases. In addition, research has shown phenotypic similarities do not correspond with comparability of health outcomes. For instance, babies born to Africa-born black mothers have higher birth-weights than those born to US-born black mothers.^{18,19} Because of lack of knowledge about the healthcare experiences of African immigrants in

the United States, critical understanding of this population is also absent. This includes the impacts of their cultural and spiritual beliefs on their construction of healthcare meanings, and barriers to their healthcare utilization. More worryingly, US healthcare providers have no information about effective healthcare delivery to African immigrants.^{3,17,20}

This study consisted of a scoping review of the literature and a qualitative investigation, the purpose of which was to explore the healthcare experiences of African immigrants living in the United States. My interest in this issue emanated from my background as an African immigrant from Nigeria, whose lived experiences in the United States encapsulated the issues examined in this study. My experiences as a patient seeking healthcare, and the years I worked in a community pharmacy serving many African immigrants, provided me an insight to the severity of the lack of knowledge about African immigrant health. I conducted the qualitative study in the city of Indianapolis, Indiana. This setting was ideal because I had lived there for multiple years and established strong connections. As a result, I was able to utilize community leads for participant recruitment. In addition, Indianapolis contains a large, representative Nigerian immigrant population, which comprises different age groups, socioeconomic statuses, educational levels, and religions. As the African immigrant group with the highest number in the United States, the use of Nigerian immigrants for the qualitative study sample represented a good first step for understanding Africans as a whole. The specific aims I sought to address in meeting this purpose included (1) to examine the existing literature on African immigrant healthcare in the United States, for knowledge-gaps to guide the development of future inquiries; (2) to assess Nigerian immigrants' meanings of health and their impact on the participants' healthcare experiences; (3) to assess factors that influence their utilization of healthcare in the United States, using one-on-one interviews and focus groups.

The results of this study are divided between three manuscripts. Due to the paucity of African immigrant health research in the United States and lack of references for delivery of effective healthcare to US African immigrants, the first manuscript

presents a scoping review of the literature focused on the healthcare experiences of African immigrants in the United States. The purpose of this paper was to identify knowledge-gaps, upon which subsequent inquiries would be predicated. The second manuscript is the first of two papers developed from the qualitative exploration of Nigerian immigrant healthcare experiences in Indianapolis. Using data from one-on-one semi-structured audio-recorded interviews, it explores the types of discrimination experienced by Nigerian immigrants, and how they affect the group's healthcare experiences. The final manuscript, through the analysis of focus group data, examines the factors that affect how Nigerian immigrants derive their healthcare meanings, and how that further influences their utilization of healthcare. At the end of the three distinctive, but connected papers, I discuss the findings of this study and their healthcare, policy, economic, and public health implications. In addition to highlighting the study's strengths and limitations, I present some future inquiry considerations, based on some of the questions borne out of this study. Before presenting each of these manuscripts, I provide an overview of the theoretical lens and methods I utilized in the study.

Theoretical Framework

Symbolic interactionism. The appropriateness of Symbolic Interactionism for the current study was derived from its views that (a) people's ways of reacting to their life experiences arise from how they define those experiences; (b) people's definitions of their life experiences originate from their social exchanges with other people; (c) people apply their definitions of life experiences in ways that will contribute to making sense of, and properly dealing with, them.^{21,22} Symbolic Interactionism is compatible with Grounded Theory because both approaches are centered on the examination of meaning through the discovery of the connection between meaning and action in a situation.²³ Since the exploration of the healthcare experiences of African immigrants in the United States was hinged on interpretation and meaning, it was necessary that the research design allowed the participants to give their own definitions of both their healthcare experiences.

Grounded theory. Grounded theory was ideal for this study because it allowed theories to develop organically from the available data. This was made possible largely by the inductive approach to data analysis, which led to theoretical analysis of the emerging data.²³ Also these considerations were ideal for this qualitative research because they zoomed the study lens on the participants' meanings²⁴, which was the same emphasis of Symbolic Interactionism²³, and the central theme of this study.

Specific Aims

The following are the specific aims of this study:

Aim 1: To examine the existing literature on African immigrant healthcare in the United States, for knowledge-gaps to guide the development of future inquiries.

Aim 2: To assess Nigerian immigrants' meanings of health and their impact on the participants' healthcare experiences, using one-on-one interviews and focus groups.

Aim 3: To assess factors that influence their utilization of healthcare in the United States, using one-on-one interviews and focus groups.

Methods

The Scoping Review was conducted in accordance with the framework developed by Arksey and O'Malley, which consisted of (a) identification of research questions, (b) identification of relevant studies, (c) screening of studies, (d) extraction and synthesis of data, (e) result presentation. The questions the Scoping Review attempted to answer were: (1) What do we currently know regarding the healthcare experiences of African immigrants in the United States? (2) What are the knowledge-gaps about US African health? To identify relevant articles in databases, I accessed EBSCO, ProQuest, and PubMed, as well as a hand-search in Google Scholar. The inclusion criteria were peer-reviewed articles, focused on the healthcare experiences of African immigrants in the United States, and published in the English language between 1980 and 2016. The starting point for article selection was 1980, because it marked an exponential rise in the number of African immigrants in the United States, due to the immigration Act, which allowed in immigrants from conflict regions.²⁵ Studies conducted using secondary data were excluded, due to the difficulty with identifying African

immigrants in US databases, and therefore the unreliability of findings from such studies. Studies focused on African immigrant refugees were excluded, due to the unique migratory experiences of that population. The keywords I used to search for the articles included, “african immigrants OR african immigration;” “african emigrants OR african emigration.” The initial articles were screened through the application of the search criteria to their titles. In the absence of sufficient evidence in those titles, I read the abstracts of the articles. If an article still failed to present a sufficient reason for inclusion after this step, I read the entire article. In addition to these steps, I performed a backward search of articles selected through a hand-search in Google Scholar, and the resultant articles were further screened using the previously described criteria. Using the inductive approach²⁶, I extracted data from the final articles, based on comprehensive reading and interpretive analysis of the organically emerging themes. For the final step of the Scoping Review methodology, the results from the selected articles were presented in a narrative format, to reflect the respondents’ perspectives.²⁷

The qualitative portion of this study was developed based on the Scoping Review. The findings from the review of the literature provided questions, which guided the formulation of the subsequent one-on-one and focus group questionnaires. For the qualitative data collection, I used purposive sampling to select participants, based on their characteristics that matched as closely as possible, the design of this study. This sampling approach allowed me to select participants who best assisted me in understanding the phenomenon, and provided the best answers to my research questions.^{28,29} Additionally, this type of recruitment was ideal for this study because immigrants are generally known to be reluctant to participate in health-related research. Not only that, participant recruitment is exceptionally challenging within the African immigrant community, due to their suspicion of researchers based on their history of exploitation of African participants.³⁰ To identify other potential participants, I used the snowball sampling approach, whereby an individual interested in participating in the research, served as a conduit to other participants with comparable characteristics.^{31,32}

In addition, community “Leads,” who had access to the Nigerian immigrant community, served as links to the settings where participants were recruited, including religious and social gatherings. In each setting, I presented the study, including participation requirements. I also provided attendees with study recruitment materials, as well as the researcher’s information. Other recruitment settings were used, such as international markets and stores. Once a participant was recruited, the time and location for the interview was set, and a safe, private location, such as library study rooms, agreed upon. Prior to each interview, informed consent of the participant was obtained. Participant eligibility included being Nigeria-born, at least 18 years of age, and English-speaking. In addition, participants had to be legal US residents (permanent residents or naturalized citizens), who were 12 years and older, at the time of migration, and had lived in the United States for at least three years. Participants who had lived in other countries than Nigeria before moving to the United States were excluded, because of possible exposure to experiences with possible altering effects on their original health perspectives in Nigeria.

Procedure. A qualitative approach to this study was necessary because it was most suitable for discovering and examining new or under-studied phenomena. Also, to understand the healthcare experiences and healthcare needs of Nigerian immigrants in the United States, a qualitative design was necessary, because of its emphasis on the meanings people attach to their own experiences.³³ This approach gave me direct insight into the thoughts, attitudes, and beliefs of the people who were experiencing the phenomenon being studied.³⁴ This qualitative study was carried out using one-on-one semi-structured interviews and focus group discussions.

One-on-one interviews. Thirty-three semi-structured, one-on-one interviews were conducted. The interviews were audio-recorded with the permission of the participants. The duration of each interview was between 30 and 60 minutes. This type of qualitative data collection was suitable because it will assisted me in obtaining participants’ historical accounts and other background information about the research problem. Also, it gave me a wider range of line of questioning, which resulted in richer

data.²⁸ Some of the questions I asked the participants included, “Can you please describe to me what “health” means to you?” and “Can you talk about any time you were sick, but could not, or did not go to see the doctor?”

Focus groups. Four focus groups made up of five participants each, was conducted. Each discussion lasted between 30 to 90 minutes, and was audio-recorded with the participants’ permission. This form of data collection created the atmosphere for participants to not only respond directly to the research question, but also provide insight into their shared experiences with other participants, through which I gained deeper meanings of participants’ responses.³⁵ This depth of exploration of participants’ responses and clarification of their views would not have been possible in one-on-one interviews.³⁶ Examples of the questions discussed by the groups included, “Can you discuss what “health” means to you?” and “Can you discuss your views about the US healthcare system?” For a more in-depth look into participants’ responses, I will use probes to tease out further clarification of pertinent information.²³

Data analysis. Following the grounded theory framework, I used the inductive approach to data analysis, which allowed the themes to be organically derived from the data.²⁴ This entailed cleaning the raw data, detailed reading of data document, and development of themes.²⁶ A trained research assistant (RA) assisted with this data analysis process, including transcription and coding. Using focused coding, we developed a codebook by identifying and labeling pivotal parts of the data documents, and then arranged them according to how they naturally fell into themes.³⁷ We achieved an inter-coder reliability of at 83%, before performing a second round of coding, which raised our percent agreement to 90%. Also line coding allowed us to refrain from imposing our own ideas on the data.²³ The final coding process was conducted by axial coding, in which we examined the grouped themes holistically, and accounted for themes that may have been previously missed. Throughout the data analysis process, the RA and maintained a trail of our steps, which allowed us to keep track of the rationales behind our revisions.

CHAPTER 2

Healthcare for African immigrants in the United States:

A scoping literature review

Introduction

African immigrant health in the context of the United States is a vastly understudied topic, despite the rapidly increasing size of the population and its uniqueness. African immigrants represent almost 5% of the US population, a 41% increase from the year 2000.¹ Healthcare needs are not universal; there is considerable variation in healthcare experiences across diverse populations.^{38,39} For instance, immigrants are twice as likely as their US-born counterparts to lack health insurance, and ethnic minorities have been found to utilize healthcare at significantly lower rates than whites.^{40,41} Prior to their arrival in the United States, most African immigrants face severe conditions and health threats such as war, extreme poverty and mental health challenges, in their countries of origin. Consequently, many of them already carry significant health vulnerabilities upon arrival in the United States, which can only worsen without proper healthcare access.⁴² More than 36% of African immigrants arrive from West Africa, followed by Eastern (29%) and Northern Africa (17%). Of these African immigrants, more than 14% come from Nigeria, followed by 10% from Ethiopia.² Many Africans relocate to the United States because of family reunification, political disturbances, and education. Other reasons include the diversity lottery program, and brain drain.^{5,6} The migration of trained professionals from Africa to the US, with adverse imports for the sending countries, is well documented. For instance, many African physicians and nurses migrate to the United States for higher-paying opportunities, leaving the health systems in their home countries dilapidated.^{7,43}

In spite of their unique experiences, which pose significant health implications, very little is known about the healthcare experiences and needs of US African immigrants. The two main factors responsible for this outcome are the absence of researchers or funding focused on this population, and clinical “black-boxing.” The majority of research on US immigrant healthcare has concentrated on Latinos and

Asians. Even when African immigrants are included, the applied quantitative analyses often are based on indirect and stretched secondary data, which leads to retrospective assumptions.^{15,44} The healthcare needs and experiences of other immigrant populations such as Latinos and Asians cannot be assumed identical to those of African immigrants. Also, African immigrants are often lumped into the “Black” category, which primarily comprises African Americans. While an African-born immigrant and a US-born African American may be both phenotypically similar, they may differ significantly when it comes to health beliefs and health outcomes.⁴⁵ For instance, babies born to African Black mothers have been found to have higher birth weights than those born to African American mothers.^{18,19} Thus, lumping these groups obfuscates the unique healthcare issues related to African immigrants which when captured, could be vital for providing effective healthcare and services to the population.^{46,47} Therefore, a robust knowledge-base, useful for addressing problems related to US African immigrant health, is needed.

The current study is an exploration of extant peer-reviewed literature on the healthcare experiences and needs of US African immigrants. A Scoping Review is well-suited for identifying literature on under-studied issues, and laying the foundation for subsequent investigations.⁴⁸ The aims of this Scoping Review were to: (a) examine available knowledge on African immigrant health in the United States, (b) identify knowledge-gaps in order to devise means of examining and understanding the issue.

Methods

As a part of the overall dissertation, this Scoping Review was approved by the Indiana University Institutional Review Board (IRB). Following the Scoping Review framework by Arksey and O’Malley, this review was carried out in five stages: (a) research question identification, (b) identification of relevant studies, (c) screening of studies, (d) data extraction and synthesis, and (e) presentation of results.⁴⁹

Identification of research questions. The specific questions the review process attempted to answer are: (1) What do we currently know regarding the healthcare experiences of African immigrants in the United States? (2) What are the knowledge-gaps about US African health?

Identification of relevant studies. Three databases were accessed, namely: EBSCO, ProQuest, and PubMed. Also, a hand-search in Google Scholar was done to identify other key literature, which then underwent snowball backward search. The following keywords were used: african immigrants OR african immigration, african emigrants OR african emigration. Table 1 contains a full list of the inclusion criteria, which included articles published in the English language between 1980 and 2016. The year 1980 was the starting point because it marked the increased influx of Africans due to favorable modifications to the US immigration laws that year.⁵⁰ Inclusion also required peer-reviewed articles, focused on the healthcare experiences of African immigrants in the United States. Studies based on secondary data, such as national surveys were excluded because the lack of a database regarding the issue, and hence the absence of required identifiers, made accurate results less likely. Additionally, studies focused on African immigrant refugees were excluded because their experiences may vary significantly due to their migratory processes.

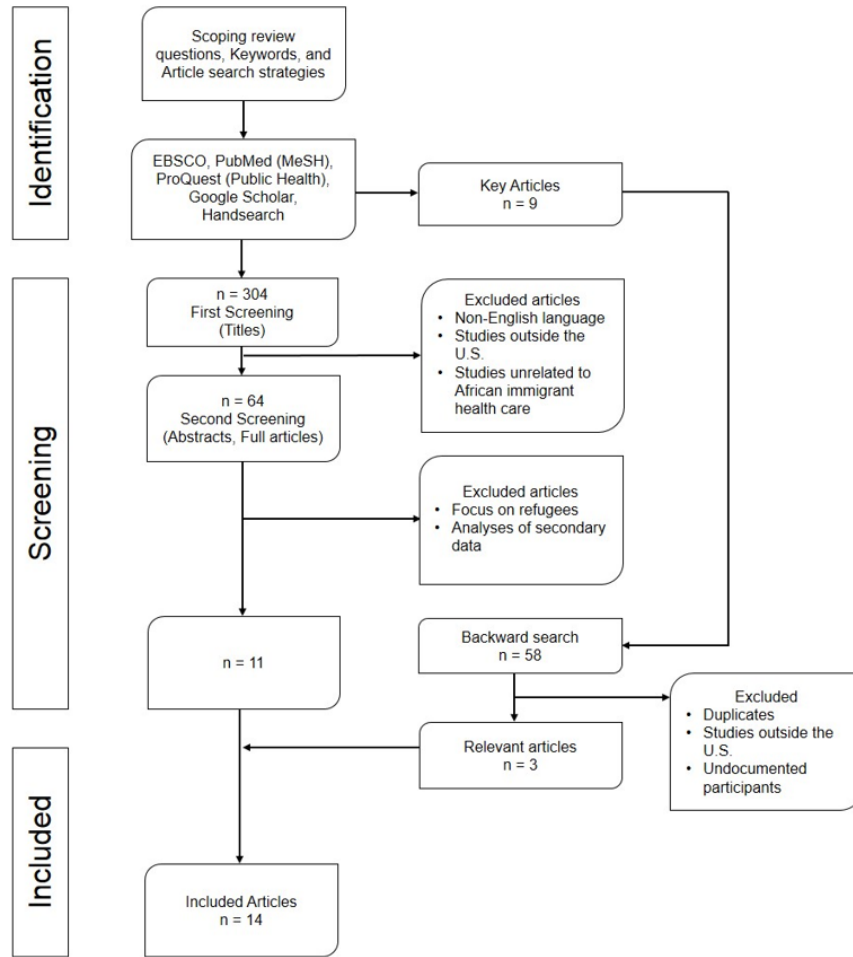
Table 1 – Inclusion criteria for article selection

Criterion	Inclusion
Time period	1980 -2016
Language	English
Type of article	Peer-reviewed
Population	Non-refugee African immigrants in the United States
Study focus	Healthcare experiences, needs, or health behaviors of African immigrants in the United States
Data type	Primary data collected directly from participants

Study screening. The initial search led to 304 articles, which were screened by applying the search criteria to their titles. If the titles contained insufficient evidence, their abstracts were reviewed, but if that step still did not offer enough evidence for inclusion, the entire articles were read. Totally, these steps yielded 11 relevant articles. Finally, a backwards search of nine key articles identified through a hand-search in Google Scholar, was conducted, which produced additional 54 articles. Of these, three

met the inclusion criteria. Figure 1 represents the article screening sequences, including the number of filtered articles from each stage.

Figure 1 – Flowchart of data search and results



Data extraction and synthesis. Articles were mined from the databases using EndNote. They included title and year of study, names of authors, study location, study design (e.g., methodology), and key findings. Using an inductive approach consistent with the approach by Strauss and Corbin, themes were identified from the article results.²⁶ Also theme derivation relied on interpretive analysis, which entailed exhaustive readings of the selected articles, with attention to cultural meanings. These steps are necessary for the current review because in cases of under-studied phenomena embedded in culture, they facilitate the organic emergence of answers, while controlling for the researcher’s assumptions.^{26,51} All coding was done by primary author.

