

Giving Voices to the Voiceless

Language Barriers & Health Access Issues of
Black Immigrants of African Descent


THE CALIFORNIA ENDOWMENT



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Summit Health Institute for Research and Education, Inc.

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Executive Summary

In answer to one of the final questions in the SHIRE survey: “Where should we go from here?” an Ethiopian woman wrote, “I have been here [the United States] 14 years – never have dental exam.... Find solution for language and cultural education both ways for immigrants and for provider[s]. Help us get health service.”

This report was conceived by SHIRE as an initial step toward identifying language and cultural issues that impede access to health care among immigrants of African descent in California. The anecdotal nature and the range of the responses to SHIRE’s surveys, focus groups, and random interviews indicate that this population has been systemically marginalized within the health care system. The near total absence of reliable disaggregated data, the lack of a body of research focused on African immigrants, and the complete absence of policy analysis regarding access to health care for African immigrants, are the principal noteworthy findings from this effort.

As immigrants grapple with arrival in the United States, they encounter not only a new cultural environment, but also the prevailing legal framework that governs federal, state, and local institutions. Cultural barriers to health care and limited English proficiency are exacerbated by the lack of cultural competency of health care providers. However, the mandates of Title VI, if enforced, can play an important role in leveling the field for immigrant communities.

Thus, the report includes a cursory examination of Title VI, an overview of U.S. Census data collection issues as they relate to immigrant communities, and a detailed examination of census data on African immigrants in California. This report’s recommendations include an appeal for further clarification of ethnic status in data collection tools and increased efforts in the collection of data.

The impact of U.S. immigration policies on data collection, particularly in the post-September 11th environment, is more difficult to discern. However, some evidence emerged, particularly in random interview encounters, that immigrants were protective of their anonymity and, perhaps as a consequence of their awareness of heightened security measures, distrustful of the motives of the survey team.

The constituents of the two communities interviewed, San Diego and Los Angeles, shared common concerns about the health status of African immigrants. The San Diego participants were more assertive respondents, suggesting that their newer experiences as immigrants and refugees, relative to the Los Angeles population, rendered the needs arising from their socioeconomic status more acute across a wider range of quality of life issues.

Within all immigrant populations exist acknowledged leaders who are often unrecognized by the society at large. SHIRE termed this African immigrant leadership “Knowledgeable Observers” and “Centers of Influence.” These leaders constitute a wealth of practical and professional experience that can be drawn upon to shape effective responses to the needs and concerns of their communities.

Key Findings

1. Recent African immigrants face formidable barriers to health care due to limited English proficiency, lack of resources, uninsured status, immigration status, and the lack of awareness of how to navigate the health care system. These special needs have rarely been addressed by the health care system or by the providers to whom African immigrants have access.
2. There is a limited pool of culturally competent health care providers serving residents of African descent. This deficit is coupled with the lack of opportunities for African immigrant health care workers, who have had relevant experience in their countries of origin and with their cultural peers in their local communities here, to obtain training and credentialing in their fields in the United States.
3. Language barriers have a central impact on the entire range of social functions, specifically: education, economics, housing, employment, politics and law. Limited language skills also manifest themselves in other areas, such as perceived discrimination in employment opportunities or housing, thereby directly affecting the economic stability of immigrant families.
4. African immigrants with limited English proficiency are generally unable to assist their children with their educational efforts. This fact, coupled with the clash of cultures – the “new” American culture versus the former indigenous African one – represents a clear and present danger to traditional African family values and mores.
5. The complexities and costs of contemporary life in America are compounded by barriers encountered daily by African immigrants. The stress of day-to-day living has negative health consequences for the health status, including mental health, of African immigrants, especially among newer arrivals.
6. There is profound recognition among African immigrants of the need to organize their own communities and form coalitions with other African immigrant communities. However, there is a simultaneous awareness that identifying willing sources of financial and technical assistance can expedite the attainment of this objective.
7. Community-based organizations (CBOs) can and do serve as advocates for community needs with municipal, state, and federal governments, as well as providing a menu of services to provide counseling and guidance for African immigrants.
8. There is growing recognition by African and Caribbean immigrants of the need to engage in dialogue with African Americans to build coalitions around specific domestic and international policy concerns that are of mutual interest. While the elected leadership of African Americans at federal and state levels has a long tradition of advocacy for African and Caribbean interests, and several African American organizations continue to provide technical assistance, the impetus to connect these communities at the grassroots and operational levels is gaining momentum.

9. Comprehensive data are critical to making informed decisions about where and how to allocate resources within these communities. Only additional research will yield a more definitive portrait of the African immigrant community, including the identification of effective media resources that can be utilized in consumer education efforts. The imperative of data collection will become more urgent as African immigrant communities continue to grow in size, both through the arrival of new immigrants and through the addition of new Americans who are the offspring of immigrant parents.

Recommendations

1. **Intensify and improve data collection efforts throughout the strata of entities that touch the lives of African immigrants and refugees.** The U.S. Bureau of the Census should develop the appropriate tools and resources for African immigrants to identify themselves. Collaboration with state and local data resources, including the Office of Statewide Health Planning and Development and the California Department of Health Services, Division of Vital Records and Statistics, should be undertaken to develop a data coding standard for African immigrants and refugees in California.
2. **Conduct additional research on how to address health barriers for African immigrants.** In particular, further research is necessary to determine how to address the needs of sub-groups within the community, such as the young, elderly, homeless, and those affected by mental health disorders.
3. **Utilize the expertise available through credible CBOs for assistance in primary research activity.** Researchers should establish ongoing relationships and rely on CBOs within the African immigrant community for survey design, data collection and data interpretation.
4. **Increase financial support and mandate continuing staff training on issues of cultural competence for health clinics and hospitals, which often constitute the primary source of health care for immigrant communities.** Provide educational opportunities for American health professionals regarding health-related values, beliefs and practices of various African nations.
5. **Strengthen CBOs serving African immigrants and refugees with technical expertise, training, and financial assistance.** These currently undervalued resources, if strengthened, can produce positive outcomes for African immigrants across a range of objectives.
6. **Expand outreach by community-based entities funded to address disparities within the African immigrant community.** This is particularly true for organizations addressing diabetes, hypertension and HIV/AIDS, three chronic health conditions that were cited as leading health problems within the African immigrant/refugee community.

- 7. Develop and fund a Health Care Advocates Initiative for African immigrants.**¹ Provide training and materials to lay health educators who will teach, inform and promote awareness on various health issues in a linguistically and culturally competent manner. These individuals would be trained to address a number of health access issues including: (a) knowledge of federal, state and local programs; (b) familiarity with documents and application procedures; (c) knowledge of specific contacts within agencies, where questions can be answered; (d) distribution of health education information in the specific languages of African immigrants/refugees; and (e) advocacy with health and welfare bureaucracies on behalf of African immigrants and their families.
- 8. Design and implement a health professionals educational program for African immigrants/refugees who have medical care training.** This training could be housed within a clinic facility using institutions of higher learning in California. The program could augment culturally competent health care in a setting where health education awareness initiatives could emerge, as well as training of African health professionals for certification and employment in the United States.
- 9. Increase patient and consumer health education efforts by utilizing faith institutions, community newspapers and other media outlets respected within African immigrant communities.** The determination of which institutions are indeed credible messengers will only be accomplished by further research efforts.
- 10. Initiate and/or expand English language tutorial programs for African immigrants.** Better mastery of English would reduce their sense of alienation and increase their self-confidence and ability to interact with their children and society at large.
- 11. Hold public hearings, along with other steps to promote awareness of African immigrant issues, to engage decision makers – in the public and private sectors – to facilitate the removal of legal, cultural and linguistic barriers to health care, employment, education, transportation, and housing.** Conduct town meetings where SHIRE can report to the community, particularly those stakeholders who participated in the study, on the findings and recommendations. These meetings could be synchronized with the release of SHIRE's report by the TCE.
- 12. Promote a statewide, regional, and national dialogue among key stakeholders from African American, African and Caribbean immigrant communities regarding shared and distinct cultural, linguistic and health related concerns.** This dialogue will be framed to collectively address specific policy initiatives that address the concerns of these communities.

Introduction

This report was conceived by SHIRE as a step towards investigating and documenting the barriers, particularly language, to health care for African immigrants. It is an attempt to raise the visibility and concerns of a heterogeneous community of human beings who share and contribute to the diverse texture of American life. *Giving Voices to the Voiceless* paraphrases a descriptive expression of thanks for our efforts by one of SHIRE's respondents.

Within the research literature on diversity in the United States, little or no mention is made of Africans when immigrant population groups are discussed. Immigrants of African descent who choose the United States as their temporary or ultimate destination pose unique challenges to America's health care system. In many respects they are an invisible people, numerically insufficient to attract the attention of policymakers who use statistically driven opinion polls as their guide. In addition, even when African immigrants are from English-speaking countries, or possess English proficiency, some SHIRE respondents said their accents make verbal communication difficult with health care providers.

Differences among cultural attitudes, mores, and practices are often unknown, misunderstood, or dismissed by health practitioners in the United States, resulting in the perpetuation of systemic inequities in the provision of health care. For example, several SHIRE respondents noted that in American culture, "looking someone in the eye" is often perceived as a measure of honesty; not doing so conveys, if not dishonesty, at the least, secretiveness. In some African cultures, deference to an authority figure, like a physician or a health care provider, is manifested by avoiding direct eye contact. Thus, from the initial encounter, the relationship between an African immigrant patient and his or her American physician may evolve from a milieu of patient discomfort and physician distrust rather than candor and empathy.

