

Barriers to Healthcare among African Immigrants in Georgia, USA

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Abstract African-born immigrants are among the fastest growing immigrant groups in the US, yet they are underrepresented in healthcare research, particularly, cancer research and tend to be categorized as African American or Black, obscuring any cultural nuances that exist. A survey designed to provide insight on the barriers to healthcare, knowledge of common cancers, and cancer risks was utilized during a health fair. Data analyses included descriptive statistics to examine participant demographics and other study variables of interest. Most of the participants reported African origin (approximately 97%), were males (59%), were aged 18–40 years (49%), had a minimum of some college education (78%), a household income of >\$50,000 (35%) and were mostly uninsured (45%). The cost of medical treatment 19 (45.2%) was reported as a major barrier to healthcare access. The Health Fair presented the opportunity to provide free health screenings, education/awareness, and referral to follow-up resources. The findings are evidence of the importance and impact of health fairs in communities of greatest need.

Keywords African Immigrant · Cancer Screening · Health Fair · Health screening

Introduction

African –born immigrants are among the fastest growing immigrant groups in the US [1]. They consist of approximately 1.6 million of the 40 million foreign-born people who resided in the United States in 2012 [2, 3]. The majority of these immigrants recently migrated to the US from West and East Africa (36 and 30%, respectively) [4], and therefore, limited data exist on their health status, particularly with chronic diseases such as cancers [1]. African immigrants are underrepresented in cancer research and tend to be categorized as African American or Black [1, 5–7], obscuring any cultural nuances that exist.

Disparities among U.S., and immigrant populations are well documented on issues such as cancer communication [7], adherence to recommended cancer screening protocols [8–10], early diagnosis [11], quality of care [12], receipt of recommended treatment [11, 12], health outcomes [13], and timely access to care [14–16]. Other reported disparities include language barriers [16], health literacy and cultural differences [15, 17, 18], having a primary care provider [19–21], and acculturation [22]. African immigrants have lower screening rates of breast, prostate, colorectal and cervical cancers compared to African Americans [23], even though; both groups have screening rates lower than recommended [23]. Black women have higher rates of mortality and higher percentage of late-stage diagnoses of breast and cervical cancers when compared to other races and ethnic groups in the US [24–26]. Similarly, Black men have a higher mortality for prostate and colorectal cancers than Caucasians [27], a phenomenon that is

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partly attributable to early onset, and late diagnosis of the disease [27, 28]. Unfortunately, there is very limited data on the prevalence, screening, and mortality rates for African immigrants, limiting the knowledge of best practices required to ensure appropriate and culturally effective cancer communication to this group.

To address cancer screening disparities that disproportionately affect the African immigrant population in the U.S., and to increase access and health literacy on cancer screening, community-academic partnerships have developed approaches to reach the target population. One of such approaches is through the utilization of Health Fairs.

Health Fairs are commonly conducted by organizations and groups, with the aim of providing awareness of health issues, screenings, and health services to people that lack access to, or may otherwise not seek these services. Limited data exist on the long-term impacts of health fairs, but health fairs have been documented to improve health literacy and health outcomes for participants [29], especially if well organized, conducted by qualified personnel, and administered as a long-term educational experience that encourages participants to make positive changes to their health. This study reports on a recently concluded health fair that focused on the health of African immigrants in the US. The overarching goal of the health fair was to provide health screenings at no cost to the participants and to use that medium to assess specific health needs peculiar to the African immigrant population.

Methods

A Cross-sectional study was conducted as a community-based collaborative project between an academic health center, Morehouse School of Medicine, and a community-based organization Redeemer's Medical Center (RMC). This project was a part of a health fair that provided over 800 free health screenings to a predominantly African immigrant population. This collaboration is a result of the Satcher Health Leadership Institute's nationally recognized Community Health Leadership program (CHLP). The CHLP aims at bridging the gap between academic health centers and communities of greatest need by identifying and training community leaders to develop and implement sustainable interventions that will reduce and ultimately eliminate health disparities in their communities [30].

The Health Fairs, which occur semiannually, at either the RMC site and its adjacent parking lot or its affiliate religious center building. Both sites have adequate parking spaces and are in proximity to public transportation. The events often include educational sessions, awareness of health issues, free health screenings, vaccinations, and referral to appropriate services. Children are engaged in fun

activities and spiritual learning sessions while their parents/adults participate in the screenings.

The data included in this study represents data collected from the most recent health fair conducted in December 2015. During the health fair, over 800 different health screenings such as cholesterol, blood pressure, blood glucose, and Body Mass Index screenings were carried out. Screenings provided at the health fair are listed in Table 1. The event was hosted by the RMC at its affiliate religious centers' premises. The entire event was planned over a 6-month period, with the planning committee meeting monthly for the first 3 months, then bi-weekly for 2 h after Sunday service for 3 months preceding the event. Publicity for the event was conducted over these 6 months through announcements made during church services and at the RMC. Reminders were regularly sent to congregants via emails. Over 30 volunteers (mostly physicians, nurses, physician's assistants, medical and public health students) were committed to ensuring the smooth running of the event.