Data presentation. Finally, findings from the selected studies were synthesized into a narrative format. This is necessary for understanding people's views of themselves, especially when their experiences traverse different cultural nuances such as languages and ethnicity.^{52,53} The findings encompassed factors that affected the healthcare experiences of the participants, as well as the participants' recommendations.

Results

Description of identified studies. A total of 14 articles met the inclusion criteria. Figure 2 is a bar chart of relevant articles based on the inclusion criteria. The horizontal and vertical lines denote the years the articles were published and how many articles were included from each year, respectively. No article before 2005 met the inclusion criteria and no relevant articles were identified from 2007 to 2009, and in 2011. The highest number of relevant articles (4) were from 2015.

Characteristics of included studies. Table 2 represents a summary of the included articles' characteristics. Seven of the 14 articles focused specifically on female participants, one article concentrated on youth and the elderly, one article looked at individuals over 40 years old, and five articles looked at the general population of African immigrants. Also, the highest number of relevant articles came from cities with high African immigrant populations such as New York (three studies), and Washington, DC (two studies).

Figure 2 – Included articles by year (1980 – 2016)

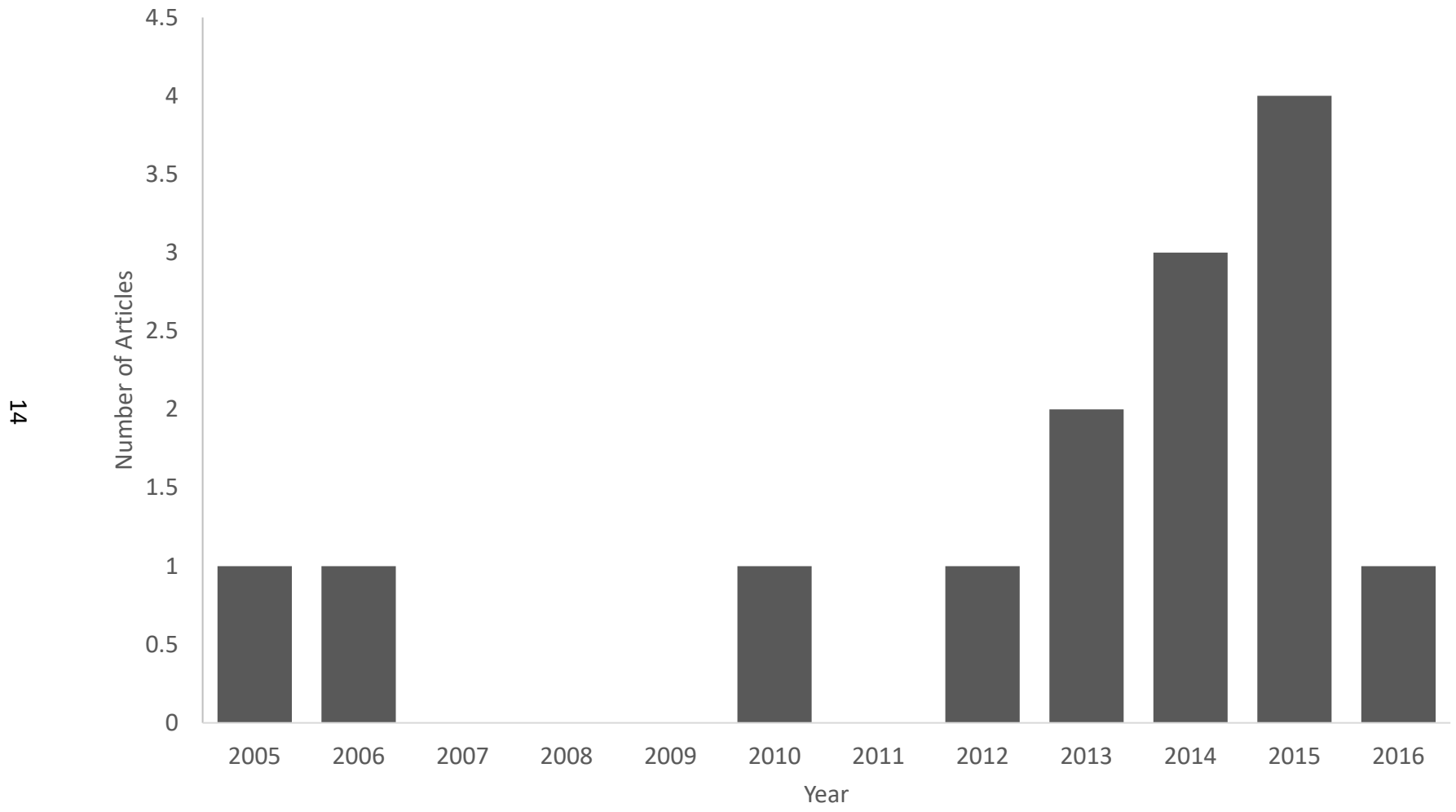


Table 2 – Characteristics of included articles

Author(s)	Year	Location	Study Design	Study Purpose	Participants
Adekeye et al.	2014	Greensboro, NC	Qualitative; Photovoice; Community-based participatory research (CBPR)	Comprehend African immigrants' views on their health and well-being, as well as barriers to their healthcare access.	Youth and elderly (Youth: 5 females and 5 males; Elderly: 1 woman and 4 men; Average age: N/A)
Asare & Sharma	2012	Cincinnati, OH	Quantitative; Cross-sectional	Understanding sexual communication behaviors among African immigrants, using health belief model (HBM) and acculturation.	General (Males: 249; Females: 163; Average age: 36.9)
Blanas et al.	2014	New York, NY	Qualitative; Focus Groups	Assess factors that affect the access to medical care of African immigrants from French-speaking countries.	General (Females: 12; Males: 27; Average age: 39)
Chu & Akinsulure-Smith	2016	New York, NY	Qualitative; Focus Groups & Questionnaires	Examine the health beliefs of African immigrants regarding female genital cutting (FGC), across different demographics.	Women (Average age: 35.2)
Daramola & Scisney-Matlock	2014	Detroit, MI	Quantitative; Cross-sectional (Correlational Surveys)	Examine the interaction between migration and health behaviors of African immigrant women.	Women (Average age: 56.5)
De Jesus et al.	2015	Washington, DC	Qualitative; Semi-structured Questionnaire	Explore health behaviors of East African immigrant women regarding HIV testing services.	Women (Average age: 31.0)

Table 2 (continued) – Characteristics of included articles

Author(s)	Year	Location	Study Design	Study Purpose	Participants
Foley	2005	Philadelphia, PA	Qualitative; Focus Groups	Understand the cultural and structural barriers that affect African immigrant women’s access to HIV services.	Women (Average age: 32)
Kaplan, Ahmed, & Musah	2015	Kaplan, Ahmed, & Musah	Qualitative; Focus Groups	Comprehend how Ghanaian immigrants perceive their health experiences.	General (Females: 16; Males: 37; Average age: 45)
Ndukwe, Williams, & Sheppard	2013	Washington, DC	Qualitative; Focus Groups & Questionnaires	Assess the health behavior of African immigrants regarding breast and cervical cancer prevention services.	Women (Average age: 46.0)
Opoku-Dapaah	2013	Winston-Salem, NC	Quantitative – Surveys; Qualitative – Interviews; Cross-sectional	Examine African immigrants’ health behavior regarding cancer-screening services.	General: 40 years or older. (Females: 152; Males: 208; Average age: N/A)
Raymond et al.	2014	Minneapolis, MN	Qualitative; Focus Groups	Assess the health behavior and attitudes of Somali immigrant women regarding cancer prevention services.	Women (Average age: N/A)
Sellers, Ward, & Pate	2006	Madison, WI	Qualitative; Focus Groups	Understand the health and well-being of Black African immigrant women.	Women (Average age: 44.0)

Identified themes. The two over-arching themes derived from the data were the influence of culture and negative experiences with the US healthcare system. Each one, along with the sub-themes, is discussed below.

Cultural influence. The ways African immigrants in the United States approached their health and the health system, were found to be steeped in their cultural backgrounds. These were evident through their application of their traditional beliefs, religiosity and spirituality, as well as the stigma regarding certain health experiences in the African immigrant community, and language discordance in their navigation of the healthcare system. These factors are expounded below.

Traditional beliefs. The impact of culture on the healthcare experiences of African immigrants was discussed in eight articles.^{4,8,17,54-58} Many African immigrants in the United States view diseases such as HIV and cancer as curses, which has resulted in many of them seeking treatment for them from oracles and other spiritual healers in their home countries.^{4,17} Also, the cultural understandings of diseases in participants' home countries affect their health behaviors in the United States. The study by Kaplan et al. showed it was common in many African communities for people to delay seeing a doctor until the disease or illness is certifiably irreversible or severe enough to halt daily activities.⁵⁴ Results from another study showed HIV-positive African immigrant women sought treatment when the condition was already in its late stage.⁵⁵ Some of the participants held the belief that "what you don't know won't hurt you," which implied avoiding any physician contact that would lead to a diagnosis. According to them, the inevitability of seeing a doctor was reserved for when symptoms were evident.⁵⁸ Prior to their migration to the United States, many African immigrants utilized herbal remedies for different health problems. Understanding that a US physician may not explore such options, many of them regard office visits and routine checks as waste of resources, especially given the high cost of healthcare.⁸ African immigrants' deference to native materials also applies to their diets. Turk, Fapohunda, and Zoucha (2015) discovered African immigrants struggled with the dietary and physical activity recommendations by US healthcare practitioners (HPs), because it difficult to replace their long-held

practices. According to many of them, a big body size considered unhealthy in the United States was regarded as a sign of healthy eating in their native cultures.⁵⁶ In addition, the participants described the US fast-food culture as inescapable, and not part of their experiences in their home countries. As a result, they found dietary adjustments challenging.^{54,57}

Religiosity and spirituality. The religious and spiritual outlooks of African immigrants on health and well-being were presented in eight articles.^{4,17,30,57-61} In Vaughn and Holloway's study, both the Muslim and Christian participants ascribed health status and well-being to God; despite their own efforts, their ultimate health status was beyond their or any human's control. Therefore, even if physicians were able to treat them successfully, that would only be through divine assistance. Further, participants explained imperfections such as health deterioration as integral aspects of life, from which no one was exempt.¹⁷ Also a study found that Muslim participants believed death by disease was a result of expiration of time on earth. According to the participants, if it was God's will that one would suffer from cancer or HIV, then there was nothing anyone could do about it.^{4,59,60} This connection between spirituality and health is not taken lightly by African immigrants. Some participants refused to answer hypothetical questions about what they would do were they to be diagnosed with diseases such as cancer. They believed words and thoughts could affect person's life outcomes, such as health experiences.⁶¹ Christian participants expressly rejected the question, on the grounds that it was "not their portion" to suffer from such diseases.⁵⁸

Furthermore, Adekeye et al. found a connection between mental health and spirituality among African immigrants. Both the Christians and Muslims described their church and mosque attendance, respectively as helpful in dealing competently with life's challenges. To them, a healthy spiritual life was tantamount to overall health.⁵⁷ The reliance on the protective function of religion among African immigrants also was an obstacle to their healthcare utilization. Findings from key-informant focus groups indicated African women were reluctant to be screened for cancer, not only to avoid the possibility of discovering they had what they deemed a curse, but also because they

believed their health was determined by God, who would shield them from suffering from diseases not meant for them.⁵⁸ Results showed that it was always a problem when African immigrants were faced with differing Western concepts of health and well-being, especially when they perceived that their own long-standing beliefs were under threat.³⁰

Stigma in the African community. The significance of culturally situated stigma in the healthcare experiences of African immigrants in the United States was demonstrated in seven studies.^{8,54,58-60,62,63} Blanas et al. found that one of the reasons why this population shied away from healthcare services was the negative reactions within their communities. They explained that even when the services were preventive, they still drew significant stigma. Sexually transmitted diseases and infections were viewed in the same light in those communities.⁶² The same sentiments were shared by participants in another study on utilization of HIV prevention services. They pointedly explained that, due to the potential stigma and social consequences, it was better for them not to know their statuses than to find out that they were HIV-positive. These participants even considered being tested would be viewed as a sign they were HIV-positive.⁵⁹ Stigma within African immigrant communities is not restricted to sexually transmitted diseases or infections such as HIV. It was also found that cancer was approached in similar manner. African immigrants interviewed by Ndukwe et al., explained that cancer was perceived as a curse in their communities. Therefore the stigma attached to it emanates from the notion that the person with a cancer diagnosis has been cursed spiritually, which is an indication they should be avoided, or at least cautiously associated with⁵⁸. Another group of participants interviewed by Raymond et al., equated cancer with HIV, in terms of perception. According to them, both diseases were viewed to be synonymous with death, so family members tended to dissociate from the sufferer in order to save face, since that person was going to anyway.⁶⁰

Although not linked with death, depression is also stigmatized within African immigrant communities. Sellers et al. discovered that even when participants showed awareness of depression and acknowledged its existence within their communities, they

still felt that the burden of being found out outweighed the need to seek treatment. They explained how this silent approach to depression was learned from their home countries where depression was viewed as a creation of white people. They concluded that, given their cultural backgrounds, they could not differentiate between symptoms referred to in the United States as depression and other mental afflictions from those considered indicative of “madness” back in their home countries.⁸ Furthermore, the impact of stigma within the African community extends to one’s family. With the cultural emphasis on a good name, many African immigrants expressed fear of what would happen to the reputation of their families were it to be known that they suffered from one of the dreaded diseases such as cancer or HIV-AIDS. Because of this stigma, they would rather not find out their health status.⁵⁹ Even when they decide to seek healthcare services, their perception of privacy often became a barrier in itself. For instance, results from Foley’s study indicated that African immigrants felt confidentiality, as presented by HPs, was insufficient because it did not guarantee their anonymity.⁶³ Due to the severity of stigma within the African community, many African immigrants became paranoid and avoided healthcare facilities where they felt they were unnecessarily tested for diseases. They feared their lives would be destroyed if any of the results were positive.⁵⁴

Linguistic discordance. Three studies discussed how the healthcare experiences of African immigrants in the United States is impacted by language.^{54,60,63} Participants explained that language was one of their most troubling problems encountered when seeking healthcare. This is because healthcare providers were not equipped with translating resources in their experiences when they had a pressing health problem that needed urgent attention. They explained translators proficient in their languages were often lacking. Additionally, they believed language barriers resulted in poorer treatment by HPs.⁶³ This concern was also supported by results from a study by Kaplan et al., whose participants felt the outcomes of their interactions with HPs would be better if both parties could communicate effectively. They also stated that poor manners

displayed by US HPs were influenced by frustration and impatience due to expected language barrier.⁵⁴

Somali immigrants in the United States have been shown to have the most available translators in the states where their population is significant. In spite of this, their communications with HPs were still problematic. According to results by Raymond et al., one reason for this was that African languages contain different cultural names and descriptions, which may be difficult to translate into the English language. Additionally, while interacting with HPs in their home countries entailed both linguistic and cultural skills, the latter requirement may not be available in the United States. Participants explained how tedious communication with HPs was and how it had become a deterrent to healthcare access. They expressed their fear that this could not only lead to their health needs being unmet, but also put them at the risk of receiving wrong treatments.⁶⁰

Adverse experiences with the US healthcare system.

Lack of culturally competent providers. The absence of healthcare sensitive to the backgrounds of the participants was a pervasive theme in six articles.^{8,17,54,56,57,60} Adekeye et al. found patients were reluctant to visit the physician's office because they felt they would predictably leave dissatisfied. Not only did they deem this a waste of already scarce resources, each ineffective visit reinforced their lack of trust in the health system to meet their healthcare needs. Participants explained that the providers they saw paid no attention to their cultural backgrounds and health expectations. In their views, doing this would have given the providers a broader and deeper understanding of their patients, which would have in turn allowed them to make more informed and effective treatment decisions. Also, they complained that even when they desired to discuss these issues with the providers, there was insufficient interaction time, as they always felt rushed through their visits.⁵⁷

In another study⁵⁴, participants explained they were not asked whether they held any religious or cultural beliefs, which could affect their interactions with the providers. They believed that as trivial as those pieces of information may have seemed

to providers, their implications were weighty because being a Christian or Muslim would make significant difference in the outcomes of patient-provider interactions. Yet another group of participants sympathized with HPs who were expected to know everything about African immigrant backgrounds. Nevertheless, they believed simple questions about their cultural and religious perspectives for example, would be very helpful in providing them culturally competent care.⁶⁰ Others explained that if HPs would listen and interact with them pleasantly, better solutions to their health problems would be arrived at, instead of what they described as strictly prescriptive approach, which did not help them to understand either their health or the care they were receiving.¹⁷ Sellers et al. found African immigrants would prefer to be seen by HPs, especially physicians, who were relatable. They believed clinicians from similar backgrounds would better understand their healthcare needs, starting from how they would explain their health problems. One participant narrated how a Black physician assisted her in resolving a serious diet-related quagmire during pregnancy, after other doctors could not help her.⁸

Furthermore, findings showed the unwillingness of providers to explore alternative treatment options, was a substantial problem. Even when the patients desired to discuss their use of other treatment options such as herbs, with HPs, they were not afforded the opportunity. The overall tension and anxiety that normally characterized their healthcare experiences prevented them from bringing up this concern.⁸ Additionally, lack of help with recommended dietary adjustment was another challenge described as a part of culturally incompetent care. When HPs used treatments that also entailed diet modification or improvement, their patients were left confused about how to achieve that goal, because the providers did not even know the existing diets of those patients. Even when providers were aware of their patients' diets, they only made recommendations the patients deemed difficult to implement, such as replacing a staple food that they had been eating since childhood. As a result, opportunities for critical patient education on diet and self-efficacy, amongst others, were lost.^{56,60}

Complex US healthcare system. Difficulty navigating the US healthcare system was discussed by four studies.^{8,17,57,63} However, this barrier did not play out in the same manner in every setting. The African immigrants in the study by Adekeye et al. ascribed their challenges with navigation of the US healthcare system, to linguistic discordance. They believed low English proficiency was responsible for their frustrations with the healthcare system. They also cited inundation with information and excessive paperwork during their office visits as another contributing factor to hampered healthcare access. Additionally, participants who had health insurance bemoaned the lack of assistance from HPs, especially when they needed help understanding their insurance coverage. And, due to this inability to comprehend health insurance, they did not know the services they were eligible for.⁶³