Given the combined impact of language and culture, the effort to quantify and qualify health care access issues confronting the growing African population in the United States will require a continuing commitment. Unlike the very visible debate about American immigration policies related to U.S.-Mexican relations, discussions about the policies and practices affecting African immigrants in the United States rarely obtain the spotlight on the national stage. When African immigrant health issues are raised, it is typically through alarmist rhetoric that swirls around discussions of starvation, HIV/AIDS or other infectious diseases, political regime changes or acts of aggression.

In the public arena, any discussion of immigration is fraught with the pitfalls of race relations in America, including stereotyping, ignorance, and fear. African immigrants are already likely to suffer from the documented disparate treatment accorded to African Americans and other minorities. Stigmatization based on ill-conceived perceptions of Africa or of immigrants' specific countries of origin can only serve to exacerbate the marginalized health status of African immigrants.

However, national efforts to examine differences in health outcomes, such as the Institute of Medicine's (IOM) report on America's health care disparities, are indicative of the recognition and admission of unequal treatment. Indeed, the title of the report: *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* is a troubling parody of the words found in the 14th Amendment to the Constitution – an Amendment that guarantees all citizens, and presumably residents not under order of deportation, “equal treatment under the law.”

While providing a range of action-oriented recommendations drawn from participants and researchers, SHIRE submits that further research about African immigrants and their health needs is critical. SHIRE is confident that its recommendations can contribute to the attainable goal of a health care system that equitably serves America's diverse population. As no arena supersedes health in the devastating consequences of ignorance, we appreciate the opportunity afforded by The California Endowment (TCE) to contribute to understanding the challenges facing America and its African immigrant population.

The National Scene/California Echoes

California in Transition: Immigration and Uncertainty

In November 2003, Californians elected an immigrant as their governor after a bitterly contested and highly publicized recall of a governor they had only recently elected to his second term.

The new governor is a member of California's 26.9 percent foreign-born population, a percentage that leads all U.S. states in that category, with Spanish-speaking arrivals from Mexico comprising the largest immigrant contingent. As the country's leader in immigrant numbers, California's reputation as a bellwether state for national trends is certainly intact. A U.S. Census survey calculated that America's "foreign-born population grew to more than 33 million in 2002, slightly larger than the entire population of Canada."²

This huge influx of newcomers from other parts of the world is occurring in a state whose economy has been battered by record budget deficits, corporate downsizing and outsourcing. California thus mirrors the country's uncertainty at the prospect of sustaining an adequate employment base for its citizens. For ethnic communities, however, facing the continuing obstacle of racial and ethnic discrimination in the job market aggravates their ability to achieve economic security. Available data continue to record an uneven playing field. Indeed in 2001-2002, "racial discrimination was the most common reported form of employment discrimination" in California, with 18,600 claims filed.³

As stated, California is frequently described as a pacesetter – "as California goes, so goes the nation." The reverse is also true. National trends find their echo in California. It is important, therefore, to describe relevant developments on the national scene that are reverberating, or are even amplified, in this trend-setting state.

Health Care Access Disparities Remain

The disparities between minority groups and America's numerically dominant white population extend over a range of diseases and medical conditions. A number of reports have shown that inferior care for minority patients occurs in the treatment of HIV/AIDS, diabetes, hypertension, to name but a few examples.

Disparities in health care have been documented repeatedly over the last few decades across a broad range of medical conditions. For example, the Agency [for Healthcare Research and Quality] supported research on access to cancer care, which showed that minority patients were more likely to be diagnosed at advanced stages of the disease than whites, receive suboptimal cancer treatment, and have lower survival rates."⁴

As insidious as disparate diagnosis and treatment are, for those with poor English language skills, in lower socioeconomic strata, and particularly for those without health insurance, the barriers to access medical care are formidable.

There is now an emerging consensus that disparities, at least between different racial and ethnic groups, arise from several factors. These include differences in access to care and health insurance and in the amount and quality of care offered and received. They also appear to arise from factors not directly related to the health care system such as socioeconomic status, literacy, language, community factors affecting health and differences in access to opportunity.⁵

Cultural Barriers to Quality Health Care

Immigrant patients, even after being naturalized or remaining in an adopted country for years, may continue to experience miscommunication with health care providers. For newer immigrants, however, one study showed "A complex set of factors – among them their fewer years in the United States, limited proficiency with English, low incomes, and the lack of health insurance appears to be influencing their health experiences."⁶

Though African immigrants were not included in that study, SHIRE's initial research corroborates that the same paradigm exists for them as it does for immigrants of other ethnic groups. For newer African immigrants, among the leading complaints about the status of their health care experiences was the difficulty in communicating with providers. This difficulty in communication seemed rooted in both the unfamiliarity of health care providers with the specific cultures of the immigrant groups, and patients' unfamiliarity with negotiating American bureaucracies, the health care system in particular. Even where the English language was common to the patient and provider, the nuances of culture still made communication difficult.

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There are an estimated 603,705 African immigrants in the U.S., of which 244,204 are females, and the majority of whom live in the state of California. The changing demographics across the United States will continue to challenge health care providers to offer relevant and sensitive health care services to members of a variety of diverse groups. Failure to recognize and respond to these differences in beliefs and cultural meanings may create service gaps for significant segments of the population. For example, African immigrants perceive the occurrence of a disease such as breast cancer in ways that are fundamentally different from the mainstream middle class American society and the health care professionals. The most challenging to reach with the early detection message are recent immigrant and refugee women from non-Western countries to whom the concept of prevention in general may be unfamiliar. Findings from this research underscore the need for culturally informed guidelines on breast cancer early detection and education in reaching African immigrant communities.⁷

One common means of addressing the language barrier to health care access among immigrant populations has been the use of children or other family relatives as interpreters or translators. In addition to questions, for example, about a child's lack of competency to interpret medical information, this practice raises many issues, among them specific cultural practices. One participant in a SHIRE focus group spoke

about a woman who refused the physician's request to assist her mother-in-law through the examination. In her culture, the daughter-in-law could not assist the physician in that setting. Her presence would have violated long-established mores in her social hierarchy.

Thus, while language alone is not culture, the lines of convergence and distinction between the two are not easily defined. What is recognized is that the "failure to understand and manage social and cultural differences may have significant health consequences for minority groups in particular."⁸

Cultural Competency

The emergence of cultural competency as a legitimate area of medical research and advocacy has given rise to the goal of setting national standards for health care providers. In 2001, the U.S. Department of Health and Human Services (HHS) provided a working framework for medical institutions and providers to improve their capacity to provide "effective, understandable, and respectful care that is provided in a manner compatible with their cultural healing beliefs and practices and preferred language."⁹

The goal of developing a culturally competent health care system cannot be attained without efforts to build a larger pipeline of qualified practitioners from medical institutions. By tapping the reservoir of diverse communities, the pool of students who eventually become those health care providers, can be enlarged.¹⁰

However, it is important to keep in mind that cultural competency is not a static paradigm. As a matter of definition, the "cultural" dimension of competency can only be achieved when it is infused by the experiences of the patient population. SHIRE's expressed concern is that the body of knowledge extant within the African immigrant experience continues to be omitted and/or marginalized in the medical literature and clinical practice.

Limited English Proficiency

Limited English Proficient (LEP) individuals often experience communication barriers in everyday activities, such as using public transportation. The consequences of poor English skills in medical encounters between patient and health care providers can be far more dangerous. Health literacy is defined as, "the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions."¹¹ The complexities of medical terminology in English can be intimidating, even to English-speaking patients. Studies have shown that among all Americans, "barely more than half understood information they were given by their doctor's office."¹² With communication a major health barrier, it is difficult to envision compliance with medication and treatment regimens.

In cases where the ability to receive an essential public service depends on effective communication, such barriers can threaten individuals' health, safety and civil rights.¹³ Moreover, LEP individuals are likely to face economic barriers to health care access:

In Los Angeles, 40 percent of non-citizen children and 22 percent of citizen children in immigrant families were uninsured in 1999-2000, compared to 6 percent of children in California's native citizen families. Three quarters of immigrant adults had limited English skills and one-third lacked a diploma. Thus, low educational attainment and limited English proficiency were closely associated with low earnings, poverty, hardship and access to health care. The most powerful predictor of poverty and hardship is their limited English skills.¹⁴

Title VI of the Civil Rights Act

Title VI of the Civil Rights Act of 1964 is federal legislation prohibiting discrimination by federal fund recipients on the basis of race, color or national origin. Regardless of the amount of funding, Title VI binds all health care entities, clinics, health centers, programs and plans that receive federal funding. Case law interprets Title VI as imposing a requirement that federal fund recipients provide access to interpreters and/or translation services. However, the reality is that persons with LEP remain ill-informed as to their rights.

In 2003, a multilingual poll of California immigrants commissioned by New California Media (NCM), now a coalition of over 600 ethnic news organizations, revealed that a majority of California immigrants were unaware of their right to ask for an interpreter when seeking medical care.¹⁵ Yet that right has been the law ever since the 1964 Civil Rights Act banned discrimination on the basis of national origin. Presumably, African immigrant communities are likewise unaware of their civil rights relating to health care access. The NCM poll included 11 languages and dialects. Neither French nor Creole was included among them. This fact may have affected communication with Haitians in California, and certainly would have eliminated responses from African French-only speakers. Similarly omitted were African languages in use among SHIRE respondents such as Twi, Tigrinya, Kiswahilli, Luganda, Amharic, or other indigenous African languages.