To maximize attendance, the event was held on a first Sunday of the month; a Sunday celebrated by the church as a Thanksgiving Sunday service. The Thanksgiving Sundays in this church are traditionally known to record the highest attendance of all services. The health fairs are always scheduled to coincide with the visit of a well-known guest preacher, sometimes from the African continent, or a revival/ another well-publicized church event. These events are widely publicized through formal and informal networks, social media, church announcements, text messages, and emails to church members, other African immigrants, and the general public.

Program Participants

This health fair was primarily conducted to target African Immigrants in Georgia, particularly the uninsured and underinsured families. All attendees were encouraged to register on-site for the health fair before receiving health

Table 1 Estimated Number of Health Screening or other medical services provided at the December 2015 RMC health fair

Screening or other medical service	Number
Blood Pressure (BP)	301
Body Mass Index (BMI)	298
Blood glucose	61
Cholesterol	56
Hearing screening	12
Vision screening	27
Dental health station	89
Total	844

services. This church was deemed an excellent community partner on this project because the congregation consists predominantly of African immigrants, and the relationship between religiosity and health is well documented among African immigrants [31].

This study was reviewed and approved by the Morehouse School of Medicine's Institutional Review Board (IRB). The data were coded with anonymous identification numbers, and names and other personal identifiers were not collected in the questionnaire, nor were the data linked to any medical records or actual screening results. All information collected were kept and processed as confidential by the research team at Morehouse School of Medicine.

Data Collection

A brief survey adapted from Murray, k. et al. [32] was utilized to collect study data. The survey was designed to provide insight on the barriers to healthcare faced by this population, and to prioritize the health issues to be addressed at future health fairs and health interventions. All services were provided on a first come, first served basis. The church congregation was informed by the pastor of the anonymous survey, and members were asked to volunteer if they were interested, and met recruitment criteria. At least 100 African-born immigrant adults ages 18 and older were targeted for inclusion in this study. Participation was voluntary, and adults who were unable to consent were excluded from the study. Volunteers were consented and asked to complete the survey anonymously, and to drop off the completed survey in a designated box. Participants who volunteered for the study completed the exercise, yielding a 100% response rate.

Measures

The questionnaires that took approximately 10 min to complete were available in English, and trained volunteers were available on demand to assist participants who required help in completing the surveys. The survey included questions on demographics, healthcare access, diagnoses and family history of breast, prostate, and colorectal cancer.

Data Analysis

Data were analyzed using IBM SPSS Statistical Package (version 21). Data analysis included descriptive statistics to examine participant demographics and other study variables of interest.

Table 2 Showing Demographic Distribution of Health fair Participants

Demographics	Frequency (N)	%
Country of origin		
African country	141	97.1
United States	3	2.9
Other	NA	NA
Gender		
Male	85	59
Female	59	41
Age (years)		
<40	71	49
40–49	43	30
50–59	16	11
60+	9	6.56
No response	5	3.47
Formal education		
Less than high school	4	3
High school	8	5
Some or completed college education	112	78
No response	20	14
Household income (\$)		
<20,000	24	17
20,000–30,000	13	9
30,001–40,000	14	10
40,001–50,000	11	8
>50,000	51	35
No response	31	21
Employment		
Employed—full time	84	58
Part-time	16	11
Unemployed	41	29
No response	3	2
Insurance status		
Insured	29	20.14
Uninsured	64	44.44
No response	51	35.42

Results

The Health Fair yielded 844 screenings. There were about 254 participants in attendance, out of which 144 completed the surveys. Of the data analyzed, most of the participants reported African origin (approximately 97%), were males (59%), were aged 18–40 years (49%), had a minimum of some college education (78%), and a household income of >\$50,000 (35%). (Table 2). Of the participants who completed the surveys, 58% were employed full-time, yet, about 45% reported being uninsured. Of those who responded to the survey questions

Table 3 Showing Barriers to Healthcare

Barriers to healthcare reported	Frequency (N)	%
Too expensive to seek medical services	19	45.2
Do not know where to get the appropriate medical services	5	11.9
Waiting too long for medical appointments	7	16.7
Waiting too long at the clinic	6	14.3
Desired Medical services were not available	3	7.1
No transportation	2	4.8

Table 4 Cancer Risk

Ever been diagnosed of any of the following cancers ^a	Frequency (N)	%
Breast cancer	1	16.7
Prostate cancer	2	33.3
Colorectal cancer	3	50.0
Cervical cancer	NA	
Other	NA	
Have you had any family member(s) diagnosed of any of the following cancers? ^b		
Breast cancer	9	40.9
Prostate cancer	6	27.3
Colorectal cancer	2	9.1
Cervical cancer	1	4.5
Other (specify)	4	18.2
If Yes, which family member ^c		
Parent	11	44.0
Sibling	1	4.3
Cousin	4	16.0
Nephew/niece	1	4.0
Uncle/aunt	5	20.0
Grandparents	3	12.0