Furthermore, results from the study by Sellers et al. revealed that the healthcare system was the most difficult to comprehend, out of all the systems the African immigrant dealt with in the United States. They also explained that they experienced emotional and mental anguish whenever they needed healthcare access, because of the pressure that came with caring for a sick family member and/or having to wade through the confusing healthcare system.⁸ In addition, in a needs assessment of African immigrant families, parents expressed anxiety over taking their children to the doctor, stating they ended up utilizing emergency care when they were confused about where to go.¹⁷

Cost of healthcare. The cost of US healthcare was discussed in five articles.^{54,57,58,62,63} Adekeye et al. found African immigrants intended to seek healthcare, but were deterred by the cost. They regretted the lack of medical centers practicing alternative approaches to healthcare, particularly the use of herbs. Not only were many African immigrants familiar with this treatment method, they believed the cost would be significantly lower than the exorbitant Western medical treatments.⁵⁷ As a result of the high healthcare costs, many African immigrants decided it was wasteful to see a doctor when they did not consider their condition serious. In addition, they expressed unwillingness to go and see a doctor simply to determine whether something was

wrong with them, as the visit would be a waste of scarce resources if nothing were wrong.⁵⁴

According to findings by Foley, even when African immigrants decided to go see a doctor, they were shocked to find out that the services they received were not covered by their health insurance. They described their realization that they would have to pay the services themselves as disheartening; it also deterred them from seeking healthcare subsequently. The participants felt they should have at least been forewarned by HPs about the healthcare services that were not covered so that the final decision regarding the healthcare service would be up to them.⁶³ The high cost of healthcare was compounded for the African immigrant participants who lacked health insurance. Although Africans are among the most educated immigrant populations in the United States, many of them work in service industry positions, which do not provide health insurance or pay high enough salary to allow the participants to afford healthcare services: these positions include taxi driving and hair braiding.^{62,64} Transportation and money were also cited as factors in seeking healthcare. In one study, some of the participants expressed their willingness to seek healthcare such as screening services, but lacked the means of attending their appointments.⁵⁸

Discrimination/ hostile treatment. Five articles discussed the barricading roles of discrimination in healthcare.^{4,17,54,57,63} In these studies, participants discussed the poor treatment received from HPs: these ranged from demeaning front-desk interactions to insensitive medical examinations and treatment. According to many participants, their accents or mode of dressing often triggered unsavory treatment from HPs. As a result, they were reluctant to follow up with their visits or interact with HPs because of anxiety and emotional stress.⁵⁷ One common experience described by the participants was the haste with which HPs attended to them, whether on the telephone or in-person, as if their concerns constituted unwanted burdens for HPs. Participants described this experience as both disrespectful and humiliating. They explained that the mere thought of interacting with HPs filled them with dread, because felt that experience was beyond their control.¹⁷

According to Foley's study, African immigrants experienced discrimination and hostile treatment from both White and Black HPs. Similar to the other studies, the participants cited their clothing and other perceptible components of their African background, as initiators of the unpleasant treatment they received.⁶³ In another study⁵⁴, the participants even claimed they were unreasonably subjected to tests for diseases commonly associated with Africans, such as HIV. Not only that, the participants felt the tests were carried out in manners that suggested the providers' suspicion of patients' predisposition to those diseases. For this reason, participants felt targeted and avoided visiting those locations. Findings from Opoku-Dapaah's, study corroborated this experience. The participants shunned available cancer screening services because they felt that the treatment or preventive methods applied to White patients differed or at the least were more targeted and effective than the ones received by African immigrants.⁴

Lack of trust of the US health system. Three articles discussed distrust of the US health system as a barrier to healthcare access.^{4,8,60} Participants in all the four studies harbored certain suspicion of the US healthcare system or HPs. Participants of Sellers et al.'s study were wary of the healthcare system and providers because of the unwelcome ways Africans in general have been treated and stereotyped. Some participants did not believe physicians had the best interest of their African patients at heart. For instance, they believed that some of their community members had gone for medical treatment, but instead ended up in worse health conditions than before. Consequently, they expressed their reluctance to completely accept prescriptions from physicians. They expressed that even in the case where the physician was cleared, s/he may not be aware of the harmful effects of the medications to the patients.⁸

This suspicion of the health system was demonstrated to stretch to the pharmaceutical industry. Participants indicated their refusal of prescriptions from their physicians because they felt those medications would make them less healthy by causing previously absent complications or exacerbate the existing problem. In their views, that was always the original intention of the drug manufactures, to whom profit-

making was the chief aim.⁸ In another study, participants also shared this suspicion of pharmaceuticals. They believed that cancer was a medical fraud used by the industry for raking in a lot of money by taking advantage of people's reactions to their fear-mongering. Other participants viewed health screenings as cover-ups, which were simply used to target Africans as objects of health research.⁴ This problem is connected to the aforementioned healthcare experiences of African immigrants. In one study, some participants cited communication difficulties, lack of culturally competent care, and low quality of care, as reasons for their lack of trust in the US healthcare system or HPs.^{8,60}

Discussion

The "black-boxing" of African immigrants by researchers and US healthcare professionals is problematic. The uniqueness of African immigrants in the United States is missed when providers and healthcare researchers lump them into the same category as African Americans and other phenotypically similar groups. The ramifications of this misrepresentation include flawed data or over-generalization of findings, and wrong or inefficacious medical treatment.⁶⁴ For instance, research has shown strong distrust of the US health system among both US African immigrants and African Americans. While there are documentations of the maltreatment of the latter by the US health system, such as the Tuskegee Syphilis experiment⁶⁵, it is pertinent to understand the underpinnings of this distrust within the US African immigrant community, because they seem clearly different. Therefore, it is important to ascertain whether a link exists between the distrust and events in their home countries involving Westerners, such as colonialism and research-subject experiences.³⁰ Yet another step towards unpacking the "Black box" entails examining how much of the discrimination described by the participants, such as dismissiveness and lack of effort by HPs, is based on the double stigma of being both African and Black. It is critical to examine the intersectionality of the US African immigrant and Black healthcare experiences in the United States, if the goal of effective care for US African immigrants is to be attained.

Until now, the over-simplified view of barriers to African immigrants' healthcare access has often identified language as chief culprit. Language as a barrier in the healthcare experiences of US African immigrants is not restricted to a lack of English proficiency. On the other hand, the availability of translators for US African immigrants does not guarantee the absence of communication barriers.⁶⁶ Also, education has been shown to be positively associated with health insurance, and therefore access to healthcare. However, despite being one of the most educated immigrant populations in the United States, African immigrants have very limited healthcare access.⁶⁷ Even when they have health insurance coverage, they are less likely than US-born citizens to seek treatment for a medical condition. Therefore, a more complex analysis of healthcare experiences of US African immigrants is necessary, to understand the underlying reasons for these barriers. Additionally, African immigrants' healthcare experiences are significantly hinged on their cultural or traditional practices such as diets and health beliefs, which they normally bring with them to the United States.⁶⁸ While the trajectories of these experiences over time have been studied in other immigrant populations, nothing is known about how they unfold within the US African immigrant community. For instance, among Hispanics, diet and acculturation have been found to vary from first-generation immigrants to their children; overweight and obesity are more likely to occur among second and subsequent generations.⁶⁹

Furthermore, the impact of religion on the healthcare experiences of US African immigrants is unique. Besides Christianity and Islam standing as the two major religions in Africa, there are also traditional African spirituality and cultures, which also are often combined with, or at odds with the two major religions. According to the African value system, a person's well-being is determined by both physical and spiritual experiences, with the latter bearing superior influence on the outcome. Because religiosity is a significant aspect of the lives of African immigrants in the United States, their understanding of health is inextricable from their religious and spiritual backgrounds.^{16,70} With religion, what is permissible for a Christian US African immigrant may be abhorrent to a Muslim US African immigrant. For instance, Muslim patients

prefer to be seen by HPs of the same gender, except when that is not possible, such as during an emergency where the person's life is at stake.⁷¹ Furthermore, within the US African community, religion and culture combine to influence gender roles, which in turn affect their healthcare experiences. While gender roles in other US populations such as Whites and Hispanics have been studied, there is no data on how they occur among US African immigrants. For example, US men who espouse traditional gender roles tend to engage more in risky sexual behaviors such as unprotected sex, as well as domestic violence.⁷²⁻⁷⁵ Understanding gender roles within the context of African immigrants is critical in the efforts to provide effective healthcare for them.

Beyond the perspectives of African immigrants of their own healthcare experiences, there is also a need to understand the views and attitudes of US HPs on the same issue. The lack of satisfaction with treatment and attitudes of HPs was a predominant theme throughout the selected articles. Even when participants did not experience any tension in their encounters with HPs, they still felt they were not equipped with sufficient information to address their health concerns adequately, especially regarding understanding symptoms and etymology of their health problems. In order to effectively address low cultural sensitivity to African immigrants among US HPs, it is important to also ascertain their outlook and obtain their own contributions towards formulating the solutions. Healthcare for US African immigrants has been an unaddressed issue. Not only does this prevent African immigrants from receiving adequate healthcare, US policy-makers continue to lack appropriate information that can aid their decision-making concerning this exponentially growing population.

Conclusion

African immigrants in the United States constitute an under-studied population for which HPs do not yet understand how to provide effective care.^{17,76} Generally, the immigrant healthcare experience is highlighted by higher morbidity and mortality rates due to lack of health insurance, residence in poor neighborhoods, and lower-paying jobs. These factors often result in lack of access to early and/or adequate healthcare.⁷⁷ However, these findings need to be verified among African immigrants in the United

States because an approach that is effective for one immigrant population, such as Latinos, may not work as well for African immigrants. The small number of articles on this population's health emphasizes the need for more research and funding attention. This study is a good foundation for future lines of inquiry, through its examination of available data, and identification of knowledge-gaps.

CHAPTER 3

The impact of discrimination on Nigerian immigrants' healthcare experiences and quality of care in the United States: A qualitative study

Introduction

Understanding the patient-provider needs of African immigrants in the United States has been identified as one of the key challenges facing healthcare providers and researchers.^{3,78} This task is even more daunting due to the lack of knowledge about the health of African immigrants in the United States. Studies have shown ethnic minorities and immigrants in the United States encounter discrimination in healthcare.^{79,80} Discrimination occurs when one social group is subjected to less favorable treatment because of their identification or perception. This experience has been shown to be a contributing factor to health disparities.⁸¹⁻⁸³ Unfortunately, due to the paucity of information about US African immigrant health, nothing is known about how discrimination may affect this group's healthcare experiences. For almost two decades, establishing health improvement of all populations by targeting sources of health disparities has been a part of the US national health priorities.⁸⁴⁻⁸⁶ To that end, the dynamics of discriminations in patient-provider interactions and their contributions to health disparities among ethnic minority populations in the United States have been extensively documented.^{82,87,88} Nonetheless, research highlighting US immigrant health is not representative of the nation's rising African immigrant population,^{89,90} which, with a current population of more than 2 million, has grown at a faster pace than any other immigrant group over the past decade, with current trends showing this growth unabating.^{78,91} This is because the majority of extant immigrant health research has focused chiefly on Latin American and Asian immigrants.^{80,92,93} Consequently, there is very little information about the healthcare experiences of US African immigrants involving interactions with healthcare providers.

Studies have revealed black US immigrants are more affected by infectious diseases and lack of access to healthcare.⁹⁴⁻⁹⁶ More than 50% of all black US immigrants are from the Caribbean, constituting the most studied of the black US population. Given

the unique backgrounds and experiences of African immigrants, we cannot assume these findings from studies on other black US immigrant populations are applicable to them, especially as research has shown their specific healthcare needs differ from those of other black US populations including African Americans and Caribbean immigrants.^{67,97,98} Studies have shown African immigrants have higher education than both US-born and immigrant populations, with almost 40% attaining a minimum of a Bachelor's degree, compared to 29% among other US immigrants, and 31% among US-born individuals.⁹¹ In addition, African immigrants are more likely than other US immigrant populations to migrate legally. They are also more likely than other US immigrants to have private health insurance, and less likely than all US immigrants to be uninsured.⁹⁹ Health insurance has been identified as a key factor in healthcare experiences and outcomes.^{15,98} Because of the critical role of health insurance in healthcare, and the other unique characteristics of African immigrants in the United States, understanding this population's healthcare experiences and the factors that shape them, such as discrimination in healthcare, is important.

A further problem is that African immigrants in the United States are often categorized as African Americans, along with other groups with comparable phenotypes. While there may be similarities in physical appearances among such groups, the health outcome differences between African immigrants and African Americans have been well documented. For instance, low birth-weight was found to be higher among US-born black mothers than African-born black mothers.^{3,67,100-102} While researchers are still dissecting the nuances of health disparities within the US black population,^{82,103,104} the exponentially-growing presence of US African immigrants makes the task of understanding their healthcare experiences even more urgent.^{3,67} Previous US African immigrant health research focused mainly on barriers to access to health services, prevalence of clinical outcomes using secondary data, and theoretical considerations. Nonetheless, the answers sought by those studies, such as barriers to health services access, may lie in first understanding the healthcare experiences of African immigrants, along with the factors that contribute to them. The knowledge of

those contributing variables will then serve as guidelines examining the health outcomes of this group and the influencing factors.

Additionally, information about African immigrants are not entered into US databases recognizably, but instead are grouped into the same categories as African American and Caribbean immigrant data. This makes it difficult to rely confidently on secondary data for gaining the critical foundational knowledge about African immigrant health in the United States.¹⁰⁵⁻¹⁰⁸ Therefore, it is necessary to focus on the healthcare experiences and needs of African immigrants in the United States in order to understand how to provide them with adequate care.^{3,109} The current paper presents findings from a larger study that seeks to explore the healthcare experiences and needs of Nigeria immigrants in the United States, using a Scoping Review, one-on-one interviews and focus groups. With the goal of understanding the healthcare experiences and needs of African immigrants, Nigerian immigrants provide a great starting-point. With a population of more than 324,000 and counting, Nigerian immigrants represent the highest number of African immigrants in the United States.⁹¹ This paper focuses on the qualitative data exploring the importance of discrimination in the patient-provider interactions of Nigerian immigrants in Indianapolis. The following were the major research questions for this paper: (1) How do the patient-provider interactions of Nigerian immigrants in the United States lead to discrimination? (2) What are the types of discrimination experienced by Nigerian immigrants in the United States in their healthcare experiences?

Methods

This study was conducted based on the Symbolic Interactionism framework, which is concerned with how interpretations and meanings shape social realities.¹¹⁰ For this study, a grounded theory approach was ideal because of its compatibility with symbolic interactionism; both emphasize the role of subjective interpretations of experiences in the formation of behaviors or actions.^{21,22,24,98} These points of view are crucial for understanding the healthcare experiences and needs of African immigrants in the United States. Furthermore, my background as a Nigerian immigrant equipped me

with a unique perspective on this study and its participants. This helped me frame the questionnaire in a more targeted manner, and allowed me to use more effective probes while interviewing the participants. During data transcription and analysis, I was able to detect and understand better the nuances contained in the participants' responses. The Indiana University's Institutional Review Board (IRB) approved all the study procedures.

Settings and participants. Thirty-three individuals participated in semi-structured, one-on-one interviews. To be eligible for the study, participants had to be Nigerian-born, aged 18 years or older, English-speaking, legal residents or US citizens, migrated to the United States by the age of at least 12 years, and had lived in the country for at least three years. Participants who had lived in other countries than Nigeria prior to their arrival in the United States were excluded because this would have exposed them to different health perspectives than those of their native country. Participant recruitment was done using Purposive Sampling, which made it possible for me to select individuals most closely matched with the study design, and who could provide the best insight into the issue.^{28,29} Potential participants were identified through a community contact who assisted me with navigating different African immigrant settings in Indianapolis, Indiana, including social and religious gatherings. At these gatherings, I presented my study information, including participation requirements. Once a participant was identified and enrolled in the study, snowball sampling was employed to recruit additional participants.^{111,112} These sampling approaches were required because recruiting immigrant participants is difficult, due to their fears that research participation may jeopardize their residence.^{113,114} This challenge is even more pronounced with African immigrants due to their distrust of researchers and suspicion of being taken advantage of.¹¹⁵ Also, because the African immigrant community is largely relational, despite my status as a Nigerian immigrant, I still needed to be vouched for, to gain the members' trust. Besides utilizing these organized settings for recruitment, I also directly approached potential participants in other settings, such as

African shops. Similar to the organized settings, I presented my research information, as well as the participant recruitment materials, including researcher contact.

Participants' demographic information is presented in Table 3. Out of $n = 33$ participants, 52% ($n = 17$) were males, while 48% ($n=16$) were females. Participants came from 17 states in Nigeria, and represented the three major ethnic groups: Igbo, Yoruba and Hausa. Respectively, the Igbo and Yoruba ethnic groups constituted 48% ($n = 16$) and 36% ($n = 12$) of the participants. The Hausa-Fulani ethnic group comprised 12% ($n = 4$) of the participants, and 3% ($n = 1$) identified with a mixed ethnicity (Yoruba-Efik). With religion, 79% ($n = 26$) of the participants identified as Christians and 21% ($n = 7$) as Muslims. One hundred percent of the Igbo ($n = 16$) and Hausa-Fulani ($n = 12$) participants identified as Christians and Muslims, respectively. Of the Yoruba participants, 75% ($n = 9$) identified as Christians, and 25% ($n = 3$) as Muslims; the Yoruba-Efik participant identified as a Christian. The ages of the participants ranged from 18 to 73 years, and the age group with the highest number of participants ($n = 14$) was 18 to 30 years. While 27% ($n = 9$) of the participants were undergraduate students, 70% ($n = 23$) reported being employed. The participants' length of residence in the United States ranged from three to 44 years.