A presidential Executive Order and policy guidelines were issued in the year 2000 to assist federal fund recipients in the implementation of Title VI requirements regarding LEP persons. These guidelines clarified the obligations of federal fund recipients to ensure that LEP persons who are eligible for health care services and benefits were provided "meaningful access" – including language and communication assistance – at no additional cost. Medical interpreting costs are paid to states by the Centers for Medicare and Medicaid Services (CMS), which provide federal monies allocated for that purpose.

Four years ago, CMS issued a letter offering states federal matching funds for medical interpreting for Medicaid recipients and low-income children receiving federal funds. Only 10 states have applied for and received these funds, according to the National Health Law Program (NHELP), which has monitored the issue for the past decade. Besides states, the American Medical Association (AMA) has unsuccessfully urged Medicaid officials for the past three years to re-issue the Clinton-era letter and clarify what mechanism would unlock funds to states.¹⁶

Federal Resistance to Funding Title VI Provisions

Unfortunately, the 2001-2004 U.S. administration, in what appears to be a federal cost-saving initiative, signaled its willingness to let state and local health care facilities and providers forgo the responsibility of providing medical interpreters “by changing mandatory orders to voluntary language . . . guidance [that now] invites providers to disregard their interpreting obligation by stating that language assistance is not necessary in ‘certain circumstances.’”¹⁷ The resulting dollar savings would occur when CMS is not required to provide matching funds, i.e., when no medical translation service would be delivered – under “certain circumstances.”

In a report on the federal administration’s disinclination to reissue a matching funds letter encouraging states to seek the legally available funds from the federal government, “one longtime, high-level federal staffer” distilled the message in the administration’s action by observing that: “Language is not a high priority around here [Washington, D.C.]. The way bureaucrats know something is not high priority is when they’re told NOT to do something, like issuing the matching funds letter.”¹⁸

The impact of these developments on immigrant communities is potentially dire, depending on how “in certain circumstances” is interpreted. Yet, even in non-life-threatening circumstances, failure to provide interpretation services can yield bitter fruit as “little children deliver awful news to the parent they love. Friends and neighbors hear sexual and other personal history that should be private.”¹⁹ Children, friends, neighbors, and relatives become the default interpreters, the precise rationale for the initial issuance of the 2000 Executive Order.

Since the Title VI mandate requires federal payment to the state, it would seem that state and local compliance with federal law would be a non-issue. “Most hospitals are aware of their interpreting obligation, but advocates say countless doctors and small clinics may not believe they have to pay for it unless threatened with state and federal enforcement.”²⁰

Title VI and Data Collection

One important use of Title VI is to establish a powerful rationale for the collection of data. “In the absence of explicit statutory requirement, Title VI provides a legal foundation for the collection of racial and ethnic data by and from recipients of federal financial assistance. Because spoken language has been recognized as a proxy for national origin, the statute also affects the policies and practices of government agencies with regard to the collection of primary language data.”²¹

Implementing data collection efforts is consistent with the goals of establishing national standards of care. “Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.”²²

Immigrant Status Impact on Health Care Access

In 2003, among the findings of the Kaiser Commission on Medicaid and the Uninsured was “that citizenship status and English language proficiency strongly affect insurance coverage, access to care and quality of care.”²³ The report noted, for example, “a legal immigrant must reside here for at least five years before becoming eligible for naturalization. Moreover, immigrants who are here for less than five years are not eligible for Medicaid or SCHIP [State Children’s Insurance Program] based on federal welfare legislation.”²⁴

In the period 1999-2000, 42 percent of immigrant adults in Los Angeles lacked health insurance coverage, rates roughly triple those of native citizens. The primary reason for this gap was that immigrants were less likely to have job-based health insurance coverage. This hardship and need for benefits is more closely associated with limited English proficiency than with citizenship or legal status.²⁵

In addition to negotiating the eligibility labyrinth of state programs or private medical plans, immigrants often have to deal with the psychological pressures of adjusting to a new environment. While the health status of refugees and asylum seekers may represent the extreme manifestations of cultural adjustment, even a cursory examination of their psychological status provides insight relevant to the immigrant population.

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The clinical research literature shows a significant degree of psychological stress among refugees with relatively high levels of physical and psychological dysfunction during the first two years of resettlement; after three years, there was some improvement and increased adaptability, but there were still serious pervasive adjustment problems affecting some sectors of the refugee population, such as high levels of somatization, depression, and post traumatic stress disorder. These symptoms have been noted five years after resettlement.²⁶

Citizenship may also affect the psychological well being of immigrants, not only by reducing the uncertainties of their environment, but by increasing the receptivity to them by their fellow citizens. “It is good for other inter-ethnic relations because the image of an immigrant is a new immigrant, which is different than someone who is a settled immigrant and is adapted to California society. People should be more receptive and more supportive of immigrants when they think of them as their fellow citizens.”²⁷ The importance of this “acceptance” factor has implications for media and public education initiatives as well.

SHIRE’s researchers also found that stress was consistently cited as a key health concern, and that the data indicate citizenship may be a good baseline or proxy to determine the health status of African immigrant communities.

Recent California Developments with National Implications

Bilingual Education Programs Curtailed

California's electoral support for its new immigrant governor, however, is hardly emblematic of the state's relationship with immigrant communities, particularly racial and ethnic minorities. An edge of hostility was on display in 1998 when Californians voted to end bilingual education in their schools by passing Proposition 227. Proposition 227 appeared to be as much a referendum on Californian's attitudes about the demographic trends of a growing Hispanic population as it was about the effectiveness of bilingual education.

Utilizing data from the California Department of Education from August, 1998 to August, 2003, a recent analysis graphically demonstrates that English immersion programs, touted as the alternative to bilingual education, have not served Hispanic students well, raising the politically laden question of whether the mechanics and objectives of bilingual education programs were ever really understood by voters.²⁸

Proposition 54 Defeated

Proposition 54, a 2003 ballot initiative that would have prohibited state agencies from collecting data by race, was defeated by a larger margin than that which passed Proposition 227 five years earlier. Advocates for a so-called "color-blind" society were unable to make a convincing case to the voters that the abolition of data collection by race and ethnicity would lead to a utopian California.

Some of the Proposition's opponents launched information and advocacy campaigns that did no more than cite the state's own statistics to demonstrate the extreme difficulty the state would have encountered in enforcing federal and state laws. For instance, incidents, evidence or patterns of housing discrimination would have been far more difficult to discern or prove in a court of law had Proposition 54 been approved. *"If Proposition 54 passes, this data collection by the Department of Fair Employment and Housing will be banned after 10 years."*²⁹

Proposition 54 would have likely exacted its most pernicious toll in the area of health care. The National Medical Association (NMA), representing African American physicians, ardently opposed Proposition 54, as did the American Medical Association (AMA) in California, a member of the largest organization of American physicians.

The NMA and the AMA believe that health care data should be collected on patients, by race and ethnicity, because it is critical to recognizing and treating disease patterns, especially in high risk and vulnerable populations, and controlling outbreaks of communicable disease," said Randall W. Maxey, M.D., Ph.D., president of the NMA. "This data is also needed for conducting effective public health efforts; targeting early diagnostic and preventive services; understanding differential death rates; and eliminating racial and ethnic health disparities."³⁰

LEP Initiatives

Among the efforts undertaken to help ensure meaningful access to health care for LEP patients is a two-year NCM social marketing campaign also funded by TCE. This study aims to increase immigrants' awareness of their right to language services in health care settings. The ethnic media's coverage of this issue is intended to increase awareness among all groups.

In large urban settings, health care providers and others responsible for the public health encounter increasing numbers of African immigrants among their patients. Health care providers are finding that there is a lack of understanding of the cultural backgrounds of these patients, including in some instances, their languages.

Developing a cadre of culturally and linguistically diverse health professionals is particularly difficult for community-based and public health clinics and health services agencies. These institutions are often the sole providers of health services for immigrant communities. Important aspects of care, such as treatment adherence and patient satisfaction, improve significantly when the cultural and linguistic gap between the health services providers and their patients and clients is narrowed. "Welcome Back," is a statewide initiative funded by TCE to assist internationally trained health professionals living in California. The mission is to build a bridge between the pool of internationally trained health workers living in California and the need for linguistically and culturally competent health services in underserved communities.

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While this SHIRE study focuses on African immigrants to the United States and LEP as a barrier to accessing health care, it is significant to note that the paradigm of unequal treatment surfaces in other countries with the same deleterious results. In announcing a grant to initiate a 2003 French-Language Health Network in Newfoundland, the Minister of Health and Community Services said:

Communicating plays an important part in the delivery of health services. Research has shown that language barriers can affect the quality of services where good communication is critical, such as primary health care services, and reduce the probability of a patient's compliance with treatment. This [language barrier] limits the effectiveness of programs and services we provide.³¹

Relevant Immigrant and Refugee Issues**Reasons for African Immigration into the United States**

Immigration, legal and illegal, is often driven by perceptions of the opportunity for financial betterment because of higher wages and broader options in target countries. Population growth results in increased competition for available jobs within a country, prompting emigration to host countries. According to one observer, "these two features are even more prominent in Africa [than in 19th century European emigration] ... Estimates of net migration and labor market performances for the countries of Sub-Saharan Africa suggest that exactly the same forces are at work."³²

Educational opportunity, closely linked to economic viability and personal fulfillment, is invariably a cherished goal among immigrants to the United States. Political imperatives resulting from internal and external conflicts also can be significant motivating factors driving immigration. The desire for family reunification can also play a role. These are other factors influencing the decision to leave the African continent.