^aTotal n = 144; Missing n = 138

^bTotal n = 144; Missing n = 122

^cTotal n = 144; Missing n = 122

on “barriers to healthcare,” 19 (45.2%) reported the cost of medical treatment as a major barrier to healthcare access (Table 3). Nine of the respondents (40.9%) that answered survey questions about being impacted by cancer reported that breast cancer had affected family members while 6 (27.3%), and 2 (9.1%) respondents reported that prostate and colorectal cancers respectively, had affected family members. The majority of the respondents reported that their parents were the family members most affected by cancers (44%) (Table 4).

Discussion

The findings of this study shed light on some of the health issues faced by African Immigrants in the U.S. and elicits the need for a targeted culturally appropriate approach to reducing the disparities in health, faced by African immigrants in the U.S. Awareness on cancers including the knowledge of the recommended routine screenings, predisposition and other risk factors for these cancers are essential. A qualitative study conducted by Gwede et al., on a similar immigrant population suggested that awareness of financial resources (health insurance), sites where screening could be obtained and additional information on when to get screened, would improve screening rates in this population [33].

Access to regular quality healthcare is equally important to ensure the health of the community; however this access is impeded by a variety of issues including lack of insurance, low socioeconomic status, and cultural and linguistic barriers. This study focused on African immigrants and health issues they face, especially with chronic diseases such as cancers. This previously understudied group, are commonly grouped as African American or Black when interventions and recommendations are considered [1, 5–7]. Over the years, this categorization has consistently suppressed subtle differences that exist between the African immigrant population in the US and the African American population, necessitating the importance of incorporating aspects that alleviate cultural differences into cancer communications.

Lack of health insurance poses a challenge to access to care. This study suggests the limited contact many of the participants may have with the health care system, particularly for preventive health, because majority lack health insurance, and find medical costs unaffordable. This is supported by other studies that have documented the lack of health insurance among African immigrants as a major barrier to healthcare [33, 34]. Despite the expansion of healthcare through the Affordable Care Act, participants in this study were mostly uninsured, drastically reducing their access to quality health care. Unfortunately, the data on the number of currently uninsured African immigrants who are aware of their coverage options is not well documented. In addition, the decision by some states not to expand Medicaid eligibility will have detrimental effects on the insurance coverage of African immigrants with the lowest incomes [35]. For example, in states that expanded Medicaid, studies show that the rate of uninsured Latino’s (another fast growing minority group) decreased from 35 to 15%, while in states without expansion, the uninsured rates remained the same [36].

Similar to other immigrant groups, barriers that may be responsible for poor screening rates in addition to lack

of insurance include language barriers and health literacy [31, 37]. Some of the participants speak English as a second language; this does not only affect their ability to communicate effectively but also affects their ability to comprehend health information [38].

Cancer awareness was increased during this health fair, with robust discussions on the value of routine recommended cancer screening at the appropriate age, cancer risk factors, and available resources to improve screening rates. The opportunity to highlight these risk factors, educate the community on the recommendations for screening, and the link to appropriate follow-up care provides an opportunity for early diagnoses and treatment when necessary.

Conclusion

The attendance at the health fair was impressive, feedback acquired from participants, volunteers, and the entire community was positive. All objectives were met, including providing free health screenings, education/awareness, and referral to follow-up resources. This event proves that well-organized health fairs that are designed to be repetitive and to include participant follow-up are effective in achieving predetermined objectives. The findings are evidence of the importance and impact of health fairs in communities of greatest needs, especially understudied communities like the African immigrants in the US.

Limitations

The health fair being a single day event did not afford organizers the opportunity to receive long-term follow-up data. Data on adherence to recommended cancer screening schedules and follow-through with referrals were not collected, as such, there is no definitive proof that this health fair served as a point of entry for participants to receive regular healthcare services. The low response to certain survey questions may be due to the documented evidence that suggests the prevalence of fatalism, stigma and privacy issues around the disclosure of cancer diagnoses among African immigrants living in the US [24]. Another limitation is the convenience sample used in this study, which may not be fully representative of all Africans immigrants in the U.S. The collaboration with the church, may have led to the exclusion of other African immigrants who may identify with other diverse religious or cultural values. Finally, only quantitative data was collected using the surveys.

Future Directions

Improved community—academic partnerships that will continuously provide necessary healthcare services for individuals disproportionately affected by health disparities should be strengthened. Development and implementation of peer-training/ mentoring programs deemed successful in similar populations [39] could be incorporated into the health fairs to allow the tracking of follow-up by peer mentors, and continuous awareness and education should be encouraged. Efforts to track follow-through with referrals would provide objective evidence on the role of health fairs as an entry point to routine recommended cancer screening.

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