Table 3 – Participant characteristics [N = 33]

Variable	n (%)
Gender	
Male	17 (52)
Female	16 (48)
Age Group	
18-30	14 (42)
31-40	5 (15)
41-50	6 (18)
50+	8 (24)
Marital Status	
Single/Never married	17 (52)
Married	14 (42)
Divorced	2 (6)
Nigerian Ethnicity	
Igbo	16 (48)
Hausa-Fulani	4 (12)
Yoruba	12 (36)
Yoruba/Efik	1 (3)
Religion	
Christianity	26 (79)
Islam	7 (21)
Education	
Associate Degree	3 (9)
Undergraduate Degree	17 (52)
Master's Degree	8 (24)
Doctoral-Level Degree (MD, PhD, PharmD, etc.)	5 (15)
Annual Income [\$]	
<25,000	2 (6)
25,000-50,000	6 (18)
51,000-70,000	4 (12)
>70,000	6 (18)
Undisclosed ^a	9 (27)
Undisclosed ^b	6 (18)
Employment	
Employed	23 (70)
Unemployed ^c	9 (27)
Retired	1 (3)
Health Insurance	
Insured	32 (97)
Uninsured	1 (3)
Length of Residence in the United States	
3-13 Years	25 (76)
14-24 Years	2 (6)
>25 Years	6 (18)

^aStudents who did not report annual income

^bNon-students who had annual income but chose non-disclosure

^cStudents who did not report employment

Procedure. Data were collected between April 2017 and October 2017. The one-on-one interviews were conducted in English, audio-recorded, and fully transcribed. The duration of each interview was 30 to 60 minutes. Examples of the questions discussed by the groups included, “Can you talk about what “health” means to you?” and “Can you tell me your views about the US healthcare system?” For a more in-depth look into participants’ responses, probes were utilized, especially as related to further clarification of pertinent information.²³ Each interview was conducted at a safe location, which the participants were comfortable with, and which allowed for privacy, such as a closed room in a public or school library. Participants were made fully aware of their choice to decline to answer a question or discontinue with the discussion entirely, at any point. In addition, each participants provided informed consent prior to each of the focus groups. At the end of each discussion, a \$5 gift-card was given to participants as appreciation for their time.

Data analysis. In this analysis, I was looking specifically at issues related to discrimination, which was a larger theme that emerged from the study. Using the principles of grounded theory, I followed an inductive analysis approach, which allowed the themes to directly materialize from the data.²⁴ These steps included: cleaning the raw data, detailed reading of data document, and development of themes.²⁶ To create the codebook, I worked with a research assistant using focused coding, to identify and label pivotal parts of the texts. This approach allowed us to arrange the emerging codes based on how they organically fell into themes and concepts.³⁷ We deemed these themes sufficiently illustrative of the crux of the participants’ responses. To refine the codes, eliminate redundancy and tighten the categories, we went over the developed codes together. To develop inter-coder agreement, we used MAXQDA Analytics Pro¹¹⁶ to perform a first round of coding of 5% (~12) of the data documents. With an agreement of 83%, the RA and I performed a second round of coding, after going over the initial results, which raised our agreement to 90%. Also, we used a line-by-line approach to our coding to arrive at the themes. This was important because it kept us from imposing our own perceptions and interpretations as coders, on the participants’

responses.²³ The final coding process was conducted using axial coding, which entailed assembling the data in new ways after the initial round of coding, to allow further connections between categories or themes to manifest.²² This was intended to enable us comprehensively look at the themes, including those that might have been misaligned initially. Therefore, we were able to sort the themes into coherent categories and sub-categories. We both kept an audit trail, which allowed us to track our rationales through each data analysis step.

Results

Three themes related to discrimination were identified during the analysis process. These themes include: (1) negative provider attitudes leading to discrimination, (2) lack of familiarity with, and dismissal of, Nigerian health issues, and (3) types of discrimination experienced. Each of these themes is discussed in detail below.

Perceived prejudice among physicians. Participants generally described provider attitudes as a deal-breaker when it comes to seeking care, maintaining patient-provider relationships, and adhering to treatment plan. Coming from cultures where respect for strangers and the elderly were emphasized, participants expressed their dismay at how US healthcare providers treated them. Participants cited providers' assumptions as a major aspect of the presumptuous attitudes with which they were treated. One participant explained:

I think that doctors and nurses, you know, they have a certain attitude, most of them have a certain attitude about foreigners from Africa that I have experienced, you know, that I've been involved in. I think they assume something when you go see a doctor, you know. Those that are a hundred percent wrong! (Participant 5, Male, 40).

These assumptions alluded to by the participants included: Nigerian immigrant patients were uneducated and they were the same as other US immigrants or blacks. As a result, the providers treated them condescendingly and were dismissive of their unique health concerns or needs. Regarding the first assumption, a participant who had lived and worked in the United States for several years expressed his frustration at being treated like an illiterate during his exchanges with providers. In his view, that would not be the

case had the providers suspended their pre-existing prejudices. His statement is as follows:

For instance, a dentist, you go see a dentist here, in America. They ask you, 'Where are you from?' This is a personal experience. Then you tell them, 'I'm from Nigeria.' They automatically assume that you are dumb and have never been to a dentist before, you know. The way they talk to you is condescending, you know, because they automatically assume that you don't know what they're talking about, you know. They'll be talking to you like a five-year old, you know, without knowing that you are very educated, and you know what they're talking about. (Participant 17, Female, 44).

Another participant viewed providers' inadequate knowledge of their backgrounds – as well as their unwillingness to obtain adequate information – as contributing factors to this assumption. He shared a recent personal experience:

See, I am an educated guy, and I work for the state, so my health insurance is also provided by them. But the thing is that when you go to the doctor's office, they treat you based on how they see you. I believe with all these things always going on, once they see you and you're African, they immediately assume you're either a clueless refugee, or someone who just ran into this country looking for help, with no knowledge. (Participant 4, Male, 50).

In response to how it could be viewed as unfair to US providers, being expected to know all about their patients' backgrounds, this participant stated, "It's like customer service. You don't know the customers, but it's still your job to serve them well. It's just knowing how to talk to people, at least. Don't just insult them because you don't know" (Participant 4, Male, 50). In addition, some of the participants felt cues, such as their accents, were also responsible for leading providers to assume they were uninformed. Another participant agreed with this view, stating, "Just because you have an accent or something doesn't mean that you're stupid. It should not be a barrier, as long as you can understand me. I think that's enough to make people not go see a doctor." (Participant 5, Male, 40).

In addition, the participants could distinguish between provider discrimination based on their background, and being treated as if they were the same as other immigrants or blacks. Some participants believed providers' negative attitudes towards

them stemmed from their assumption that they would fit African American stereotypes. These include being sexually active at a young age and proving difficult and too demanding. One participant believed this was the case during her first Pap smear in the United States, which was recommended by a physician without verifications, which would have revealed she was not sexually active. She kept the appointment because she had no prior knowledge of the process. The following is her narration of her ordeal:

So I guess if you're over a certain age, um, they recommend you get like, a Pap-smear. And I, I was like, because they wanted to check for like, urinary tract infection and gonorrhea, in my head I'm like, 'Really?' But I said, 'Okay.' So I scheduled an appointment. Um, so I got there and they tried to do their stuff and it wasn't possible. Um, the doctor had to call someone else, like, they were having difficulty doing the procedure. So um, the lady came in and she said I didn't need it. I don't need it because it's not, there's no way they can do the procedure. They were trying and it was so painful. Oh my gosh! They had to stop. Like, that was so traumatizing. (Participant 21, Female, 24).

According to the patient, even after the traumatizing experience was over, the providers did not explain what was going on to her. Rather it was only as she was crying and getting ready to leave that one of the providers attempted to ascertain her sexual status. She stated:

They were asking me, okay, am I sexually active? And I said, 'No.' So I didn't know what they meant by sexually active. I didn't know, but I said, 'No.' Um, so the lady said, she said I didn't need it. I got on my clothes so fast and headed out. I didn't even want to see anyone. So I didn't, I didn't even check out. (Participant 21, Female, 24).

In the participant's view, this painful incident could have been prevented had the providers not applied their stereotypes of African American females to her case. In essence, her background as a black patient stereotypically influenced her healthcare experience in a painful and scarring way. She explained:

In that hospital, I walked in and it was all white people. With the way they treated me, they treated me as they would um, any other black, you know, African American female. They assumed that okay, I'm, I'm old enough to have a child, I'm old enough to, you know, have sex. Um, I was so disappointed actually that they, they um, they didn't, they just assumed. So yea, it was pretty, pretty bad. I was just so upset, I didn't

even want to sign anything, look at any paper. I just got out of there.
(Participant 21, Female, 24).

Regarding providers' expectations that they would be difficult to interact with, the participants expressed their frustrations with the unwarranted healthcare access barrier constituted by this assumption. The services this assumption barricaded them from ranged from medical bill resolution to denial of care without founded reasons. One participant explained how, despite an error by her dentist's office on her treatment plan, she did not get an explanation of the charges she incurred against her choice, because she deemed difficult and too demanding. She described her experience as follows:

At my dentist's, they did a, they did a filling on this tooth that I wasn't aware of. And they didn't tell me that, 'Okay this is not on your, your statement,' and they did it and my copay increased. And I was upset about that because I would not, I would rather know so I can, you know, when I'm ready, come for it. So I tried to sort it out with them. This lady who worked there, she was like, 'Listen, I've been doing this for 15 years. This is, this is it.' But I wasn't understanding my treatment plan, and it was so expensive. So it's like, I wanted to understand this and she was angry like, she has already explained it to me. So I just paid it off and just left that clinic. (Participant 31, Female, 33).

Regarding denial of care, one participant described her frustration trying to take care of her health emergency. According to her, she was mistaken for an African American female, and thus was not given any time to present her health concerns; instead, she was dismissed without any help. The following is her account:

I was in Bloomington, but I drove all the way back to Indianapolis. So I'm like, 'Let me just go to Indianapolis where, you know, that's where my doctor is and everything.' So I got there and finally the doctor came to see me and you know, I told the doctor what was going on, and then she, like, ugh! She, she just was very dismissive without even getting into the problem. I don't wanna go into details, but I was so taken aback. She was like, 'Oh, I'm sorry, but we can't help you here.' Like, she was just very rude and I could tell like, she didn't, she didn't want me there. I could just tell in her face, she was thinking like, 'What is this black lady doing here?' Um, it was almost like she felt offended that I was black. I've never felt so defeated and I was like, 'Wow, these people are supposed to be here to

help me, but apparently she just wasn't in the mood to see me today.'
(Participant 26, Female, 23).

According to the participant, even if the providers could do nothing for her, they could have at least treated her more humanely and tried to discover how she could have been directed to resolve her health problem, without dismissing her coldly, and without making an effort. She further explained, "The lady won't even hear me out when I tried to explain that I just needed to know where to go. Mind you I was really scared already and didn't know what to do." One of the participants who worked in healthcare gave a first-hand account of providers' negative attitudes. From her experience, the presence of Nigerian immigrants tended to trigger hostile attitudes from providers. The following is the insight she provided:

When those Nigerians come in, it's hard. They kind of like, dismiss them, and you know, I hear the nasty comments they make. Like, 'Oh, these Africans!' or 'Oh, these people are here again.' Like, they just kind of like, they don't make an effort to understand what you're saying. To them, usually they're pissed that you know, that you're there pretty much.
(Participant 27, Female, 25).

Furthermore, participants believed these discriminatory provider attitudes could translate to low quality of care, with serious health consequences. The reluctance to address health concerns with providers or even ask them questions was described as one of the adverse effects. One participant recalled how she and her parents were affected by always expecting providers to exhibit such attitudes each time they visited the doctor's:

Initially, I remember even for my parents as well, it was more so like, 'Oh, we can't really speak too much. They, you know, they're gonna talk about, they don't understand our accent.' So you feel like you don't wanna push the limit. Your answer to everything is, 'It's okay. It's okay.' You're not really confident because you don't want them to think you have accent. (Participant 26, Female, 23).

Types of discrimination experienced. The participants explained that the discrimination they experienced while interacting with US healthcare providers, came in

forms of inattentive care and insensitivity to their cultural backgrounds and differences. These are discussed in detail below.

Inattentive care. Some participants described dissatisfaction with providers' lack of attentive care as a roadblock to their patient-provider experiences. Similar to their views on providers' presumptuous and negative attitudes, the participants explained how the providers were dismissive, hasty, and did not take the time to listen to their descriptions of their health needs or what their diseases were. Instead, they were rather quick to start treatment, which often resulted in wrong or unnecessary approaches and financial burden. This, the participants explained, not only voids their own chance of self-advocacy, but also fosters borderline dictatorial form of patient-provider interactions. In line with the commonality among the themes from this study, the participants provided insight into how they believed their background as African immigrants played a role in creating this problem. In their views, this absence of relational patient-provider interactions robs them of opportunities to be understood by providers, which severely hampers their chances of receiving effective care. Regarding this shortcoming, one participant stated, "Honestly speaking, I think that I, as a, as a foreigner from Nigeria, I don't think that most doctors here pay attention to me the way they pay to the natives." (Participant 5, Male, 40).

Story-telling is an important aspect of African cultures, and in dealing with US providers, African immigrant patients expect to explain their concerns. This background information was pointed out by one participant, "Where I'm from, we like someone who's able to make conversation with me and I'm not just another medical record number or something like that. Like, someone that actually hears me and addresses each of my concern." (Participant 29, Female, 25). In addition, another participant narrated how providers' lack of attention during his visit to the hospital due to a stomach upset, ended in the unauthorized removal of his umbilical hernia. Added to that was the huge medical bill from the hospital because his health insurance did not cover the procedure preferably. According to him, umbilical hernia was common where he grew up in Nigeria, and was not considered a health problem. In his view, the

providers' knowledge of this would have saved him from the unnecessary surgery and medical bill, but they did not pay attention to his attempt to give them this piece information and his own assessment of the case. He stated:

One of my uh, one of the hospitals I went, the bill was thirty thousand plus. I went because my tummy was hurting, but what did they do? I had this tummy button right from birth. Where I come from, it is normal, and you just carry it. So I went to hospital for another thing, but they said that it was hernia. They treated it as if it was a medical emergency, and I even feared for my life thinking it was something else. I had no idea it was something to do with my tummy button, the way they handled the whole thing. So do you know the bill? Thirty thousand plus! (Participant 1, Male, 55).

Just like the other participants, he expressed how his unpleasant experience acted as a disincentive to his healthcare utilization. According to him, "So, if you look at all these things, you see that for you, if you uh, even if you're sick, if you remember what you're gonna face as an African, you have to say, let me stay here." (Participant 1, Male, 55).

One participant's account demonstrates other participants' views of how providers' lack of attention to their backgrounds as Africans contributed to ineffective or wrong treatment and unnecessarily steep medical bills. His attempt at verifying directions to the office of the specialist to whom he was referred ended in a needless, costly intervention by the hospital providers. The following is his description of the event:

I was affected with frost bite, so my three hands were swollen, with uh, with heavy pains. Then going to the doctor, they said that they would send me to their main hospital, that's where they had a specialist. I had never gone to the main hospital before, and uh, I asked them how to get there, so they said they would provide me means. And I was there in the waiting room, then 911 came, you know. They were surprised seeing me sitting down, because I think they thought I had an emergency. So they said I should follow them, that they would take me. I did not have any experience with 911 before, so I had to follow them to the main hospital downtown. The doctor there, what did he gave to me? It was aloe vera! At the main hospital, it was aloe vera. So after a while, I got a bill of about two thousand dollars. (Participant 13, Male, 36).

In this participant's view, this outcome could have been prevented if the providers had just listened to what he was trying to convey, rather than assume they knew what he needed. He also was convinced that stereotypes regarding his African background played a role. He maintained that once he spoke with an accent, they just tuned him off mentally and stopped paying attention. He reasoned:

I went to this hospital with my car, and when I said I didn't know where the place was, they said they would provide me transportation. It's just, in their minds, Africans, we don't know anything. I don't think that, that they even bothered to pay attention to find out what I was looking for. I was trying to let the person know that I needed to know how to get to the place they were sending me, not looking for transportation.
(Participant 13, Male, 36).

In addition, participants felt providers' lack of attention to their needs was not only isolated to their descriptions of health needs, but also stretched to the type of treatment they receive as patients. According to them, providers sometimes were unwilling to provide the same quality of care given to people of different ethnicities. A participant who worked as a caregiver gave a witness-insight into how an elderly Nigerian immigrant patient was poorly treated by the nurses who were in charge of his care. Her testimony is as follows:

Being an African, things can be better um, with being a patient because at one point I, I was working at one hospital and there was this Nigerian man, he's also Igbo, who was admitted at that hospital. The nurses, they didn't pay attention to that patient as much as they will pay to other people, and I didn't really like that. Even to give the patient a bed-pan, a urinal, they wouldn't, and this patient had to get up and pour the thing in the sink! And then they were like, 'Oh is that what you Africans do there? You guys pour urine in the sink? You guys don't have toilets?' I'm like, 'What are you guys talking about? You guys should have attended to that man more. Number one, you know he was on that bed, he couldn't get up, he couldn't move long distances and you guys couldn't help him. He has been putting on his light, he has been asking for his bed-pan.' So um, like I said, when you are an African, you come in, you have an accent, number one, that just, it, it's not the same thing as when you are an American. (Participant 27, Female, 25).

According to this participant, there is a distinction between lack of cultural competence and inattentiveness. In her view, the way the patient she advocated for was treated, had

little to with cultural insensitivity but a lot to do with unwillingness to provide quality care due to the man's background. This, she stated, was usually the case when providers noticed their patients were Africans, coupled with their assumptions that African patients did not know their rights. According to the participant, "When you don't know your rights, you're just like, 'Okay, okay, thank you,' to everything." (Participant 27, Female, 25). For another participant, her visit was rushed, without attention to the concerns she was attempting to convey to the physician. Not only that, the providers assumed she needed an interpreter simply based on her background as a Nigerian. Her account is as follows:

Last week, when I was in the hospital for like two hours, forty-five minutes and I was really, really in pain, you know. And the nurse just walked in and told me, 'The doctor is gonna come and someone will interpret things to you, so just hold on.' And the doctor came in and he took like, two minutes, and he was just ready, so ready to leave like, quick. And I'm like, 'I have a question.' Uh, he didn't really have interest in looking into my question, my own concerns. I'm like, 'So what is the point of me going to the hospital and you guys are still going to bill me at the end, if you don't really take your time, you know, to sit down with me to, you know, to ask me what happened, what do you think I can do to help you?' (Participant 28, Female, 29).