Mass African emigration often occurs between neighboring countries. African emigrants also are migrating to Europe, in part because of proximity and a shared colonial history, but also to other countries, including Australia, New Zealand, Canada and the United States. In 2001, researchers concluded that “estimates suggest that the pressure on emigration out of Africa will intensify, manifested in part by a growing demand for entrance into high-wage OECD [Organisation for Economic Co-operation and Development] labor markets.”³³ This projection has been borne out by more recent data.

The 2003 edition of the “OECD’s annual *Trends in International Migration* notes that the economic down-turn in some OECD countries has not affected the upward trend in international migration which began in the mid-1990s.”³⁴ There are no indications that the primary reasons for international emigration or African emigration patterns will soon change. “Factors affecting where arriving immigrants decide to settle in the host country are primarily: 1) the economic attractiveness of the destination region; 2) the presence of family members or people of the same ethnic origin; and 3) the point of entry into the country and the proximity of the country of destination to the country of origin.”³⁵

As a consequence, the United States is likely to continue to be a target country for African immigrants given their perception of America’s promise of employment and economic security relative to African economies, and the family ties between immigrant families here and their relatives abroad.

The factors that impel *refugees* to flee to foreign soils are varied and complex. Refugees are a select category of immigrants, in that their exit from their country of origin was typically as a result of armed hostilities, famine or disease, and seldom carefully planned. Refugee ceilings also are set annually through a consultative process with the Executive and Legislative branches of the U.S. government.

U.S. Citizenship and Immigration Services (USCIS)

In 2003, the then newly formed U.S. Department of Homeland Security (DHS) assumed administrative control of immigration services through the USCIS. USCIS still functions under the framework of the existing laws, particularly the Immigration Act of 1990, and regulations that governed its predecessor, the Immigration and Naturalization Service, formerly administered by the U.S. Department of Justice. “The 1990 Act divided the preference classes into two general categories – family-sponsored and employment-based. Limits on the number of visas issued in these two categories are determined annually.”³⁶

The 1990 Act also sets an annual worldwide immigration limit into the United States, ranging “between 421,000 and 675,000” based on a formula that includes immigration levels from specific countries during prior years.³⁷

USCIS administers the programs, services, and benefits affecting immigrants, such as the Lawful Permanent Resident status or the “green card” program, visas, employment and family immigration, and asylum applicants.

USCIS and Africa: Data Snapshot

USCIS data are not used in U.S. Census counts, nor is race recorded. Immigrants of African descent originating from the United Kingdom or Canada, therefore, would not be reflected as African in this data. Nor is USCIS data used in Census counts. However, in 2002, another million immigrants from Africa and the Caribbean came to the United States on nonimmigrant status programs.³⁸

**Numbers of Immigrants to the United States by Region and Top 20 Countries of Birth
Fiscal Years 2000-02 – Extract from Table B³⁹**

	2002		2001		2000	
	Number	Percent	Number	Percent	Number	Percent
All countries:	1,063,732	100%	1,064,318	100%	849,807	100%
Africa:	60,269	5.7%	53,948	5.1%	44,731	5.3%
Caribbean:	96,489	9.1%	103,546	9.7%	88,198	10.4%
Mexico:	219,380	20.6%	206,426	19.4%	173,919	20.5%
India:	71,105	6.7%	70,290	6.6%	42,046	4.9%
China:	61,282	5.8%	56,426	5.3%	45,652	5.4%
Philippines:	51,30	4.8%	53,154	5.0%	42,474	5.0%
Vietnam:	33,627	3.2%	35,531	3.3%	26,747	3.1%
El Salvador:	31,168	2.9%	31,272	2.9%	22,578	2.7%
Cuba:	28,272	2.7%	27,703	2.6%	20,831	2.5%
Bosnia-Herzegovina:	25,373	2.4%	23,640	2.2%	11,828	1.4%
Dominican Republic:	22,604	2.1%	21,313	2.0%	17,536	2.1%
Ukraine:	21,217	2.0%	20,975	2.0%	15,810	1.9%
Korea:	21,021	2.0%	20,742	1.9%	15,830	1.9%
Russia:	20,833	2.0%	20,413	1.9%	17,110	2.0%
Haiti:	20,268	1.9%	27,120	2.5%	22,364	2.6%
Canada:	19,519	1.8%	21,933	2.1%	16,210	1.9%
Colombia:	18,845	1.8%	16,730	1.6%	14,498	1.7%
Guatemala:	16,229	1.5%	13,567	1.3%	9,970	1.2%
United Kingdom:	16,181	1.5%	18,436	1.7%	13,385	1.6%
Jamaica:	14,898	1.4%	15,393	1.4%	16,000	1.9%
Pakistan:	13,743	1.3%	16,448	1.5%	14,535	1.7%
Iran:	13,029	1.2%	10,497	1.0%	8,519	1.0%
Subtotal of Top 20 Countries	739,902	69.6%	728,009	68.4%	567,842	66.8%

No African countries are among the top 20 countries of origin for immigrants to the United States. Although the Dominican Republic, Cuba, Haiti and Jamaica have populations of African descent, only the latter two are primarily non-Spanish-speaking.

African Refugees

In a 2004 speech to the African Union, an organization that represents Africa's 53 countries, Botswana's President Festus Mogae decried the causes that have led to the flow of refugees within and from his continent, and urged African leaders to take steps to address the crisis.⁴⁰ The United Nation's High Commission on Refugees reports "there are 4.5 million African refugees around the world, many of whom fled to avoid the continent's many wars and widespread poverty. A further 12 million Africans are internally displaced persons (IDPs)."⁴¹

The reasons for Africa's refugee crisis are complex, ranging from drought, famine, and civil and regional wars to European Union and American agricultural subsidization policies that have had devastating effects on African economies.⁴² Many of these countries are faced with debt repayment burdens that divert resources from infrastructure development and much-needed social services.

In the United States, "for the 2004 fiscal year (i.e. October 1, 2003 - September 30, 2004), the total ceiling is set at 70,000 admissions and is allocated to six geographic regions: Africa (25,000 admissions), East Asia (6,500 admissions), Europe and Central Asia (13,000 admissions), Latin America/Caribbean (3,500 admissions), Near East/South Asia (2,000 admissions) and 20,000 reserve."⁴³

The United States has resettled refugee populations from Sudan and Somalia, with additional 8,000 to 12,000 Somali Bantus due to arrive before October 1, 2004. Somali Bantus, an immigrant population new to America, first arrived in 2003. They will be dispersed to rural and urban communities in 35 states, including California.⁴⁴

However, the greatest proportion of America's African immigrant population arrived through more traditional immigration procedures.

The Lottery

As the rates of immigration from African and Caribbean countries have been relatively low, those from African and Caribbean points of origin who already are living in the United States with temporary or student visas are often eligible for the USCIS Diversity Lottery Program, informally known as the Lottery.

The first criterion for eligibility is that one's country, one's spouse's country, or even one's parent's country, has been selected by the U.S. State Department, which lists countries that have sent no more than 50,000 immigrants to America during the five immediately preceding years.⁴⁵ Individual eligibility can be determined by a number of factors, including educational status. Winning the Lottery enables an immigrant to apply for permanent residency. "If permanent residence is granted, then the individual will be authorized to live and work permanently in the United States. You will also be allowed to bring your spouse and any unmarried children under the age of 21 to the United States."

Participants in the SHIRE focus groups noted an increase in the heterogeneity of their communities, particularly as reflected by the numbers per African countries represented. However, precisely because of the basis for the random selection process – that is, a low number of total immigrants from that country in the United States – some of the newer immigrants do not have an extensive network of support upon arrival. Though they may have immediate family members in the U.S., they may lack critical institutional, economic and political resources of longer-established immigrant communities.

DHS and Immigrant Concerns

The Department of Homeland Security's origin was as a response to the attacks on the United States on September 11, 2001. Its subsequent actions, however, have had a chilling effect on immigrant populations.

Increased enforcement by the USCIS for infractions once considered relatively minor have resulted in deportations even among traditional European immigrants. For example, holders of expired student visas are, in effect, illegal aliens. If they travel out of the United States to visit relatives in their homeland, it is unlikely that they will be able to gain readmission if their status becomes known. Heightened enforcement has affected immigrants of all ethnic backgrounds. "Irish illegal immigrants continue in the same grim limbo they have inhabited since Sept. 11, 2001 ...a terror of deportation that led many of those interviewed to insist on anonymity. For many illegal immigrants, that grimness has long been par for the course, but as educated, English-speaking Europeans, the Irish have had relative advantages. For them, living in the United States became harder when enforcement of immigration laws tightened after 9/11."⁴⁶

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While SHIRE focus groups were drawn from voluntary respondents, data collectors who conducted "person on the street" surveys were confronted with the same concern about "anonymity" and a palpable reluctance to be forthcoming about personal information, experiences, and attitudes toward access barriers.

The African Immigrant Presence in the United States in Census Data

Though African immigrants in the United States are drawn from an increasing number of countries, their statistical presence barely registers. In California, no African or Caribbean countries are listed among the top 15 countries of origin for foreign-born residents.⁴⁷ The SHIRE survey conducted in Los Angeles at the 2003 "Annual Marketplace Celebration," yielded respondents (in greatest numerical order) from: Uganda, Senegal, Cameroon, Ivory Coast, South Africa, Gambia, Nigeria, and Zimbabwe. Of these countries, only Nigeria and South Africa are listed among the top 15 countries of origin for foreign-born populations in any state. (See Appendix D).