Furthermore, the ability of providers to correctly identify what is wrong was roundly described by the participants as supremely important. Many Nigerian immigrants viewed an office visit as expensive, time-consuming, and the last line of action. In addition, according to them, the decision to seek care was not easily made, as it cut across financial, religious and cultural lines. Despite this, they still had to deal with US providers' lack of familiarity with the illnesses or symptoms they presented. One participant narrated how her brother almost died of malaria after returning from Nigeria, because the providers were unfamiliar with tropical diseases and could not determine what he was suffering from. Not only that, they were unwilling to listen to "this African woman," even though I was more familiar with the disease. She described her experience as follows:

My brother returned from Nigeria and then all of a sudden, like he got ill, and his condition got worse so fast. We went to the hospital and he was

admitted because they didn't know what was wrong. One day, I was on the phone with my sister back home and she asked me if we had given him malaria treatment. I said, 'Oh my God! I didn't even think about that.' So I told the doctors that it was probably malaria, but they did not even listen to me. I was afraid he was going to die, so I got malaria drugs and gave them to him. As soon as he started recovering, everyone was rejoicing, but they did not know it was me. I mean, my brother could have died! (Participant 31, Female, 39).

Another participant also described this experience of US providers' unfamiliarity with Nigerian health issues. Her father visited her from Nigeria during the summer, and broke out in hives one day. The itchiness and inflammation became so severe that she and her husband rushed him to the emergency room. The doctors could not figure out what was wrong. A serendipitous meeting with a Nigerian physician outside steered them to the effective treatment. She narrated:

My dad had chicken pox, but the thing was he took a shower while like, the whole thing was just starting, so everything came out. And then we went to the hospital like, me too, because me too, I thought it was an allergic reaction to the soap, and then this doctor like, we were there, they gave him Benadryl for almost an hour and it didn't work. And then the emergency, the ER doctor was like, 'Well, just go to your family physician,' because he had no clue on what was wrong. And then on the way to the family physician, we met this Nigerian doctor and then he was just like, 'Oh, it's just chicken-pox, go and put calamine lotion on it.' Like that was it, like, we didn't have to even go to the family physician. (Participant 19, Female, 44).

Not only did providers struggle to figure out the participants' health problems, the trial-and-error approach attracted exorbitant medical bills also. One participant had this experience when her aunt who was visiting from Nigeria, was sick. She described her case as follows:

I remember a time my aunt came from Nigeria. She had an issue and first we went to the emergency room, where we sat for at least two hours. And then after that, they moved us into a room but the doctor wasn't ready, so we spent at least another three hours. And then they were you know, infusing her with different things. Those things weren't even helping with the issue, so it was just money that we went to spend. And then when the bill came, I was looking at \$10,000. (Participant 22, Female, 22).

According to the participants, misdiagnosis of their health problems was yet another blight in their interactions with US healthcare providers. One female participant detailed a wrongful quarantine experience she had, due to a misinterpretation of her X-ray results, which she felt was a result of inattentiveness due to preconceived bias from the providers attending to her. The providers assumed she had tuberculosis (TB) because of a nodule showing on her lung, and her background as a Nigerian immigrant. She believed that their assumption and hasty conclusion were based on the reports of higher TB rates among US African immigrants. She explained her damaging experience as follows:

The doctors noticed that there was a nodule on my lung. I didn't know where it came from, and you know how they are here – you're from Africa and you have a nodule, so the first thing is that you have tuberculosis. So they quarantined me immediately. So everybody puts on masks and, and I'm looking at them like, 'Number one, I'm a nurse so I know what is going on, and I see you guys all masked up coming into my room.' I'm like, 'What's going on?' 'Oh we think you have TB.' 'What kind of TB? I'm not coughing. Okay you saw a nodule, but that's okay.' So with that, they immediately started treatment. They even cut me open for nothing. So all those troubles, just because you're from Africa, you know. It's just one of those things just because they are so scared. If I was from here and if I lived here, they wouldn't have handled that same nodule as if it was tuberculosis. (Participant 11, Female, 42).

Also, the participant commented on how her traumatic experience with the unwarranted TB treatment lingered, resulting in further discrimination in other interactions with providers. According to her, the fact that the discrimination she faced was not a one-off occurrence cemented her belief that it was real and not perceived.

She stated:

You know the thing kept following me for a long time, even when I was pregnant. They've already cleared me, but I'll be pregnant and going to have a baby, and they're putting on masks again. I'm like, 'Are you guys serious?' It was kind of crazy, and that even, that even made me, I didn't feel like going to the hospital again, because by the time I get there, they put on masks again for things that happened years ago, because it was in my, uh, in my chart. So that was kind of, I'm like, 'I didn't want to see all that anymore.' (Participant 11, Female, 42).

This participant's frustration did not merely cease there. It translated into her avoidance and delay of care, which almost claimed her daughter's life. According to her, her daughter was getting ready for school one day, and it was obvious she was unwell. Instead of taking her to see the doctor, she took no action. She explained:

I was not ready to take her to the hospital, you know, just being tired of all the crazy stuff. But it ended up that she fainted and then we had to start calling 911 at that point, you know. (Participant 11, Female, 42).

Cultural insensitivity. Participants described their dissatisfaction with providers' lack of cultural sensitivity to their health concerns. From their accounts, this was manifested in different ways such as ascribing a health problem in one region of Africa to the whole continent, dismissing cultural gender-roles, and writing off Nigerian folk remedies. A participant gave an account of the discriminatory treatment he received due to the providers' failure to verify the possibility of his link to the parts of Africa associated with an infectious disease. According to him:

It was around the time of the Ebola problem. Actually I had strep-throat, you know, so, I went to see a doctor. I felt so uncomfortable with the way they handled the whole thing about investigating what was going on. I was so uncomfortable, and I felt like I was, I was being interrogated as if I was an Ebola victim, just because of my background. And I think that if I was, if I had been white or a native, they wouldn't have treated me like that. I had not even left the country in a very long time, but they did not even start from there. (Participant 5, Male, 40).

Also, the participants described their experiences with providers who were unwilling to acknowledge the role of gender in their cultures. A participant who was a nun shared how her request for an-female care team for her medical procedure, was denied. The following is her experience:

Um, two years ago, I was having some pains in my tummy, so they told me they want to do endoscopy. And uh, the people that came in there they were three: two men and one woman. Being a nun I said, 'I don't want a man,' and the lady there said, 'Well, um, that's the doctor that will handle you.' I said, 'No.' I didn't do it because I wasn't ready to do that, so I told them if there was no female doctor to do whatsoever they wanted to check, I was sorry, I won't do it. The woman, she was nagging, I must tell you, she was nagging. So, I told her, 'Well, you cannot push

me, I'm sorry.' She refused, so I got up and left. I decided not to go back. (Participant 17, Female, 44).

Additionally, participants described providers' aptness to write off Nigerian folk remedies, as another form of cultural insensitivity. One participant was irked by the way providers' approached treatment of Nigerian immigrant patients. According to him, they are not given the opportunity to go over their folk therapies, which they actually have used verifiably for many years. He stated:

When you go see a doctor, it's like you're trying to go see God in a way. I mean, you're kind of scared, you know, to bring up your own ideas about treating the problem. This happens a lot, you know, to us foreigners from Africa. (Participant 28, Female, 29).

Also, another participant felt providers avoided dealing with Nigerian folk medications by using government regulations as an escape route. She explained:

They don't even go into our own types of medicines because they claim they don't know what's in it, and it's not FDA-recommended, it's not FDA-approved. So because FDA doesn't approve it, you know, we could just cook it up in our house, and use it or sell it. So um, I believe that's why. (Participant 6, Male, 45).

In addition, another participant felt the situation could be better if providers stopped ignoring their input regarding their folk remedies, in the assessment of their health problems. According to him:

This happened to me, you know. If you go see a doctor, and the doctor asks you what kind of drugs you've been taking. You start telling the doctor, 'I'm taking this traditional drug, I'm taking this drug, you know. They just switch off, you know. So I think that is a barrier. (Participant 8, Male, 62).

Discussion

This study is an important contribution to the literature because it produced previously unavailable data about US African immigrants' healthcare experiences. It identified factors that potentially affect health outcomes of Nigerian immigrants. The findings provide insight into how providers' negative attitudes, discrimination, lack of attentive care, and symptom misdiagnosis, contribute to the creation of health

disparities within an African immigrant community. Discrimination refers to when one social group is treated less favorably due to their background or how they are viewed.⁸¹⁻⁸³ One way discrimination manifests in healthcare is through prejudice or implicit bias. This refers to an involuntary racial or ethnic bias which is fed by social stereotypes.⁸⁸ In 2009, the prevalence of TB among Sub-Saharan African immigrants in the United States was 27 times higher than US-born individuals.⁷⁸ The participants' accounts support previous findings about providers' implicit bias towards patients viewed as "Black," a category which Nigerian immigrants belong to. Certain diseases and treatment options are more readily associated with black patients,^{78,83,117} which, in the case of Participant 11, was TB.

The motivation behind patient-provider interactions among US Nigerian immigrants is the complete resolution of the emergent health problem, starting with providers' recognition of the symptoms. Therefore, when treatment approaches result in prolonged investigations by providers, Nigerian immigrants become apprehensive and may even view the processes as a waste of time. The background factor responsible for this expectation is not immediately evident, because the traditional medical treatments most of the participants are familiar with are taken over a course of time. So, the discernible chief contributing factor is cost.¹¹⁸ In the participants' views, the quicker their health needs are met, the less the cost of care. This may explain why they prefer detailed single interactions with their providers, as opposed to repeated visits. Anything outside of this expectation then becomes an unaccounted-for challenge. Regarding this expectation, many of the participants harbored lack of belief in the providers' ability to correctly decipher what was wrong with them. This is often seen with tropical or imported diseases and illnesses with heavy cultural constructions. For instance, the *P falciparum* infections that lead to malaria are most prevalent in sub-Saharan Africa,¹¹⁹ so US providers may not be fully equipped with the knowledge for combating them. This is why providers' attitude is critical because a relatable patient-provider interaction may foster the bridging of the provider's knowledge-gap regarding such health problems. Also, communication within the African community is heavily fused with color, as is

evident in their folklore, figures of speech, and proverbs. This integral aspect of their experiences is also employed in their description of illnesses and symptoms. Therefore understanding African immigrants' symptoms may require more than textbook references.

Furthermore, cultural competence in healthcare should not consist merely of the acquisition of stereotypical data about a certain people regarding a particular matter. It also requires grasping the social and cultural underpinnings of that group's health experiences and behaviors.¹²⁰ To that effect, cultural sensitivity allows the ability to recognize explicit and covert differences and similarities, and still resist the lure to give them biased tags.¹²¹ As patients interact with providers, it is necessary to understand their cultural construction of diseases and illnesses.¹²² Cultural competence may be a good step in many cases, but it may also lead to stereotypes (e.g. Black Box). While cultural competence focuses on group characteristics, cultural humility makes it possible to recognize individual attributes.¹²³ With a population as culturally complex as African immigrants, attention to their constructions of health and illnesses is necessary for achieving culturally sensitive care. The African way of communication relies heavily on narratives and meaning importation. Therefore, it is important for US providers to exercise patience in dealing with this population, in view of this aspect of their interpersonal interactions.

This study has highlighted the impact of discrimination on the healthcare experiences and quality of care of Nigerian immigrants. For a population that is generally highly educated, navigating their interactions with US providers still constitutes significant challenges for Nigerian immigrants. Negative attitudes of providers lead to discrimination, which may then morph into low quality healthcare, and the discouragement of involved patients from returning or even readily seeking care subsequently. This is an important finding, with implications for healthcare costs to society and health policy. It therefore requires a follow-up study, using a larger, representative US African immigrant sample. Not only that, patient-provider interactions unfold bilaterally, and this study presents only the views of the Nigerian

immigrant participants. It is important to understand providers' views of their interactions with African immigrants.

Additionally, studies have revealed African immigrants and African Americans show similar patterns of severe distrust of the US healthcare providers. However, the events that contributed to shaping the provider distrust among African Americans were different from those that unfolded in the home countries of US African immigrants. We know that the two populations have differing health experiences and outcomes, so part of the efforts to decode the "Black Box" entails understanding the underpinnings of this convergent health behavior. This is necessary because an effective intervention against provider distrust within the African American community may yield the same expected outcomes among African immigrants, and vice versa. Moreover, it is important for future inquiries to verify the impact of length of residence and acculturation on the healthcare experiences of African immigrants in the United States. In other immigrant populations, decline in health has been found to occur over time in the United States,¹²⁴⁻¹²⁶ so it is vital to ascertain whether this is also present within the African immigrant community. Therefore, a linear appraisal or other approaches to healthcare needs, which may be effective with other populations, may not produce similar results with African immigrants. In addition, no research has compared the healthcare experiences of different African cultures to one another. This is important in understanding the overall problem because the continent is vast. Therefore, the possibilities of variances in the interactions between cultures and health behaviors within the African immigrant community exist.

One strength of this study is in its innovative nature. To my knowledge, this is the first study focused on understanding the underpinnings of the healthcare experiences, behaviors, and needs of an African immigrant population in the United States. In a field of study without a database for reference, this study provides the much-needed foundational data for future inquiries. Moreover, the use of two coders enhanced data reliability, and reduced researcher bias. My status as a Nigerian immigrant was advantageous throughout this study, which resulted in a deeper

understanding of the data, as it allowed me to grasp the nuances in participants' responses. Also, the line-by-line coding method for theme derivation was important because it checked the imposition of the coders' biases on the meanings arising from the data. In addition, previous studies on US African immigrant health were based on examination of clinical outcome patterns using secondary data, barriers to utilization of healthcare services such as disease screenings, and theoretical permutations by the authors. Further strength of this study is found in the sample size (n = 33) which exceeded general guidelines. The recommended number of participants for grounded theory methodology ranges from 20 to 30,^{127,128} and for all qualitative research, recommended sample size is a minimum of 15 participants.^{129,130}

While this study is important in filling a critical knowledge-gap, it also has some limitations. The sample for the study consisted only of Nigerian immigrants, and as such, was not a representation of the US African immigrant population. Still, as the foundational study in an area without preceding database, the knowledge gained from this research will be useful in informing the development of future inquiries. While my background was beneficial, it might have constituted an inadvertent barrier to some participants. During the collection of demographic data, some participants chose not to disclose their annual income, which they probably would not have any qualms with had the researcher been from a widely different background. Furthermore, this study has elucidated some of the ways in which Nigerian immigrants seeking healthcare in the United States perceive discrimination. However, these results, it must be emphasized, represent the perceptions of the study participants. Therefore, an exploration of the attitudes of the healthcare providers is still required. In the meantime, we know that with Nigerian immigrants' healthcare experiences, the process of navigating healthcare in the United States becomes more complicated as they attempt to make sense of their original identities in the presence of often varying and challenging cultures and conditions, including complex provider-patient interactions, which may often be perceived as antagonistic by the immigrant patients.

CHAPTER 4

Factors that impact healthcare meaning among African immigrants in the United States: The case of Nigerian immigrants in Indianapolis

Introduction

In the extant literature, there is paucity of information about the healthcare experiences and healthcare needs of African immigrants in the United States. Specifically, nothing is known about how African immigrants' interpretations of healthcare are derived and how they affect the population's utilization of healthcare in the United States. The population of US African immigrants is over 2 million, which is about 5 percent of the total US immigrant population. In the past decade, the number of US African immigrants has grown more than all other immigrant groups, and is expected to keep rising rapidly.^{78,91} Moreover, African immigrants have the highest education level out of all US immigrant populations, and are more likely than all US immigrants to have private health insurance. Also, they are less likely than all US immigrants to be uninsured.^{91,99} These unique characteristics make understanding this population's healthcare meanings and experiences very important. Immigrant health findings indicate negative healthcare meanings may result in decline in health outcomes and overall well-being.^{131,132} It is necessary to find out whether this is valid among African immigrants, because understanding a population's healthcare meanings and the factors that influence them, is critical for addressing its healthcare needs. This is because meaning impacts utilization of healthcare, which then affects health outcomes.^{132,133}

Healthcare meanings are largely derived from subjective interpretations regarding self and the environment, which then guide the manners in which health and well-being are handled.^{132,134} For African immigrants, the formation of healthcare meanings is a multi-layered process, deeply rooted in cultural, spiritual, and religious beliefs.^{3,135} These connections are indispensable because of their impacts on the assessment of symptoms and illnesses, interactions with healthcare providers, and perceptions of treatment approaches.^{120,136} One commonality among these health

behaviors is their contributions to shaping health outcomes. Positive healthcare meanings may lead to increased disposition to utilization of healthcare, and vice versa.^{133,136,137}

One reason for the paucity of research on African immigrant health in the United States is the focus of immigrant health research on Latino, Asian and Caribbean populations.^{80,92,93} Consequently, reliance on data based on other US immigrant populations for understanding African immigrant health, may result in inaccurate permutations, which may further compound the problem. For instance, some immigrant health studies have found a connection between health outcomes and the product of the interaction between education level and health literacy.^{57,138} However, since African immigrants constitute the most educated US immigrant population,^{91,139} this connection is unlikely to apply to them, especially given the non-standardized assessment of health literacy.¹³⁸

Furthermore, even when studies look at black immigrant health issues, focus is normally on Caribbean immigrants. Still, this is insufficient because research has shown healthcare experiences and needs of African immigrants vary from those of other black populations in the United States.^{67,97,98} Currently, there is no database dedicated to documenting African immigrant health information.^{105,106} Also in available US databases, African immigrants are categorized as African Americans and other physically related groups, such as Caribbean immigrants. As a result, it is difficult to utilize secondary data to study African immigrant health.¹⁰⁵⁻¹⁰⁸ Besides, regardless of the phenotypic comparisons, there are health outcome differences between African immigrants and African Americans.^{3,67,102} For example, studies showed African-born black women and US-born white women had similar rates of birth-weight, which were higher than the rates among US-born black women.^{100,140,141} Not only that, the lack of trust of healthcare researchers is another contributing factor to the dearth of research on US African immigrant health. There is a high level of healthcare researcher distrust within the African community, because of their experiences of being taken advantage of by trusted health researchers. This in turn makes it challenging to recruit participants.¹⁴²⁻¹⁴⁴

Understanding the healthcare meanings of African immigrants in the US is of high importance, because it is required to also understand how to meet their healthcare needs. The findings discussed in this paper constitute a part of a larger qualitative study aimed at understanding the healthcare experiences of Nigerian immigrants in the United States. Nigerian immigrants present a great first opportunity for understanding African immigrant healthcare experiences and healthcare needs in the United States. With a population of more than 330,000, Nigerian immigrants represent the highest number (about 19%) of the US African immigrant population.⁹¹ This paper presents the factors that contribute to shaping the healthcare meanings of Nigerian immigrants in the United States. The questions it attempted to address include: (1) What are the contributing factors to the healthcare meanings of Nigerian immigrants in the United States? and (2) How does healthcare meanings influence Nigerian immigrants' utilization of healthcare in the United States?