Race is “Self-Reported”

The U.S. Census Bureau collects population data on its “short-form” which is mailed to every U.S. household and then supplemented by the field work of U.S. Census takers. Racial data, however, has been collected on the “long-form,” mailed to approximately one in six U.S. households and thus is only a statistical sampling of the U.S. population. Compounding the difficulty in yielding an accurate characterization is that non-responsiveness to the long form is fairly high.⁴⁸ Though the long-form will likely be replaced by an alternative methodology in the 2010 Census, the issue of “race” remains complex and difficult to quantify. However, the six racial categories that appear on the Census form are actually determined by the U.S. Office of Management and Budget.

For many immigrants “race” is a difficult concept to grasp. “Some foreigners simply check ‘foreign-born who have immigrated’ or ‘American,’” according to one U.S. Census Bureau employee.⁴⁹

Census takers in the field are instructed not to assist respondents in the selection of racial categories. Race is “self-reported” and left to the discretion of each respondent. During a SHIRE focus group session with African immigrants in San Diego, a group of Ethiopian men explained that they had chosen not to identify themselves as “Black” or “African American.” To an American, these would be the two seemingly logical options available to them on the Census form. But, as Ethiopians, they were not African Americans as the term is commonly used. Whether they found “Black” to be a pejorative term is not known. They were, however, encouraged by a U.S. Census taker to identify themselves as “White.” A U.S. Census Bureau spokesperson said that the worker acted in contradiction to Bureau training and policy.⁵⁰

Given the small percentage of African immigrants relative to the overall population of the United States or to a specific state, like California it is unlikely that variances in their selection of race have any meaningful statistical impact on population estimates.⁵¹ This also is partially due to the fact that long-form survey respondents can select more than one category to identify race. “In dismantling the ‘check-one-box-only’ system, we’ve basically opened the door to the idea that race is not fixed, that we’re not a separate species—as some would like to think,” said Bay Area resident Ramona E. Douglass, a member of the Commerce Secretary’s Census 2000 Advisory Committee and past president of the Association of MultiEthnic Americans.⁵²

Advocates for full minority representation in U.S. Census data argued that allowing respondents to have the option of selecting “mixed race” would quantifiably dilute the “Black” or “African American” category totals in the 2000 count. Educational campaigns mounted prior to the 2000 census on this issue however, were rarely directed to immigrants from Africa and the Caribbean.

U.S. Census Undercount

Respondents to the SHIRE survey and focus groups expressed their opinion that African immigrants are undercounted in the Census process. That the U.S. Census undercounts minority populations is a well known fact, but the methodologies and marketing efforts to develop outreach to communities of color are improving. “The Census 2000 Language Assistance Guides were also translated and printed in the following additional languages for ‘targeted distribution’ . . . Amharic, Burmese, Dari, Dinka, Hebrew, Kurdish, Roma, Somali, Swahili, Tibetan, Tigrean . . . These language Assistance Guides were made available at Questionnaire Assistance Centers identified by community leaders and Partnership Specialists from the Census Bureau’s regional offices. These were places where the public could find the help they needed to fill out their Census 2000 questionnaire.”⁵³

As a political issue, the question of undercounting minority populations was a heatedly debated topic during preparations for the 2000 Census. Disagreement centered on whether an undercount would reduce federal dollars available for minority populations, particularly with “Mixed Race” available as a self-reporting option.

The only racial group on the Census form that is *directly* tied to federal funds as a group is “Native American,” due to treaties and obligations of the U.S. federal government to sovereign nations.⁵⁴ However, many federal programs, administered through the states, are derived from U.S. Census information.⁵⁵ Thus, each immigrant community should be concerned that the federal dollars for which their state qualifies is collected. These funds, in part, can appreciably affect the quality of life in cities and counties by supporting hospitals, housing, highways, and other critical core infrastructure, as well as programs like health education and other much needed health access initiatives.

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Profile of Foreign-Born African Americans in California

Very little is known about immigrants of African origin in California, and no population-based survey has focused comprehensively on their identification or their clinical and social needs. At least 4.6 percent of all blacks in California are foreign-born. Data from the year 2000 U.S. Census indicates that of the 8.9 million immigrants residing in the state of California, 183,390 were from Africa or the Caribbean. While this number is only 2 percent of the immigrant population in California, it represents a heterogeneous group of newcomers whose unique needs have been ignored.

Target Population

While recognizing the diversity of the African diaspora within California, the SHIRE team – given the time and resources available – sought to maximize its existing relationships with African and Caribbean immigrant communities in Los Angeles and San Diego. French-speaking Africans were included, as well as Haitians or other French-speaking immigrants from the Caribbean. However, given that California is making outreach efforts to Spanish-speaking communities, in order to emphasize the health and language barriers of immigrants of African origin, this report’s analysis is restricted to individuals from Sub-Saharan Africa and

countries of the Caribbean that are not predominantly Spanish-speaking. The Spanish-speaking immigrant population from the Dominican Republic in the Caribbean, for example, was excluded. Boers and other Africans of identifiably European descent or from Arabic-speaking countries also were excluded from the study. (See the countries of origin listed on Table 1, Appendix A)

SHIRE identified 102,655 persons in California who claimed Sub-Saharan Africa or the Caribbean as their place of birth on the 2000 U.S. Census, with 74.2% from Sub-Saharan Africa and 24.8% from the Caribbean. This immigrant population is from countries as diverse as Ethiopia, Ghana, Angola, Botswana, Barbados and Jamaica. California's Los Angeles County, which has over 9.5 million residents, is home to over 37,000 residents who reported being of African origin. San Diego County has over 12,000 residents of African origin. (See the population of African Americans in California's most populated counties, Table 2, Appendix A)

Data Sources

SHIRE's preliminary analysis of the target population used data from three sources: the 2000 U.S. Census, the DHS, and the 2001 California Health Interview Survey (CHIS). (It was determined that the data for San Diego was not as comprehensive as that for Los Angeles, and that any comparable analysis would have demanded more time and resources than were available for this preliminary study). The census provides information on individuals and households who have immigrated to the United States. Therefore, the census information may omit relevant data on undocumented immigrants and second-generation immigrants who were born in the United States but retain strong ties to Sub-Saharan Africa or the Caribbean. The DHS source data included information on refugees and asylees to California between the years 1998 and 2002. The 2001 CHIS, which was collected from Asian, Spanish-speaking and English-speaking persons in households throughout California, provided limited data regarding the language characteristics and health status of immigrants of African descent. These two areas were selected for qualitative assessments by the SHIRE team.

Socioeconomic Status in Los Angeles County

The socioeconomic status (SES) of the neighborhoods, where most immigrants of African descent reside in Los Angeles County, was calculated based on five characteristics: median family income, median housing value, percentage of the population who did not graduate from high school, percentage of blue collar workers, and percentage of the population who were unemployed. Living in a neighborhood with a low SES is associated with higher mortality⁵⁶ and lower self-rated health.⁵⁷ Immigrants of African origin in Los Angeles County were found to have SES that is generally higher than that of immigrant Latinos, comparable or higher than the SES of U.S.-born African Americans, and comparable on many measures to the SES of Asian/Pacific Islander groups.

Still, it is difficult to draw hard conclusions about economic status from SES data because it draws on mean data. For example, the proximity of a home to downtown Los Angeles may increase the value of the property, but its resident or owner may not have the disposable income to maintain it. Gentrification, as one aspect of the housing market, may skew the reality derived from SES data.

SES also does not distinguish among refugees, new immigrants, and more established immigrants. To the extent that we rely upon SES data as a measure, we must be aware of the subsets within the immigrant community.

Analysis was limited because census tract level data were used, which precluded evaluation of the socioeconomic and language characteristics of individual immigrants and groups. Further, qualitative data obtained during this study suggest that the SES of persons *not* included in the U.S. Census may differ markedly from those who were counted.

Future Efforts

SHIRE's preliminary investigation indicates that California's heterogeneous immigrant population and sub-population (e.g. refugees from Sub-Saharan Africa and the Caribbean) may have substantially unique language and health care needs, as do various groups of Asian/Pacific Islander immigrants. Additional study is required to better identify these needs and focus efforts to improve care. Specifically, further work is needed to identify immigrants of African origin, their health status, where they live and receive health care, the quality and accessibility of that care, and whether there are language-related barriers to the receipt of health care.

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Further study is also needed to determine whether patterns observed in these ecologic analyses are consistent with individual-level effects. Further information on individual level characteristics may play an important role in evaluating the relative influence of individual SES, neighborhood SES and other individual and health care system factors in influencing health outcomes for these populations.

Qualitative Investigation: Los Angeles and San Diego, California

Census and community data indicate that recent immigration to the United States is largely concentrated in the urban areas. Additionally, according to a study published by the Urban Institute in 2003, "Immigrants make up one in nine U.S. residents, one in seven U.S. workers, at least one in five low-wage workers.... Immigrants are over represented among both low-wage workers and less educated workers."⁵⁸ Los Angeles-Long Beach exceeds even New York City as the intended destination of new immigrant arrivals, followed by Chicago, Miami, and the greater metropolitan region of Washington, D.C.⁵⁹

As stated, Los Angeles County and San Diego were the target areas chosen for survey investigation and assessment of the role of language and cultural barriers relative to the delivery of health care for immigrants of African descent in California. Los Angeles County, the largest county in the State of California with 9.5 million residents, also has the highest numbers of residents who reported being of African origin. (See SHIRE Report: Profile of Foreign-Born African Americans in California, Table 2 – Population of African Americans in the most populated counties in California by place of birth.) The third highest numbers of residents of African origin reported are from San Diego County, which is also home to relatively large numbers of recent immigrants from Africa.