Methods

This study followed a grounded theory approach using a symbolic interactionist framework. Grounded theory and symbolic interactionism both identify meaning as the foundation for data interpretation and derivation of theories regarding the problem being examined.^{21,22,24} This is necessary for studying African immigrant health because the healthcare experiences of this population are grounded in meaning and interpretations derived from their culturally-rich backgrounds.⁹⁸ Also, my unique perspective on this study comes from my background as a Nigeria immigrant who has been navigating the US healthcare system for several years. This advantage gave me a more in-depth look into the participants' responses through the identification of certain nuances and implications. The Indiana University's Institutional Review Board (IRB) approved all study procedures.

Settings and participants. Twenty individuals participated in focus group discussions. Participant eligibility for this study included being Nigeria-born, and 18 years of age or older. Also they had to be English-speaking, legal residents or US citizens, migrated to the United States by the age of at least 12 years, and had lived in the

country for at least three years. Previous residence in other countries than Nigeria before moving to the United States was an exclusion criterion, as that would have exposed those participants to varying health experiences from those in their home country. Using purposive sampling for participant recruitment allowed me to select only participants with the most fit with the study design. These were also individuals with the most relevant perspectives of the issue.^{28,29} To navigate African immigrant settings in Indianapolis, community “Leads” helped me gain access to social and religious gatherings, where I presented my research information. Potential participants were identified through community “Leads” who assisted me with navigating different African immigrant settings in Indianapolis, Indiana, including social and religious gatherings. At each of these gatherings, I was given opportunities to present my research at each of the gatherings.

Furthermore, once a participant was identified and enrolled in the study, snowball sampling was employed to recruit more participants. These sampling approaches were required because recruiting immigrant participants is difficult due to their wariness of exposure to situations that could jeopardize their sojourn.^{113,114} This is even more pronounced among African immigrants due to the deep-lying distrust of healthcare researchers among Africans, emanating from their well-documented accounts of their experiences with health researchers’ exploitative practices.^{30,142-144} Much of the African immigrant community is relational, and, despite my position as a Nigerian immigrant, I needed to have someone vouch for me to establish trust. In addition, I directly approached individuals whom I viewed as potential participants in various places such as international markets. I presented my research information to them and provided my recruitment flyer bearing pertinent research information, including researcher contact.

Participants’ demographic information is presented in Table 4. The most represented ethnic groups were Yoruba (45%, n = 9) and Hausa-Fulani (25%, n = 5), respectively. The ages of the participants ranged from 22 to 60 years, and the age group with the highest number of participants (n = 13) was 22 to 30 years. Forty percent (n =

8) of the participants had a Bachelor's, 35% (n = 7) had a Master's, 10% (n = 2) had doctoral-level (pharmacy and medicine), 10% (n = 2) had an Associate, while the remaining 5% (n = 1) had a high school diploma. Ninety percent (n = 18) and 95% (n = 19) of the participants reported having employment and health insurance, respectively. The length of residence in the United States of the participants ranged from three to 20 years.

Procedure. Data were collected between April 2017 and October 2017. The focus groups were conducted in English, audio-recorded, and fully transcribed. The duration of each focus group interview was 30 to 60 minutes. Examples of the questions discussed by the groups included, "Can you talk about what "health" means to you?" and "Can you discuss your views about the US healthcare system?" For a more in-depth look into participants' responses, probes were utilized, especially as related to further clarification of pertinent information.²³ Each focus group was conducted at a safe location, which the participants were comfortable with, and which allowed for privacy, such as a closed room in a public or school library. Participants were made fully aware of their choice to decline to answer a question or discontinue with the discussion entirely, at any point. In addition, each participants provided informed consent prior to each of the focus groups. At the end of each discussion, a \$5 gift-card was given to participants as appreciation for their time.

Table 4 – Participant characteristics [N = 20]

Variable	n (%)
Gender	
Female	7 (35)
Male	13 (65)
Age Group	
22-30	13 (65)
31-40	2 (10)
41-50	2 (10)
50+	3 (15)
Marital Status	
Single/Never Married	11 (55)
Married	9 (45)
Nigerian Ethnicity	
Hausa-Fulani	5 (25)
Idoma	2 (10)
Igbo	4 (20)
Yoruba	9 (45)
Religion	
Christianity	15 (75)
Islam	5 (25)
Education	
High School	1 (5)
Associate Degree	2 (10)
Undergraduate Degree	8 (40)
Master's Degree	7 (35)
Doctoral-Level Degree (MD, PhD, PharmD, JD, etc.)	2 (10)
Annual Income [\\$]	
25,000-50,000	9 (45)
51,000-70,000	3 (15)
71,000-90,000	2 (10)
N/A ^a	1 (5)
Undisclosed ^b	5 (25)
Employment	
Employed	18 (90)
Unemployed ^a	2 (10)
Health Insurance	
Insured	19 (95)
Uninsured	1 (5)
Length of Residence in the United States	
3-13 Years	16 (80)
14-24 Years	3 (15)
Undisclosed	1 (5)

^aStudents who did not have annual income

^bNon-students who had annual income but chose non-disclosure

Data analysis. According to the principles of grounded theory, I followed an inductive analysis approach, which allowed the themes to directly materialize from the data.²⁴ These steps include: cleaning the raw data, detailed reading of data document, and development of themes.²⁶ Using focused coding, I worked with a Research Assistant (RA) to develop a codebook by identifying and labeling pivotal parts of the data documents. The resultant codes were arranged according to how they naturally aligned into themes.³⁷ We deemed these themes sufficiently illustrative of the core of the data. By going over the developed codes together, we refined the codes, eliminated redundancies and tightened the categories. We developed inter-coder reliability by using the MAXQDA software to code the data documents. Following an initial agreement of 83%, the RA and I performed a second round of coding, which yielded 91% agreement. Also, we used a line-by-line approach to our coding to arrive at the themes. This was important because it kept us from imposing our own perceptions and interpretations as coders, on the participants' responses.²³ The final coding process was carried out using axial coding, which allowed us to comprehensively look at the themes, including those that might have been previously misidentified. Consequently, the themes were organized into logical categories and sub-categories. Throughout the data analysis process, the RA and I both kept an audit trail, which allowed us to track our modifications and rationales. Additionally, my status as a Nigerian immigrant familiar with the healthcare system in the United States provided me a unique outlook, which translated into a deeper view of the data.

Results

From the data analysis process, four themes connected to factors that shape healthcare meaning were identified. These themes include: (1) cultural, spiritual, and religious beliefs (2) length of residency, (3) age of participant, and (4) prejudice and discrimination. Each of these themes is discussed in detail below.

Cultural, spiritual, and religious beliefs. Cultural, religious and spiritual beliefs play critical roles in determining how Nigerian immigrants approach healthcare, so the decision to seek care in the United States is not made lightly. Nigerian immigrants came

from cultures that view health as a by-product of the interaction between the spiritual and physical, which affects both the mind and the body. Therefore, their understandings of illnesses and symptoms were derived from this notion. Participants' responses for this theme will be presented in two sub-themes: the influence of culture on preventive care and religious and spiritual influence on care seeking.

Cultural influence on preventive care. According to the cultural norms in Nigerian, preventive healthcare is viewed as unnecessary, unless when an individual is severely sick. As a result, Nigerian immigrants in the United States tend not to utilize preventive healthcare due to these cultural norms and religious convictions. Contributing to the discussion about seeking care in the United States, one participant bluntly stated, "When you're not sick, you don't need to go to the doctor. Like, if I don't get sick, what is the reason for going to see a doctor?" (FG 2, Participant 5, Male, 49). Even when health insurance was not an issue, this cultural understanding of healthcare prevailed. One participant who worked as a healthcare professional, shared her unwillingness to visit the doctor, which she admitted was beyond her comprehension. She explained:

With my *yearlies*, which I'm really bad at, like my yearly physical, I don't think I've ever been to that, to be honest, even though I have insurance and I pay for it, and I could go. But just because of, you know, we just have this mentality of, if I'm not sick, and I don't have any symptoms, then I don't need to go. So I just don't go, even though as a nurse I know better, but I just still don't act. (FG 3, Participant 2, Female, 29).

Also some participants believed seeking preventive healthcare when they felt convinced they were in good health, was only a way of inviting health problems, because they would end up discovering something wrong with their health. According to one participant, even having health insurance should not necessarily translate into the utilization of care, if there was no perceived health problem. Her view is as follows:

You know, in Africa we didn't have the insurance thing. But once my whole family got here and they got insurance, they started doing dentists, hospitals, doing check-ups. I'm like, 'You didn't do, use to do that in Africa, so why is it now that you have, you know, all these

privileges?' And then the more they go, the more problems they find. I don't do hospitals. (FG 1, Participant 4, Female, 30).

Another participant described this belief as a fear of life's slippery slope, which may manifest in healthcare, whereby one undesirable event could result in a chain of other unfavorable outcomes. The following is her explanation of this phenomenon:

I guess I will say it is the fear of the unknown. Like you don't want to find out like, 'Maybe if I go, then, they'll say, they'll say that it's A wrong with me, and then there's B, and there's C, and there's D.' And then it goes on and on from there. So yea, I guess it's fear of the unknown. (FG 3, Participant 2, Female, 29).

In addition, some Nigerian immigrants viewed healthcare as a ploy by providers to siphon patients' money. From their perspectives, providers would always detect something wrong within the body, even though it may not be life-threatening. According to one participant, her mother's experience at the dentist served as a cautionary tale for her to steer clear of seeking care when she felt nothing was wrong.

The following was her rationale:

So, I'll give you an example. Um, one time my mom went to the dentist and they literally told her, 'Well, we have to pull all your teeth out.' Until today, she hasn't done that, and she's fine. So that just tells me, you know, the more you go there, even when there's nothing wrong, the more they find something to tell you, just so they can take your money. (FG 1, Participant 4, Female, 30).

Also, For Nigerian immigrants, dealing with symptoms where everything is influenced by culture, is challenging. In one participant's view, one outcome of this complicated processing of healthcare is complacency towards healthcare. According to her, "Some illness that you have, that you know you're supposed to uh, go to the hospital, in Africa, we like, we don't take it seriously. And here, we still do the same thing, you know?" (FG 1, Participant 5, Female, 33).

Religious and spiritual influences on care seeking. According to the participants' religious and spiritual beliefs, certain illnesses could be resolved by having faith in God. They explained how protection from ailments was one of the promises of God to

believers. According to one participant, recalling this promise was one way of dealing with illnesses. The following is his rationalization of this belief:

When you're sick, religiously you want to pray about it and say, 'My faith will carry me through,' you know. I will use my faith because God has said, 'I will heal you from every form of diseases and infirmities.' You want to use that, that faith. We pray about it. (FG 2, Participant 2, Male, 57).

In agreement, another participant within the same group explained how, even in the face of life-threatening health problems, faith in God's healing would still serve as the initial approach. Going to the doctor when sick would then be the last resort. His explanation is as follows:

Religion is what too can make me not to go to the doctor. It is possible for um, someone to have faith. When you are talking about religion, if probably you have a life-threatening issue and you believe in God, you pray about it, 'I don't want to see the doctor because I believe in God, that God will do this for me,' and sometimes it works. Most of the time it works and that is faith, and stops you from seeing the doctor. (FG 2, Participant 4, Male, 41).

Length of residence. The impact of length of residence on the healthcare meanings of the participants was evident in how they defined health and conceptualized healthcare. These were equally evident in their ways of handling illnesses. Although the African notion of health comprises interactions between the physical and spiritual, some participants discussed how they still had varying meanings, prior to living in the United States. In their home country, participants generally had different healthcare experiences, including predominantly uninsured healthcare and informal office visits. Also, the impact of length of residence in the United States on the participants' notions and attitudes about health and healthcare, was evident in the ways they were influenced by social networks. These effects of length of residence will be discussed in detail below:

Definition of health. Regarding the effect of length of residence in the United States on his healthcare meanings, one participant explained how his idea of health was different back in his home country. He described the transition as follows:

I used to have the notion that health is all about physical well-being until I got here and also started my training. So I quite understood that health was well beyond physical well-being. It also includes the mental well-being and then social well-being. And I would add uh, based on the religious background that I have, I think health is also about spiritual well-being. I think spiritual well-being has a lot to do with someone's mental well-being, so it cannot be separated, even if someone doesn't have a religion. (FG 4, Participant 1, Male, 30).

Furthermore, length of residence affected how participants interpreted physical appearance, which in their cultures, served as a key indicator of health. In many African settings, a bigger body size signifies adequate nutrition while leanness is deemed undesirable and a sign of poor health. One participant described how residence in the United States led her away from this view:

My overall understanding of health changed. You know, in Nigeria if you're rich and healthy, you're supposed to be like, I don't know, big. If you're like, lacking, you're thin and bony and everything. But that's actually different here. Like now, it's like, healthier for you to maintain a certain way, you know, how you look and stuff. (FG 1, Participant 2, Female, 26).

Providing a comparative assessment, another participant highlighted the impact of length of residence on the progression of his family's understanding of health and healthcare, over the years in the United States. His account is as follows:

Dealing with our healthcare with my mom was really difficult when we first moved here. It was really difficult for her to change, but being in the United States all this time, I think, has changed her. Now for me and my dad, she understands that yes, our ways of handling health issues have changed too. You know, she understands now that, 'Oh, he's sneezing, he's not sick. Just let him do him and he'll be fine.' Or when I have a migraine, 'Let him take some medicine and sleep, he'll be fine.' Or when my dad is sick, 'He has to go to the hospital.' She understands that now, and she's no longer like, forcing the Nigerian ideology about healthcare on us. (FG 4, Participant 3, Male, 24).

Social relationship influence. In addition, social networks was identified as impactful on healthcare meanings over time in the United States. For instance, one participant accredited his improved understanding of physical fitness to the social bonds

he forged in college, which he lacked in his previous years in the United States.

According to him:

Social networks, like, you know, my peers, helped me change, because back in high school, I didn't go to the gym or do anything about my health. But as I came into college and I didn't do those things, but I saw my peers going to the gym or starting to take more of an approach towards, you know, their health, I learned from them. So I started going with them, and learning more about my health, which I didn't do before. (FG 3, Participant 1, Male, 29).

Concerning health-seeking behaviors, participants felt their health-seeking behaviors have evolved since moving to the United States. For one participant, this change occurred in his overall approach to his well-being. According to him:

The frequency of the annual visit has changed over the last um, 20 years. Prior to that, I never went or I didn't have a doctor. Now I'm just more disciplined, more rigid about, about the annual healthcare, and being more conscious about my health. (FG 3, Participant 3, Male, 32).

Moreover, another participant believed length of residence assisted her in overcoming her long-held skepticism about healthcare in general. The following was her view:

Back home, you're not even sure of the medications you're going to take, whether they will work. And I'll give you an instance, an elected official in one state was given um, pain-reliever because he complained of his feet, or his legs or something. But the man died of um, overdose. In the time I've lived in this country, my perception, it has gone through like, a paradigm shift, you know, to really having the awareness that if I go to the hospital, I'm going to be well. So I don't hesitate like I used to. (FG 4, Participant 4, Male, 26).

Age of participant. In the Nigerian immigrant community, age is an important variable in the assessment of meanings of experiences. The ages of this study's participants ranged from 22 to 60. There were striking differences between the healthcare meanings of participants aged 22 to 40 and 41 to 60. The older participants viewed the US healthcare as an opportunity, which could be readily taken advantage of. Also, they expressed satisfaction with the quality of healthcare in the United States in general, such as in technology and research. On the other hand, the younger participants were unimpressed by their experiences with the US healthcare, mainly due

to their dissatisfaction with the quality of care, especially regarding their patient-provider interactions. Some of the younger participants even believed foreign-trained healthcare providers would be more likely to provide more effective care to them, because of their multi-cultural experiences. Concerning these differences in perspectives between the two age groups, one older participant's response alluded to the vantage position of having comparative experiences. While explaining his perspective, he stated:

For those of them who live here, I tell them, 'You guys are very, very lucky. For those of us that are coming um, from a different environment and culture, we really see it as an opportunity. To be treated over there, you don't even see what you're getting.' So it's different here. (FG 2, Participant 1, Male, 60).

On the contrary, the younger participants' understanding of the US healthcare was cynical and dismissive. Viewing profit as the main factor in US healthcare, ahead of patient well-being, one participant explained:

Even if they're there to help, they're also there more to make money, that's my take on it. Um, everything is so expensive, um, so they're more concerned with making as much money as they can make from one patient. (FG 4, Participant 2, Male, 27).

In addition, the older participants' points of appreciation of healthcare in the United States included the technological advancements, which they viewed as an advantage to African immigrants who used to navigate healthcare in resource-challenged settings, prior to moving to the United States. His insight is as follows:

The scientific diagnostic equipment that we have around here has helped us a lot, you know to, identify the particular illnesses that were not, you know, diagnosed in Africa. There, you might have diabetes, you just go to the hospital, and they give you medication. No test is conducted either because the, the technology is not there to test it or the reagent is not there to test your blood or to test your urine blindly. People just give you medication and you go your way, and the condition persists. But when you get here, because of the modern equipment that are available, they easily detect that in you. (FG 2, Participant 1, Male, 60).