On the Ground: Focus Group Sessions

SHIRE conducted both written surveys and focus group discussions at four focus group meetings. Two meetings were held in Los Angeles in September and August 2003 and two in San Diego during October 2003. The purpose of the surveys and focus group discussions was to perform a preliminary assessment of the language barriers and health care needs of African and Caribbean immigrants in those two cities. In both cities, these sessions averaged from 2 to 2.5 hours each.

During its focus group sessions, Los Angeles team members worked with well-respected members of the African immigrant community, including those listed in Appendix B-1. SHIRE's San Diego team worked with the San Diego Urban League and the Alliance for African Assistance (AAA) to identify individual participants in the focus groups and surveys. The AAA, an African support group for immigrants and refugees resettling in San Diego, convened a focus group of 34 participants representing 6 countries.

Common Threads: San Diego and Los Angeles

In San Diego and Los Angeles, the participants in the SHIRE focus groups spoke English well enough to sufficiently communicate their concerns. Some participants originated from French-speaking countries where French, in addition to tribal languages, (like Wolof, for example, which is spoken in French-speaking Senegal) were still prominent means of communication within their communities in America. Tribal languages also were still spoken within and among English-speaking households in African immigrant communities.

However, mere identification of a country's primary language was not necessarily synonymous with the language proficiency of an individual. For example, one respondent from Gambia, an English speaking country, communicated primarily in French, further revealing that language was among this individual's leading barriers to accessing health care and other social services.

When asked about the "number one" problem of African immigrant and refugee communities, language emerges as being an important consideration in Los Angeles, but did not head the list; having "money" did. In San Diego, language was cited as being the "number one" problem, but then receded depending on the context of the discussion, such as financial status. Lack of health insurance was critical for both groups. What also is evident from the responses is that weak English language skills can inhibit the attainment of important goals, like gainful employment, or even the ability to fill out the forms necessary to qualify for government assistance.

Regarding access to health care, there was agreement about the nature of encounters in health care settings with a range of responses indicating a significant level of psychological discomfort. Respondents from both Los Angeles and San Diego expressed dissatisfaction at the low level of cultural competence exhibited by their health care providers. "Health providers cannot speak my language so it's very hard for me to explain what problems I have," said one participant. The opinion of one respondent, that "There

is much miscommunication between provider and patient, also they [providers] don't understand their [immigrant] cultures" was an equally blunt assessment shared by the two groups. Respondents acknowledged that among health care workers, the level of ignorance about Africa, even at a minimal level of geographic familiarity was disappointing.

Health conditions similarly identified by the two groups as a major concern were HIV/AIDS, diabetes, high blood pressure. Whether these latter two conditions were due solely to lifestyle adaptation to American eating habits and culture or were in some way unique to African immigrants as opposed to other immigrant communities was unclear. It is clear, however, that certain lifestyle practices in America are hazardous to the health of immigrants, particularly immigrant children. A report entitled *From Generation to Generation: The Health and Well-being of Children in Immigrant Families*,⁶⁰ makes the point with razor sharp clarity: "Nevertheless, on the basis of available data, it appears that, along a small number of important dimensions, children in immigrant families experience better health and adjustment than do U.S.-born children in U.S.-born families. This relative advantage tends to deteriorate with length of time in the United States and from one generation to the next."⁶¹ A few respondents identified stress, particularly the stress of negotiating day-to-day survival, as a chief culprit for poor health outcomes of African immigrant communities.

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Gender issues, specifically relating to women, also appeared to have their origin in cultural mores rather than language proficiency. Some respondents acknowledged the preference of African women to be seen by female health providers. When this preference is added to cultural inhibitions to speak openly about certain body parts or functions, the combination should indicate a potentially dangerous disconnect between African immigrant patients and the resulting quality of care from male health care providers. Other mores noted by respondents, such as not making eye contact with a treating physician, have at times been misread by American health providers as measures of untruthfulness on the part of the patient. This is consistent with the literature documenting clinical encounters with patients who are Asian, Middle Eastern and Native American.⁶²

There was a consistent perception among participants, moreover, that health care providers underestimate the knowledge that African immigrants have about specific disease states, particularly tropical diseases like malaria. One respondent noted that during the time required for "lab results" in America, medical interventions would have initiated had he been in his country of origin. That health care providers are not making use of the cumulative knowledge within the African immigrant communities was often reiterated and found offensive. It is also apparent that many providers have limited if any knowledge of tropical diseases that may affect individuals coming to them for treatment.

Faith organizations easily led the category among all respondents of entities that should be contacted next to discuss immigrant issues. There was no great variance in ranking the other categories listed on the survey; including: county representatives/policy makers, other CBOs, community chairmen, and business people.

Perceptions about racism are difficult to qualify. Racism did emerge as a barrier to health care, but whether discriminatory treatment was due to one's immigrant status, continent or country of origin, or simply "race" was unclear. In addition, the hierarchy of racism in the United States and how race affects social interactions were not always clear to African immigrants. Among San Diego respondents, in particular, there was evident confusion in how to sort through the racial complexities associated with the relationship between African Americans and Africans, African Americans and Whites, etc.

Divergence: San Diego's Newer Arrivals

The discussion group participants from San Diego included more refugees among recent African immigrant arrivals than the Los Angeles group. Collectively, the San Diego group response on the surveys identified lack of communication as the greatest single barrier affecting immigrant access to better health care. Communication ranked ahead of lack of cultural competence, misuse of services, employment issues, and mental health.

One refugee respondent indicated that his failure to understand English well results in his inability to fully comprehend medical instructions. "There aren't any doctors or nurses that administer chemotherapy who speak my language to explain to me what reactions to expect." Conversely, another, in describing the flow of information from patient to provider, in response to whether language was a barrier, wrote simply, "difficult to tell the doctor how I am sick."

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In the surveys, residents of San Diego expressed more concern about culture as a barrier than did the Los Angeles group, a finding seemingly consistent with newer immigrant and refugee populations. They also heavily outscored their Los Angeles peers when responding to "Access/lack of knowledge" as a selection option in the "Top Health Problems in the Community" category.

The Los Angeles survey results also reflect the perception that communication, lack of cultural competence, and misuse of services impact health care access, but reported these to a lesser extent. (See Chart, Impact of language barrier on access to better health care, African/Caribbean Community Service Survey).

Mental health was equated closely to depression and correlated closely with a sense of alienation from the mainstream of American life. This alienation was heightened by the inability to find well-paying employment. There was an expressed dissatisfaction with the difficulty in getting educational credentials from their countries of origin accepted in the United States. Thus, respondents were subjected to a cycle of unemployment and/or underemployment resulting in relatively low wages. Without sufficient income, the purchase of health insurance for themselves or family members was unlikely. "Money" or language related to employment, like "job finding" appeared several times as a response to identifying their chief problem.

There was a preponderance of agreement among the San Diego and Los Angeles communities that there had been a change in the types of immigrants that have arrived in the United States in the last five to 10 years, but less agreement as to the nature of the change. Many in San Diego were “unsure” as how to characterize the population of recent arrivals. Yet, some respondents claimed that more youth were arriving, as well as more women who were heads of households, particularly among the refugee population. Regardless, residents of San Diego expressed concerns about having the tools, such as language skills, finances, and employment opportunities to assist youth – immigrant, refugee, or native-born Americans – in adjusting to life in America. Educational advancement for youth was expressed as a parental concern and a broader social issue.

One Los Angeles physician who participated as a SHIRE respondent, best captured the sentiment of both communities when recommending effective “strategies” to incorporate into existing health care programs to eliminate health access barriers. His strategies consisted of “making oneself available by letting the community understand and know we are there to help and serve them with respect and trust” and of “having a sense of empathy.... they would not feel embarrassed, threatened, looked down [on] when and if they come to see us as health care providers.”

Knowledgeable Observers/Centers of Influence in Los Angeles County

Within most immigrant groups, there exist individuals who have a profound understanding of their own culture and who, from collective and individual experiences, have learned to note the dynamics of adjusting to their new homeland. SHIRE’s team termed those seasoned individuals who responded and participated in focus group discussions and surveys: “Knowledgeable Observers” (KO), who are listed in Appendix B-1 (Los Angeles) and B-2 (San Diego). A subset of the Knowledgeable Observers group is comprised of individuals who are more akin to service providers, such as physicians or agency administrators, or who were identified by KO as having “gravitas” within their communities. Members of this subset were termed “Centers of Influence” (COI).

Though each country of origin for African immigrants in California was not represented among the KO/COI, they hailed from West and East African countries, one Central African country, and one each from Trinidad and Haiti.

The KO/COI group comprised 20 individuals, three of whom had been in the United States for more than 30 years. Another 15 had been living in the United States between five and 30 years. Close to 50 percent of KO/COI identified themselves as having an active “advocacy role” in at least one of the following generally descriptive categories: political, social, cultural, or health. Only 20 percent claimed their “advocacy role” to be “religious,” fewer than the 30 percent who selected “business.”

Collectively, therefore, given their cumulative years of U.S. residency, diversity, and range of experiences, the KO/COI were well suited to comment on language and access barriers to health care and other services.

KO/COI Observations about Baseline Health Status

To provide a framework for their responses, KO/COI were asked to rate the overall health status of their communities. “Excellent” as the optimum state typically garnered the lower percentages on a scale with three other choices (Good, Fair, and Poor) that were to total 100 percent. Distressingly, “100 percent” under the “Poor” category was listed by one KO/COI as the apt descriptor. The answer was reminiscent of another SHIRE survey respondent who, when asked to describe the leading problem in his community, wrote: “There are so many!”

Importantly, the KO/COI who characterized the overall health status of African immigrants as “Poor,” also made a telling observation that serves as a lens through which to view not only health, but behaviors and attitudes that inhibit successfully coping with life’s daily challenges: “There is depression and loneliness. We spend hours to try to find out what is happening in their lives.” While some KO/COI responded very generally to the survey question about, in their opinion, which subpopulation groups were ignored by service providers, another KO/COI listed “people with mental health problems and issues, HIV/AIDS, and drug addiction.” These observations point toward the need to gain a better understanding of cultural norms so as to be able to distinguish them from behaviors driven by depression and/or other mental health conditions.

Concerns about the mental health status of African immigrants, particularly of refugees, are especially relevant when evaluating the mental health status of the elderly. KO/COI uniformly identified the elderly within immigrant communities as the most likely subset to be the most severely impacted by health care barriers due to difficulties adjusting to a new culture and a higher likelihood of an inability to speak English. KO/COI noted that though English may be spoken, it is sometimes not understood well enough to render an individual functionally literate or independent. Thus, it logically follows that, from observations of their communities, KO/COI ranked “family members” and “friends” – when grouped together as a bloc – as high as health care providers on the list of sources for primary and secondary sources of health information. Family members and friends are typically those who speak the same language.

At a 90 percent response rate, “money” outscored all other categories as an access barrier to health care. This correlated strongly with the KO/COI observation that the primary reason for their clients’ lack of health insurance was cost.

Much of the discussion on finances centered on whether an immigrant could afford health care costs or medical insurance as an individual or for his or her family. However, one KO/COI made an important observation about the potential consequences of immigrant sponsorship, noting that “the sponsor of an immigrant is totally responsible for all financial matters. If the immigrant gets sick, the sponsor is on the hook for the bill.” The observation points to the multiple layers of health care costs that can impede timely delivery of medical care.

Language scored as the next highest barrier, yet only four KO/COI identified language alone. There was a general consensus that language did not exist as a barrier for well-educated immigrants. KO/COI stressed the need to differentiate among immigrant subsets, such as students who come to the United States to obtain education and/or training in select vocations, as opposed to refugees who may have had little or no exposure to English – Amharic-speaking Ethiopians, for example – before their arrival.

Seventy percent of KO/COI cited the stereotypes of immigrants held by health providers as an access barrier. This figure matched the percentage of KO/COI who agreed that the negative “attitude” exhibited by providers also was an access barrier. These two indices ranked ahead of “translator availability” and more than twice the response rate to the question of whether immigrants “feared not being treated at all.”

Less clear were the distinctions KO/COI made between discrimination and racism. KO/COI ranked them near equally as barriers, 50 to 45 percent respectively, yet consistent with immigrants’ reports of being discriminated against for various reasons, of which racism may be one factor.

Other barriers that had some impact on KO/COI communities included “lack of information” and “transportation.” While acknowledging that immigrant patients prefer interaction with providers from their own countries, KO/COI determined that their communities were generally trustful of health care providers. Despite the level trust, there was almost unanimous agreement (95 percent when combining “major” with “somewhat of a barrier”) among KO/COI that their constituents “do not want to disclose medical problems.”

KO/COI were well aware of systemic access issues related to immigrant status, such as difficulty in obtaining housing. One question, however, elicited a response that should provoke serious reflection among policy makers and public health officials. Again, when combining “major” and “somewhat of a barrier,” over 50 percent KO/COI concurred that “fear of deportation” was a key access barrier.

Primary Care Facilities: A County’s Safety Net

KO/COI were asked to identify the health care facilities or institutions their clients utilized. There was sufficient data from the KO/COI responses to indicate that African immigrant communities rely heavily on the clinics and hospitals that comprise the health care system in Los Angeles County. Even a respondent who did not know which facilities were frequented by constituents, readily identified “county hospital” in answer to “Where would your clients go for health care if they became sick in the next week?”

Out of a range of five choices, the second highest – “somewhat satisfied” – was the answer most consistently given when asked to rate the health care service at those facilities. The selection of “somewhat satisfied” seemed to correlate with the demand for more culturally competent staff and more receptive staff attitudes towards immigrants. However, since disparity data have shown that culturally incompetent care can have real health consequences, there is a compelling rationale for cultural competency, as it relates to African and Caribbean patients, to be at the core of staff training in county facilities.

It was unclear if lack of medical insurance or cost alone were the determinants prompting high clinic or county facility usage. Since “money” was identified as the lead barrier to health access by the KO/COI, there is no way to measure, should their personal financial status improve, whether county facilities would still be the facilities of choice for KO/COI constituents. Transportation barriers are often related to socioeconomic status. At present, though transportation was sometimes cited as an access barrier, the availability of geographic locations of clinics and county facilities seem to provide a safety net for Los Angeles County immigrants.

The African Marketplace: Survey Yields More Questions than Answers

SHIRE’s Los Angeles team opted to take on the additional task of conducting a random survey at the Annual African Marketplace Celebration. This “person-on the-street” survey was conducted by approaching attendees. Of the 54 individuals who were contacted, 36 completed the survey. The responses gathered yield insights that suggest the need for further investigation. SHIRE researchers encountered suspicion as to their motives and concerns by attendees as to the nature of the survey and the uses to which the answers would be put. It cannot be stated definitively that fear of deportation or illegal immigrant status prompted the reluctance to participate in the survey, but those concerns were implied as potential survey respondents asked, “Why do you want to know?” or “What are you going to do with this information?”

Survey Responses Warrant Further Investigation of SES

Of interest in examining the demographic profile of SHIRE’s study population was the presence of African immigrants from Uganda, the Ivory Coast, Cameroon, Rwanda, and Senegal. Approximately 90% of the Ugandan respondents, though they spoke English, said they had a problem getting health care. One respondent, who said he did not, did state that health care related to tropical diseases was a problem.

Of the five countries cited, Uganda is the only English-speaking country and even one of its respondents spoke French. Cameroon is an officially bilingual country and its survey respondents listed English and French respectively as languages spoken, in addition to tribal languages. No Cameroonians listed “language as a problem in getting health care” nor did any claim to have a problem getting health care.

Respondents from the Ivory Coast, another Francophone country, also reported no problems getting health care nor in encountering language barriers. These respondents listed English, French, and Spanish as their spoken languages.

The sole Rwandan respondent, who spoke French, English, and one tribal language, similarly had no language barrier or problem getting health care.

In contrast, more than half the Senegalese respondents said they had a problem getting health care. A few identified language as a barrier, but lack of money appeared as the unifying theme as a barrier whether language was a barrier or not. Without further research, it is difficult to determine whether Senegalese immigrants comprise a newer subset of African immigrants, possibly refugees, or whether their socioeconomic status as a group is less well established than their peers from other countries.

Need for Outreach

The one striking finding in the random survey in Los Angeles was the apparent inability of the greater preponderance of respondents to name an organization that “does the most to help individuals in the African/Caribbean immigrant community.” Answers ranged from “none” or “none that I know about” to no reply to the question. The sole Cameroonian who answered the question identified four organizations: Hope for Africa, Africare, USAID, and CARE. However, when asked what individuals “do you believe to be most helpful, the answer was: “myself.”

Ugandans, as a group, had the highest number of respondents who identified an organization that provides assistance, but even with that set of affirmations were responses like the “African community” or “Ugandan community.” These very general responses shed little light on the awareness of existing organizations or the level of confidence in them held by African immigrants. “County hospitals” was listed as “most helpful” by one respondent.

One Ugandan respondent who identified “church” and “African organization” as the most helpful organizations, listed no individuals as “helpful.” However, this respondent noted, “African American professionals could be role models for immigrant students.”

Cross-Cultural Perceptions: African Immigrants and African Americans

There are few relationships with more complexities than that between African Americans and immigrants to the United States. African Americans, immediately after suffering through the legacy of slavery, found themselves competing with or displaced by European and Chinese workers in the U.S. labor market.⁶³

In more modern times, African American organizations like the National Urban League and the NAACP, in concert with African American information technology (IT) professionals, were protesting the expansion of the H1-B non-immigrant visa program as early as 1996. They argued that the private sector’s requests to Congress for foreign engineers and scientists, if only through the temporary H1-B mechanism, intentionally overlooked a qualified pool of African American professionals.⁶⁴

In tracing the history of African American labor patterns, Frank Morris, a former dean of graduate studies at Morgan State University in Baltimore, reduced this history to its simplest, though arguable, economic terms. “Anything, including immigration,” Morris wrote, “which increases the supply of labor in America works

against the interests of African Americans.”⁶⁵ Recent history, however, has shown that the laws of supply and demand have been subject to manipulation by parties with vested interests in the economic disenfranchisement of African Americans. In 1995, an op-ed column in the *San Diego Union-Tribune* cited:

A 1988 study of the Los Angeles hotel industry by the General Accounting Office found that jobs formerly held by African-Americans were now performed mainly by immigrants. This study was not based on some econometric model of questionable assumptions. On the contrary, it was a direct result of the hotel owners’ actions to break up the largely black unions, and replace union workers by immigrant workers. Studies have shown a similar displacement of blacks in the restaurant industry, at airports, and so on. Even the staunchly pro-immigration Urban Institute now concedes that such effects are real.⁶⁶

It is unclear whether African Americans primarily view African or Caribbean immigrants as potential allies in obtaining economic and social parity in America or as labor market competitors. What emerges from anecdotal data is that there have been some successful efforts at collaboration, exemplified, for example, by the San Diego Urban League’s initiative to assist African immigrants with job training, counseling and other services. Yet, these successes are enmeshed in a social landscape still checkered by assumptions, stereotypes and mutual distrust.