However, the younger participants viewed their attempts to seek care as a waste of time and resources, since their health needs still were unmet. One younger participant

narrated how he was once in a position to access healthcare without any barrier, but rather elected not to, based on his appraisal of the expected outcome. According to him:

I developed allergies last, what, four years now? And that's one of the things that I went and then they told me, 'Okay you have allergies. Here you try this, it will solve it.' But it doesn't really work. So it's like, I could go again, but why would I waste the time when you're going to tell me the same thing again? (FG 3, Participant 1, Male, 29).

Even when the participants had families, this trend in healthcare meanings between the two age groups prevailed. The older participants saw the way healthcare in the United States was set up as a safety-net against life's unpredictable eventualities, which could prove useful any time. One older participant who had four children described this perspective as follows:

When you have a seizure, you cannot just beat it out. You have to go to the hospital because you don't know where you are at. They just have to call 911 and to take you to the hospital because you are in a coma. If I know I'm sick and it's affecting me two, three days, and I take uh, this herb, this medicine, but it's not going, next thing is to go see the doctor. Accident is another one, because you know, it may be a life-threatening issue. So you don't have a choice other than to just save your life. (FG 2, Participant 5, Male, 49).

On the other hand, a younger participant who had two children maintained seeking healthcare was only reserved for verifiably dire situations. Despite her children being toddlers, she did not reveal any perception of any issue with her mindset regarding their healthcare. She categorically stated:

If nobody is sick, we're not going to see the doctor. She has to be sick, and I mean my daughter, she has to have a fever that is really high for like two, three days before we'll go see the doctor. Like, if I give her Ibuprofen and it's not working, then after which, when we go, they give her the same thing and the fever goes. Then I think, next time, I guess, like, I, I'll wait the whole thing out. (FG 3, Participant 5, Female, 30).

Prejudice and discrimination. Generally, participants identified negative provider attitudes, which often crystallized into prejudice and discrimination, as a key contributing factor to their perceptions of healthcare in the US. These providers'

attitudes included treating the participants without respect, assuming they were all uneducated, and dismissing their input or concerns. One participant alluded to her accent as a prompt for providers' assumption that African immigrant patients like her were ignorant. She narrated:

When you have an accent they think you're dumb. There was this time I argued with this lady, like, full-blown argument because like, she was telling me that [name withheld] who's my kid, was AS. I was like, 'No, that's not possible. You can't tell me she was AS because I'm AA and [husband's name withheld] is AA. So how could she be AS?' And then she's there staring at me with this disrespectful look. So I was like, 'Explain it to me. Because you know, like, just because I have an accent, you now think I'm stupid.' So it's like, I know what I'm saying, so there must be a mistake, but she won't even explain it to me. (FG 3, Participant 2, Female, 29).

In addition, participants cited stereotypes based on limited knowledge about African immigrants, as one of the factors contributing to negative provider attitudes towards them. For instance, one participant explained how, due to the reported high prevalence of tuberculosis (TB) among certain African immigrants, providers began applying a sweeping, and often wrong, assumption to the detection and treatment of this disease among African immigrant patients. The following is the participant's account of this experience:

My own experience is um, you see most of us from Africa, we have what we call BCG. Every child that is born is given BCG, to prevent tuberculosis. And that has built a kind of anti-body, you know, so anything that is injected in us like PPD, will always be reactive. But here, they don't want to know about that. All they know is that, 'Oh you are reactive. This is 12mm, this is 15 mm. So you are positive, you have tuberculosis.' Even though you don't have it, they treat you as such. Immediately they give you a mask, you go and stay somewhere. They want to quarantine you and all that but, it is not so. They need to understand that because of this, we are being treated as second-class citizens, you know. Right away, they take you out of the community, people start visiting you. Then when they are coming into your house, they put masks on and all that. So this is an experience that is very nasty here, which should be addressed. (FG 2, Participant 1, Male, 60).

Some participants were convinced their identification as African immigrants, subjected them to sub-par treatments by providers. One participant, who believed his son was not promptly attended to when he took him to see the doctor, because the providers regarded them as less important, shared this view. He explained:

I have my kids, one of my kids was having a problem in the school, and I was taking him to [name of hospital withheld]. As we got there, the doctor told me we had to wait until he went to lunch and came back. I said, 'What the [expletive] are you talking about?' You see, if I am from here, he will not go to lunch. He will attend to my kid before he goes to lunch. That's the problem. (FG 2, Participant 5, Male, 49).

Furthermore, the participants described a type of discrimination they encountered which was linked to being put in the same category as African American patients and other physically related groups, by US healthcare providers. As a result, the participants faced the same negative stereotypes associated with those groups by the providers. For instance, one participant discussed how providers' lack of respect for African American patients who had Medicaid health insurance, was transferred to her. She stated:

They already see black people in this country a certain way. So when we walk in there, they will be like, 'Ah, they're here for the free doctor.' Even though there's something wrong, they think we're there to abuse the service. They have a way of um, grouping black people, like they know the kind of people that keep coming. So most times when you come, they're just looking at you like you're one of those frequent visitors. (FG 1, Participant 5, Female, 33).

According to the participants, discrimination and prejudice affected their healthcare perceptions in different ways, such as the decision-making whether to return to the same healthcare facility or not, and their own attitudes towards healthcare providers generally. One participant stated this clearly:

I must tell you, when I go to the doctor and I meet any of those people, and I see that the person wants to pick on me, because of my background or my color, I wouldn't mind turning back and going back home. (FG 1, Participant 3, Female, 25).

Discussion

In the United States, there is still a lack of knowledge of African immigrant health experiences and needs.^{3,16,98} The current scope of US immigrant health research does not reflect the nation's diverse immigrant population. With the majority of immigrant health studies focusing on the Latino and Asian populations,^{80,92,93} this study provides important findings aimed at critical knowledge-gaps. The study identified cultural, religious and spiritual beliefs, length of residency, participant age, and discrimination and prejudice, as key factors influencing healthcare meanings of Nigerian immigrants in the United States. Prior to relocating to the United States, Nigerian immigrants' healthcare meanings were predominantly guided by cultural, religious and spiritual beliefs. However, in the United States, they are faced with the herculean task of deriving functional healthcare meanings from these multi-faceted beliefs, along with the different cultures and beliefs in their new setting. This quandary may influence Nigerian immigrants' understanding of western medical treatment, which may in turn affect their healthcare utilization.

Findings from this study show the participants were unwilling to seek care, even when they had health insurance. The western view of many African traditional treatments as alternative treatments implies African ways of treating maladies are not only secondary, but also possibly unsubstantiated. Nevertheless, many of those treatments regarded as alternative have been in effective use for hundreds of years.¹⁴⁵ It was possible for western treatment approaches to be deemed imperialistic and culturally insensitive by the participants. It is important to verify whether this was a contributing factor to the non-utilization of healthcare in the United States, by the study participants. Moreover, it is important for US healthcare providers to understand how African immigrants perceive western treatments, as that is critical in their adherence to treatment and patient-provider interactions. Furthermore, despite being mostly educated, majority of the participants did not readily utilize healthcare, but used their traditional treatment methods first, before visiting the doctor when the health issues were deemed life-threatening. Cost has been frequently identified as a major deterrent,

which constantly latches on to the other factors that shape healthcare perceptions.^{3,109} Although majority of the participants had health insurance, they probably still were faced with high co-pays and premiums.

Furthermore, it is necessary to gain further insight into underpinnings of the participants' belief that healthcare utilization in the absence of discernible health crisis, would result in a cascade effect of health problems. Some of the participants' responses indicated its possible link to their cultural or spiritual beliefs, regarding well-being and healthcare in general. Also, it could be connected to their distrust of the US healthcare system, because some of the participants described US healthcare as mainly profit-driven, at the expense of unsuspecting patients. Additionally, the participants' religious belief that faith sufficed for certain illnesses requires further examination. With diagnosable conditions, it is unclear how the participants determined the occurrence of healing. Without this verification, some diseases the participants believe they have been healed from may return in more severe forms. This supports the research finding that members of the African immigrant community are more apt to seek care during the late stages of diseases such as cancer, especially because many of them choose to explore traditional treatment options first.^{4,98}

While the exploration of the impact of length of residence in the United States provided an insight into the changes in the participants' healthcare experiences, one discordance needs to be noted. Participants unanimously acknowledged they no longer ignored their symptoms as they used to do in their home country. However, this seemed to be an isolated change, which did not translate into utilization of healthcare in the United States. The same participants still admitted to putting off or completely avoiding office visits, even when health insurance coverage was available. This was true across all the age groups. One of the often-cited findings in immigrant health research is the positive relationship between level of education and healthcare utilization.^{80,146} However, results from this study did not support that correlation. As a whole, the participants represent the most educated immigrant group in the United States,¹ and in this study majority of them had a minimum of an undergraduate degree, along with

health insurance. Yet these factors did not observably influence their utilization of healthcare in the United States. For effective delivery of healthcare to this unique population, understanding the interplay between their healthcare perception and utilization of healthcare is of paramount importance.

Furthermore, there was a pattern by age group, regarding the study participants' understanding of healthcare in the United States. While the older participants viewed the US healthcare as a lifeline, especially given their prior healthcare experiences in their home country, the younger participants were blasé about it, describing it as unsatisfactory. It is unclear whether this trend was related to the number of years a participant had spent in the United States. Although that a positive correlation, this might not be the case with this finding. These varying health meanings between the two age groups cannot merely be ascribed to length of residence in the US, because some of the younger participants had lived in the United States longer. Additionally, age at immigration might be a contributing factor to interpretations of self and the environment, which then may influence healthcare meanings. As shown by the progression of the participants' understanding of what was healthy, regarding physical appearance, healthcare meaning is a combination of the participants' experiences prior to, and since moving to the United States. Regarding the impacts of length of residence and social networks, it is indeterminate, what factors might make one or the other more important. To have an in-depth understanding of the process of African immigrants' construction of healthcare meanings, this knowledge is essential.

Additionally, the forms of discrimination and prejudice described by the participants revealed a double-edged sword involved in African immigrants' healthcare experiences and construction of healthcare meanings in the United States. Being recognized as African immigrants based on their characteristics, such as accents, elicited negative provider attitudes towards the participants. Equally, being perceived as African Americans also left them susceptible to the same negative provider attitudes directed to that population. It is necessary to fully address how discrimination affects the healthcare experiences of African immigrants, because it is key to understanding how

they approach healthcare utilization. For instance, the reluctance of the participants to utilize healthcare in the United States, may be linked to the traumatizing and demoralizing effects of discrimination and prejudice they faced or were anticipating.

To my knowledge, this is the first study specifically focused on understanding the factors that contribute to the healthcare views of an African immigrant group in the United States. Although the overarching objective is the understanding of African immigrant health, the knowledge gained from this study is a starting-point. Prior studies on US African immigrant health were based on clinical measures using secondary data. However, their findings are unreliable due to the difficulty identifying African immigrants in those types of data. Other studies were centered on African immigrants' healthcare access barriers, and theoretical conjectures about their healthcare needs, based on the authors' personal views. These results may not be dependable since they did not emanate from the primary data from the target population. Because of the lack of knowledge about African immigrant health in the United States, findings from this study may be used to develop future lines of inquiry, as well as serve as the foundation for US African immigrant health database. Another strength of this study was its sample size (4 focus groups, with 5 participants each), which exceeded general guidelines. The standard number of focus groups for a grounded theory study, ranges from 3 to 5.^{130,147} Moreover, my background as a Nigerian immigrant gave me a unique insight, which proved useful in different ways, including probing for further elucidations during data collection and recognition of nuances in participants' responses during data analysis. In addition, African immigrants harbor profound distrust of healthcare researchers because of previous maltreatment by researchers who gained their trust. However, my background as a Nigerian immigrant helped me gain access to the community, to recruit participants for this study. A further strength of this study was that the RA whom I worked with was not African, and so was able to provide additional objectivity to the study.

Despite this study's unique contributions to the field, it has limitations. The study sample consisted only of Nigerian immigrants, which is not representative of US African

immigrants. However, Nigerian immigrants constitute the most populous African immigrant group in the United States. Regarding the impact of participant age, only one focus group was composed of participants aged 40 years or older, while the remaining three focus groups comprised participants between the ages of 22 and 33. Due to this skewed sample, the comparative analysis of the healthcare meanings of the older and younger was imbalanced. Regardless, because data collection was through focus groups, and there was unanimity of responses within the two age groups, the results from the comparative analysis of the data are still important. In addition, my background as a Nigerian immigrant may have posed an inadvertent barrier to some participants. While one may anticipate that this would be an advantage as regards obtaining in-depth responses from participants, some participants chose not to disclose their annual income during demographic data collection. My understanding is they probably would not have been hesitant about divulging that piece of information, had I been a researcher from a different country or background. Regardless, this study is a step in the right direction of understanding African immigrant health in the United States. In addition, it has shown immediate attention to the variables that shape the healthcare experiences and views of African immigrants, is of immediate priority. This is because healthcare views determine utilization of healthcare, which further plays a critical role in shaping health outcomes.

CHAPTER 5

Conclusions

The lack of information about the healthcare experiences, needs, and outcomes of African immigrants in the United States is alarming. With the health and socioeconomic implications of this knowledge-gap for African immigrants, and their sustained exponential increase of the population, there is need for urgency in addressing the issue. This study was a step in that direction, with the primary objective of understanding the healthcare experiences and needs of African immigrants in the United States. To accomplish this, a qualitative approach, using a symbolic interactionist framework, was necessary. The qualitative method allowed the study participants to comprehensively address the research questions, leaving little or no room for presumptive data analysis.³⁴ Symbolic interactionism provided me the lenses to examine how the meanings derived by the participants from their overall experiences influenced their healthcare experiences.²¹ This is crucial because, while meaning is important for everyone, African immigrants have different perspectives from other US immigrant groups. These unique perspectives need to be understood because of their roles in shaping healthcare meanings and behaviors, which further play important roles in health disparities. The meanings African immigrants attach to their healthcare experiences manifest in their perceptions of the US health system and providers, which then translates to how they utilize healthcare. This dissertation has revealed an overriding impact of culture on the healthcare experiences and meanings of African immigrants, including in the determination of patterns of healthcare utilization. This remained true, irrespective of religion, education levels, and health insurance access. To develop effective healthcare delivery to African immigrants in the United States, it is necessary to understand confounders such as this, which will then lead to an understanding of how to deliver effective healthcare to the population.

Understanding African immigrants' perceptions of their health experiences, as related to their culture, spirituality, and religion, is of prior importance. The three manuscripts provided insights into the healthcare experiences of African immigrants in

the United States, including their understanding of health and healthcare, and the impacts of their interactions with providers, and perceptions of healthcare. The second and third manuscripts focused specifically on Nigerian immigrants in Indianapolis. The scoping review revealed a severe lack of African immigrant health research in the United States. The selected articles for the study showed culture, religion, and spirituality as barriers to African immigrant healthcare access in the United States. Also lack of culturally competent healthcare, linguistic discordance, distrust of the healthcare providers, complex US healthcare system, and its exorbitant cost, were identified as major healthcare access obstacles. The scoping review was critical for exploring US African immigrant health, because it identified knowledge-gaps, which were used to develop the subsequent lines of inquiry. The study identified as a key reason for the absence of African immigrant health data in the United States, the lack of dependable documentation of national origin and language of African immigrants in medical settings.³ Majority of the studies on African immigrant health were based on secondary data and assumptions by the authors. Those types of results are not reliable because African immigrants are not identifiable readily in US databases, due to their classification as blacks, along with African Americans, Caribbean immigrants, and other physically similar groups.^{19,56} This points to the necessity of formulating a way of setting up US health databases so that African immigrants can be identified in them. This is a critical policy implication of this study because currently, African immigrants are invisible in the US healthcare databases because of the “black-boxing.”

The scoping review also found that to African immigrants in the United States, culture and spirituality were indispensable in their decision-making regarding all aspects of life. As a result, their conceptualizations of illness and healthcare sometimes resulted in their delay or total ruling out, of going to see a healthcare provider.⁵⁵ Furthermore, they were discouraged from visiting healthcare providers by the lack of cultural sensitivity they were experiencing. This is a double-edged sword because US healthcare providers need to interact with African immigrant patients to understand their healthcare experiences and therefore, needs. However, this is difficult when members

of this community avoid such exchanges. This is a challenge for healthcare providers delivering care to, and professionals developing interventions for, African immigrants in the United States. Part of the challenge involves this group's distrust of US healthcare providers and health system. Removing African immigrants in the United States from the "black box" will lead to examining how their provider and system distrust compares to that of African Americans. This is important because the historical paths of African immigrants and African Americans to the distrust of providers were not the same. For instance, African immigrants were not participants in the inhumane Tuskegee experiment in the United States, involving African Americans.⁶⁵ Additionally, the challenge for researchers and healthcare professionals include re-examining previous conclusions about US African immigrants. African immigrants in the United States roundly identified language, as a barrier to access to healthcare, but this is an oversimplification because of its assumption that proficiency in the English language suffices to eliminate language barriers. Some descriptions are difficult to translate inter-culturally, for both individual patients and translators.⁶⁶ Also, the impact of religion on the healthcare experiences of African immigrants has hitherto, been given a simplistic analysis. Among US African immigrant patients, a Muslim may deem what is acceptable to a Christian sacrilegious. Not only that, there may also be a confluence of culture and religion at times, thereby making it difficult to decipher which factor is at play. For instance, an African immigrant Muslim may prefer to be attended to by a healthcare provider of the same gender, due to religious beliefs, while a Christian counterpart may have the same preference, but for a different reason, such as cultural gender roles.⁶⁰

The second manuscript examined the impact of discrimination on the healthcare experiences and quality of care of Nigerian immigrants in the United States. Results based on the study participants' experiences, demonstrated providers' negative attitudes, discrimination, lack of attentive care, and symptom misdiagnosis, likely play key roles in the production of health disparities. For the study participants, being viewed and treated as black is yet another double-edged sword that results in discrimination, which severely hampers their healthcare. When healthcare providers, alongside African

Americans, viewed them as black, participants were subjected to the same discriminatory treatments given to that population. Likewise, their identification as African immigrants still resulted in discriminatory treatments, based on providers' stereotypically negative perceptions of the population. Because implicit bias – which is the driving force behind many forms of discrimination – is not readily detectable, this is a challenge that US healthcare providers must tackle with more fervor, for the goal of effective healthcare delivery to African immigrants to be achieved. Becoming culturally aware is a way of checking one's implicit biases towards a group. Nevertheless, becoming culturally sensitive entails more than simply being armed with stereotypical information about a particular group. Understanding that group's experiences from their cultural perspectives is also necessary.¹²⁰ Furthermore, cultural humility is required to prevent the imposition of one's own interpretations on the acquired knowledge about a particular group.¹²³ Without this component, cultural competence may become instrumental to health disparities, through the inadvertent reinforcement of stereotypes, which may foster unintended adverse effects. The critical barriers to African immigrants' healthcare access in the United States have been described, but the main factors contributing to those barriers have not been understood.^{16,98} For instance, Nigerian immigrants, albeit representing the most educated African immigrant group, still described their interactions with United States healthcare providers as very challenging and discouraging. It is necessary to identify the underlying factors because of the healthcare cost and health policy implications. Negative provider attitudes translate to discrimination, which may then lead to low healthcare quality. As a result, this may prevent affected patients from returning to the same healthcare providers, or even seeking care in general, subsequently.

The third paper explored how the healthcare meanings of Nigerian immigrants were formed, and how they played out over the years in the United States. Findings indicate cultural norms, religious and spiritual beliefs, length of residency, participant age, and prejudice were key influencers of the participants' healthcare meanings. The overarching result showed an overriding effect of culture on participants' healthcare

meanings, through its impact on every aspect of their health experiences. The study revealed participants, despite their high education levels and availability of health insurance, were not motivated to seek healthcare in the United States. This was a startling find because high education level and health insurance, which had been described as chief determinants of healthcare utilization, seemed not to have any influence on the participants' approach to utilization of healthcare. It is vital to gain further knowledge about this confounding finding because the success of health interventions and effective healthcare, for this group depend on it. Additionally, US healthcare providers need to be open to understanding how African immigrant patients perceive Western medical approaches. Before that, they need to pay attention to this group's perception of their own traditional approaches to illness and treatment. To this study's participants, going to the doctor was hinged on two expectations: the healthcare services rendered would be affordable and the treatments given would be effectual. The latter implied that prior treatment attempts, such as traditional methods, were unsuccessful or there was no treatment available. In addition, the study revealed an age-group pattern, which requires further examination. Participants aged 40 years or older had a more positive perception of the US healthcare system, while those under 40 years were dissatisfied with the US healthcare system. Despite the variance in perspectives, both groups reported low utilization of healthcare. Based on this outcome, it seems a positive of healthcare, and longer residence in the United States are insufficient in driving the participants towards more utilization of care.

In all three manuscripts, one common outcome of the participants' healthcare experiences was deep distrust of US healthcare providers. However, this should not be restricted to a superficial view. The participants' distrust of US healthcare providers and health system was shown to occur in relation to multiple factors such as discrimination, cultural incompetence, high cost of healthcare, and history of maltreatment by western healthcare researchers and professionals. Results from the three manuscripts showed participants were unwilling to engage, or completely avoided interactions, with healthcare providers, due to their fear of being given sub-par treatments, which they

often described as offensive and sometimes humiliating. Also, lack of trust could emanate from the participants' lack of belief in the healthcare providers' ability to figure out their health needs and provide adequate treatments. Consequently, they tended to perceive visits to the doctor as a waste of resources. Moreover, the lack of trust could be linked to participants' views that to US healthcare providers, their well-being was secondary, due to the primary focus on financial profit. When patients believe providers lack respect for, or are unconcerned about, their preferences, low or absent engagement is usually the end-product.¹⁴⁸ For ethnic minority patients, research has shown patient-centered care as often absent in the healthcare services they are provided.¹⁴⁹ Healthcare providers need to become conversant with interacting with African immigrants in ways that do not reinforce the existing suspicious notions of them. One approach to this is doing away with the dismissive approach to the healthcare concerns and input of African immigrant patients. Poor patient-provider interactions among ethnic minorities have been identified as a major contributing factor to poor health outcomes and health disparities.^{150,151} Patient-provider trust makes effective healthcare more likely, due to its facilitation of accurate symptom assessment and treatment adherence.¹⁵²

In addition to the already identified gaps, there is a roadmap for future work regarding this issue. The current study sample consisted only of Nigerian immigrants, which is not representative of the home countries of all African immigrant groups in the United States. It is pertinent to point out that due to the marked cultural, political, and phenotypic considerations, *African immigrants* in this context refers to individuals from Sub-Saharan Africa. As a result, one of the goals of future lines of inquiry is the inclusion of a study sample inclusive of a more diverse African immigrant, as regards countries of origin, gender, age, and religion. Nonetheless, one of the strengths of this was the use of Nigerians as a first focus of the study of African immigrant health. They constitute the largest African immigrant population in the United States. In addition, they are the most representative of the African profile in the United States, as regards culture, religion, level of education, and socioeconomics.¹ Also, low utilization of healthcare is pervasive

among African immigrants in the United States. However, its inner workings remain indeterminate because the factors generally associated with utilization of healthcare were found to be impotent among this study's participants. Future inquiries will seek to explore the gap between healthcare meanings and healthcare utilization among African immigrants in the United States. A study of an African immigrant group in another country identified three ways in which they approached healthcare: traditional treatment for those who were not acculturated, a blend of traditional and western treatments, and reliance only on western treatments by those completely acculturated.^{61,153} However, this study's participants did not seem to belong fully to any of those categories. The predominant disposition among the participants, even those with positive healthcare perspectives, was an aversion to utilization of healthcare, unless in circumstances they deemed life-threatening. This is critical because of the key role of utilization of healthcare in health outcomes and health disparities.

While similarities abound among Sub-Saharan African countries, there are also observable differences between them, especially according to regions, for instance East, West, and Central. Therefore, an objective of future work is to conduct comparative studies of the healthcare experiences of US African immigrants from those different Sub-Saharan African regions. In every sphere, including healthcare, policy and politics, Africa is often erroneously viewed as a monolithic singular population. Also subsequent inquiries should include comparisons of healthcare experiences of US African immigrants to those of other more studied US immigrant populations, such as Caribbeans and Latinos. Although healthcare experiences, needs, and in many cases, health outcomes, vary across immigrant populations, it is still necessary to check for data convergence among them. Regardless of the outcome, it will have important implications for healthcare, policy-making, research soundness, and resource conservation. Furthermore, it is necessary to explore the perceptions of US healthcare providers of African immigrants and their healthcare experiences. Due to the bilateral nature of healthcare interactions, and the subjectivity of meaning derivation regarding those experiences, these complementary data may provide deeper insight into the

problem. The product will be a useful tool for addressing healthcare providers' implicit biases towards African immigrants, which have been shown to contribute to discriminatory, low-quality patient treatments. Hitherto, the breakdown of communication between African immigrants and US providers has not been addressed. Therefore, learning about their own healthcare experiences through the lenses of US healthcare providers, may give African immigrants a deeper understanding of their interactions with US healthcare providers. Besides the goal of providing an in-depth understanding of US African immigrant health, another aim of this future work roadmap is to amass sufficient information to establish a database dedicated to African immigrant health in the United States. This will provide the springboard for other researchers who may be interested in exploring this issue, but might have been put off by the lack of research or facilitating resources.

To my knowledge, this is the first examination of the factors that shape the healthcare experiences of a US African immigrant group, as well as how that group's perceptions of those healthcare experiences, including their underpinnings. African immigrants are a heterogeneous population, and as such, African immigrant health needs to be approached distinctly, and not meshed with research on other physically comparable groups such as African-Americans, or other immigrants such as those from the Caribbean. For the progress of African immigrant health research, the project should not be construed as another appeal to conscience to help Africans. This research is not an application for pity, but rather a highlight of a population's healthcare challenges, which need to be addressed as part of the efforts towards elimination of health disparities and promotion of public health. To achieve health equity in any setting, attention should be directed to the disadvantage points. Understanding African immigrant health issues in the United States is necessary because of its healthcare, public health, health policy, and economic implications. Additionally, the rationale for African immigrant health research is no different from that regarding any other immigrant population whose healthcare experiences have become well studied. One can imagine that once upon a time, that group's healthcare issues were deemed a niche

concern, with little or no resources for their exploration. Also, this research represents the much-needed involvement of health researchers of African descent in the examination of African health. This helps create more culturally sensitive and nuanced methods. Beyond that, the examination and presentation of African health issues using western or imperialist lenses, has remained the status quo in healthcare research, which has in turn created negative constructions of the healthcare experiences of Africans.¹⁵⁴ This is prominent in the western perception of African approaches to illness management as naïve and unfounded. In delegitimizing African healthcare experiences, this view commits a scientific error of assuming health experiences and beliefs are uniform across cultures,¹⁵⁵ as evidenced by African immigrant healthcare experiences in the United States and other parts of the world.⁹⁸

The current study is a step towards the use of African epistemological framework in examining African health. Its benefit is not only for African immigrants because the idea that western meanings of health and healthcare are universal, is tantamount to the condemnation of the health beliefs and experiences of other culturally diverse groups.^{154,155} For African immigrants in the United States, the processing their healthcare experiences becomes more complicated as they attempt to make sense of their original identities, in the presence of varying cultures and challenging factors in their present environment, such as negative provider attitudes, discrimination, and being invisible in an already complex healthcare system.

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155. Waldron I. The marginalization of african indigenous healing traditions within western medicine: reconciling ideological tensions & contradictions along the epistemological terrain. 2010.

CURRICULUM VITAE

Ogbonnaya Isaac Omenka

EDUCATION

Doctor of Philosophy (PhD)
Major: Health Policy and Management
Degree Minor: Sociology

Indiana University Richard M. Fairbanks
School of Public Health, 2019

Dissertation Title: "Understanding
African Immigrant Health in the United
States: An Exploratory Study of the
Nigerian Immigrant Healthcare
Experience."

Bachelor of Science (BS)
Major: Biology

Metropolitan State University, 2011

INTERESTS

Population Health, Health Disparities, Immigrant Health, Health Policy, Mixed-Methods,
Healthcare Services, Policy Consulting, Cultural Competence

POSITIONS AND EMPLOYMENT

**College of Pharmacy and Health Sciences
Butler University**

- Assistant Professor 2018 –
- Diversity Initiatives Facilitator 2018 –

Center for Health Policy

IU Richard M. Fairbanks School of Public Health
Graduate Research Assistant 2014 – 2018

GreenThumb Consulting

- Co-Founder 2015 –

Indiana State Epidemiological Outcomes Workgroup (SEOW)

Researcher/Support Team 2015 – 2017

**AMPATH [Academic Model Providing Access to Healthcare]
Eldoret, Kenya**

Visiting Monitoring & Evaluation Officer 2015

Department of Health Policy & Management
IU University Richard M. Fairbanks School of Public Health
Research/Support Team, Indiana Attorney General's Office
Opioid Overdose Senate Bill 406 2014 – 2015

Walgreen's Pharmacy
Certified Pharmacy Technician 2003 –

TEACHING AND ADVISING

Butler University

- BSHS 490 – Exploring Public Health
- SW261 – Health Disparities

Indiana University Richard M. Fairbanks School of Public Health

Guest Lecturer – Spring 2017

- H315: High Risk Health Behaviors and Harm Reduction
- Topic – “HIV and Public Health: Policy Perspectives”

Graduate Teaching Assistant – Fall 2013

- PBHL H320 – Health Systems Administration [Enrollment – 48]
- PBHL H375 – Management of Health Services Organizations [Enrollment – 29]

LICENSURE AND CERTIFICATIONS

ResearchTalk Inc.

Designing, Analyzing, and Synthesizing
Mixed Methods Research Results 2017

Indiana University

Collaborative Institutional Training Initiative (CITI) 2017

Yukon Learning

Fundamentals of Rapid E-Learning 2014

Pharmacy Technician Certification Board

Pharmacy Technician (CPhT) 2003

PROFESSIONAL ORGANIZATIONS

American Public Health Association 2013 –

Academy Health 2014 –

American Sociological Association 2015 –

Society for the Study of Social Problems 2015 –

UNIVERSITY AND COMMUNITY SERVICE

Butler University

Department of Health Science

Undergraduate Honors Committee 2018 –

Indiana University Richard M. Fairbanks School of Public Health

PhD Student Government

Vice President 2014 – 2015

Century College, MN

Black Student Association

Founding Secretary 2005 – 2006

United Way / ReadUp Corps

School Tutor and Mentor 2014 –

Big Brothers Big Sisters of America

Coach/Mentor 2011 –

RESEARCH ACTIVITIES

2016 - 2017

Indiana SPF PFS (Strategic Prevention Framework Partnerships for Success). Indiana Family and Social Services Agency (IFSSA), Indiana Division of Mental Health and Addiction and the Center for Substance Abuse Treatment (CSAP), Substance Abuse and Mental Health Services Administration (SAMHSA),

Award# 1U79SP020788, \$750,000, 9/30/2015-9/29/2020.

PI - Dr. Dennis Watson | Role: Graduate Research Assistant

2014 - 2016

Pilot Testing of An e-Learning Strategy for Housing First implementation. National Institute on Drug Abuse (NIDA) Award# R34DA036001, \$638,428, 7/1/2014-6/30/2017.

PI - Dr. Dennis Watson | Role: Graduate Research Assistant

2014 - 2015

The Impact of Traditions, Moral Values and Social Norms on the Portrayal of Health and Well-being in Nollywood films.

PI - Dr. Kathryn Coe | Role: Graduate Research Assistant

2014 - 2015

Dynamic risk prediction for vascular risk factors and Alzheimer's disease using clinical electronic medical records and data from elderly community-dwelling African-Americans.

PI - Dr. Hugh Hendrie | Role: Graduate Research Assistant

2014

Health Needs assessment of African immigrant patients | Eskenazi Health, IN
Role: Principal Investigator

2013

Evaluation of Aging in Place (AiP) | Indiana Housing and Community Development Authority (IHCDA)
Role: Co-Principal Investigator

PEER-REVIEWED PUBLICATIONS

Watson DP, Adams EL, Shue S, Coates H, McGuire A, Chesher J, Jackson J, **Omenka OI** (2018). Defining the external implementation context: an integrative systematic literature review. *BMC Health Services Research*, 18:209.
<https://doi.org/10.1186/s12913-018-3046-5>.

Norwood CW, Biviji-Sharma R, Knotts A, **Omenka OI**, Stone C, Purviance D (2015). Fighting prescription drug abuse through state policy. *Journal of Addictions Nursing*, 26, 203-207.

MANUSCRIPTS UNDER REVIEW/IN PREPARATION

Omenka OI, Watson, DP, Hendrie, HC (2019). Healthcare Experiences of African Immigrants in the United States: A Scoping Review. [Journal of Healthcare for the Poor and Underserved]

Omenka OI, Watson DP, Oruche UM, Modibo NN (2019). A Qualitative Examination of the Impact of Culture on the Healthcare Experiences of Nigerian Immigrants in Indianapolis [In Preparation – To be submitted to the Qualitative Health Research, Spring 2019]

NON-PEER-REVIEWED PUBLICATIONS AND REPORTS

Greene MS, Kooreman HE, **Omenka OI**, Balio C (2017). The Consumption and consequences of alcohol, tobacco, and drugs in Indiana: A state epidemiological Profile 2015. Indiana State Epidemiology and Outcomes Workgroup. Center for Health Policy, Indiana University Richard M. Fairbanks School of Public Health, IUPUI.

Omenka OI, Greene MS (2017). Polypharmacy among Prescription Drug Users. Center for Health Policy, Indiana University Richard M. Fairbanks School of Public Health, IUPUI. Issue Brief, 17-H08.

Wright ER, Watson DP, Greene, MS, Kooreman HE, Jackson JR, **Omenka OI**, Chesher J (2016). The Consumption and consequences of alcohol, tobacco, and drugs in Indiana: A state epidemiological Profile 2015. Indiana State Epidemiology and Outcomes

Workgroup. Center for Health Policy, Indiana University Richard M. Fairbanks School of Public Health, IUPUI.

Omenka OI (2014). Culturally Competent Healthcare for African Immigrants: A Health Needs Assessment. Eskenazi Health, Indianapolis, IN.

Norwood CW, **Omenka OI** (2013). Policy Evaluation of Aging in Place. Indiana University Richard M. Fairbanks School of Public Health. Indiana Housing & Community Development Authority, Indianapolis, IN.

CONFERENCE PRESENTATIONS

Omenka OI. Is African Immigrant Healthcare Research Translational? Poster presented at the Indiana Clinical and Translational Sciences Institute (CTSI) 8th Annual Meeting, Indianapolis, IN | September 2016.

Omenka OI. The Invisible Patients: Barriers to Capturing African Immigrants by Healthcare Providers. Poster presented at the Indiana Public Health Conference, Indianapolis, IN | September 2016.

Watson DP, Adams EL, **Omenka OI**, Jackson JR, Chesher J. Identifying Structural-level Factors Affecting Implementation of Complex Interventions. Poster presented at the 8th Annual Conference on the Science of Dissemination and Implementation, Washington, DC | December 2015.

Omenka OI. The Impact of Ethnicity on the Healthcare Experiences of African Immigrants. Oral Presentation at the 65th Annual Meeting of the Society for the Study of Social Problems, Chicago, IL | August 2015.

Brown BL, **Omenka OI**, Watson, DP. Using the Housing First Model (HFM) Fidelity Index to Evaluate the Current Supportive Housing System in Indiana. Poster presented at the 142nd American Public Health Association Annual Conference, New Orleans, LA | November 2014.

CONFERENCE PARTICIPATION

110th American Sociological Association Annual Conference, Chicago, IL | August 2015. Session Presider | Medical Sociology Round-Table – Immigration, Migration, and Health.

National Association of Health Services Executives Conference, Cincinnati, OH | February 2015. Panelist | Minority Health and Wellness – A Healthcare Professional Perspective.

TRAVEL AWARDS

American Public Health Association (APHA) Annual Meeting and Expo, San Diego, CA | November 2018

- Butler University College of Pharmacy and Health Sciences | \$2840

142nd American Public Health Association Annual Conference, New Orleans, LA | November 2014.

- Indiana University Richard M. Fairbanks School of Public Health | \$400
- Center for Health Policy, Indiana University Richard M. Fairbanks School of Public Health | \$500