Azeb Tadesse, one of SHIRE’s “knowledgeable observers” and a senior assistant director of UCLA’s James S. Coleman African Studies Center, holds the media accountable for fueling initial misperceptions and perpetuating misunderstandings. “The way Africa is portrayed in the media and the way African Americans are portrayed feed into stereotypes.”⁶⁷

In *Hardened Images: The Western Media and the Marginalization of Africa*, the author examines the condescending treatment of the continent during East-West rivalries and the nostalgia of the Western press for the era of European colonialism. “The memos of the *Los Angeles Times* reporters and editors also revealed some of what many scholars pointed out as the other deadly sins that the Western mass media commit in their coverage of Africa: the tendency to look at the entire continent as one undifferentiated mass, and the constant attempt to portray the region through the prism of Eurocentrism.”⁶⁸

African Americans are not immune from being influenced by negative characterizations of Africa, while “many African immigrants, even before they leave home, have adopted stereotypes of black Americans as being only good at sports and music – and crime.”⁶⁹

It doesn't take long for immigrants to realize that if they look black, they'll be treated like a black person, many say. 'That's not a good category to be in, 'Some West Indian families tell their children not to associate with black Americans.' That's why black immigrants, like immigrants of any color, tend to cling to national identities first. They gradually embrace racial identities.⁷⁰

One analysis of 2000 Census data asserts that "Blacks from Africa and the Caribbean tend to be better educated, have higher income and live in more prosperous neighborhoods than African-Americans."⁷¹ However, traditional African American strongholds are adapting to the new and shifting demographic presence of the African immigrant/refugee community – and the political accountability that appears to be ensuing. For one African American city councilman, "The black agenda now must include a push for multilingual education in public schools and multilingual staffing in health care and law enforcement."⁷²

This position was reinforced by several respondents in San Diego who underscored the need for a politically united front involving all persons of African descent. This union would work together to address common issues that confront the Africa diaspora in the United States.

Recommendations

1. **Intensify data collection efforts throughout the strata of entities that touch the lives of African immigrants and refugees.** The U.S. Bureau of the Census should develop the appropriate tools and resources for African immigrants to identify themselves. Collaboration with state and local data resources, including the Office of Statewide Health Planning and Development and the California Department of Health Services, Division of Vital Records and Statistics, should be undertaken to develop a data coding standard for African immigrants and refugees in California.
2. **Conduct additional research on how to address health barriers for African immigrants.** In particular, further research is necessary to determine how to address the needs of sub-groups within the community, such as the young, elderly, homeless, and those affected by mental health disorders.
3. **Utilize the expertise available through credible Community-Based Organizations (CBOs) for assistance in primary research activity.** Researchers should establish ongoing relationships and rely on community-based organizations within the African immigrant community for survey design, data collection and data interpretation.
4. **Increase financial support and mandate continuing staff training on issues of cultural competence for health clinics and hospitals, which often constitute the primary source of health care for immigrant communities.** Provide educational opportunities for American health professionals regarding health-related values, beliefs and practices of various African nations.
5. **Strengthen CBOs serving African immigrants and refugees with technical expertise, training, and financial assistance.** These currently undervalued resources, if strengthened, can produce positive outcomes for African immigrants across a range of objectives.
6. **Expand outreach by community-based entities funded to address disparities within the African immigrant community.** This is particularly true for organizations addressing diabetes, hypertension and HIV/AIDS, three chronic health conditions that were cited as leading health problems within the African immigrant/refugee community.
7. **Develop and fund a Health Care Advocates Initiative for African immigrants.** Provide training and materials to lay health educators who will teach, inform and promote awareness on various health issues in a linguistically and culturally competent manner. These individuals would be trained to address a number of health access issues including: (a) knowledge of federal, state and local programs; (b) familiarity with documents and application procedures; (c) knowledge of specific contacts within agencies, where questions can be answered; distribution of health education information in the specific languages of African immigrants/refugees; and (e) advocacy with health and welfare bureaucracies on behalf of African immigrants and their families.

8. **Design and implement a health professionals educational program for African immigrants/refugees who have medical care training.** This training could be housed within a clinic facility using institutions of higher learning in California. The program could augment culturally competent health care in a setting where health education awareness initiatives could emerge, as well as training of African health professionals for certification and employment in the United States.
9. **Increase patient and consumer health education efforts by utilizing faith institutions, community newspapers and other media outlets respected within African immigrant communities.** The determination of which media are indeed credible messengers will only be accomplished by further research efforts.
10. **Initiate and/or expand English language tutorial programs for African immigrants.** Better mastery of English would reduce their sense of alienation and increase their self-confidence and ability to interact with their children and society at large.
11. **Hold public hearings, along with other steps to promote awareness of African immigrant issues, to engage decision makers – in the public and private sectors – to facilitate the removal of legal, cultural and linguistic barriers to health care, employment, education, transportation, and housing.** Conduct town meetings where SHIRE can report to the community, particularly those stakeholders who participated in the study, on the findings and recommendations. These meetings could be synchronized with the release of SHIRE’s report.
12. **Promote a statewide, regional, and national dialogue among key stakeholders from African American, African and Caribbean immigrant communities regarding shared and distinct cultural, linguistic and health related concerns.** This dialogue will be framed to collectively address specific policy initiatives that address the concerns of these communities.

Afterword

The uniqueness of each immigrant community is manifested in the way it adapts to its new environment. These communities develop distinct characteristics and coping mechanisms, some drawn from their country of origin and others from the synthesis of experiences in their new homeland. Yet, they face common barriers experienced by other groups – speaking different languages and having different customs – that preceded them.

African and Caribbean immigrants have an opportunity to learn from other immigrant groups that have put in place institutions and organizations that provide a sound infrastructure of communal support.

As SHIRE's report demonstrates, the interest, willingness, and need for African and Caribbean groups to speak among themselves, the opportunity to likewise convene forums with Latinos, Asians, Pacific Islanders, and other immigrant groups from sister continents, stands as an exciting opportunity. There is much that can be learned from foreign-born immigrants from other countries. The California Endowment would be a most appropriate sponsor of such a gathering.

A ready audience waits among immigrants of African descent. But there is potential interest among policy makers and stakeholders, advocates for communities of color and organizations and individuals interested in multicultural coalition-building, as well as those who are committed to improve the cultural and linguistic competency of health care delivery.

APPENDIX A

Profile of Immigrants of African Descent in California

Immigrants of African descent represent a small, but heterogeneous, proportion of the foreign-born population of California. Data from the 2000 U.S. Census indicates that of the 8.9 million immigrants residing in the state of California, 183,390 (2%) were from Africa or the Caribbean, compared to 4.9 million (56%) from Latin America, 2.9 million (33%) from Asia and the Pacific Islands, and almost 700,000 from Europe. There are limited data from other sources on foreign-born African Americans in California. The Immigration and Naturalization Service (INS) of the Department of Homeland Security (DHS) estimates that 28,704 immigrated to California between 1998 and 2002, including 3724 classified as refugees or asylees. The California Health Interview Survey (CHIS) estimates that, among the 2 million persons in California who identify as African American, approximately 99,000 are immigrants.

Unlike some of the more populous immigrant groups, very little is known about immigrants of African origin in California, and to date, there has been no population-based survey that has focused on their identification or their clinical or social needs. This report uses data from several sources, including the 2000 Census, CHIS, and DHS to present a profile of immigrants of African origin in California, with a focus on the counties where this group is most prevalent. We will first identify their numbers and locations and then describe the socioeconomic status and linguistic characteristics of the areas where they reside. We view this as a first step in better characterizing this diverse population.

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Methods

Numbers, Location, and Country of Origin.

Our main data source is the 2000 U.S. Census SF3 file (www.census.gov). We conducted two types of analyses to describe persons of African descent. For several analyses, we evaluated African Americans who were either non-citizens or naturalized citizens. Additionally, because this report emphasizes the health and language barriers of black immigrants of African origin in California, we restricted the analyses to individuals from Sub-Saharan Africa and countries of the Caribbean that are not predominantly Spanish-speaking. They are referred to in the report as Sub-Saharan African (SSA) immigrants.

To increase the likelihood that we evaluated black Africans in these analyses, we excluded North Africa and focused on immigrants from four other regions: Eastern, Western, Middle, and Southern Africa. We recognize, however, that whites, Asians, and other racial/ethnic groups may have emigrated from countries of Sub-Saharan Africa.

For the analyses of Caribbean immigrants to California, immigrants from Cuba, Puerto Rico, and the Dominican Republic were excluded from the analyses that assessed Afro-Caribbean immigration because they are predominantly Spanish-speaking countries. Because this restriction results in the exclusion of

some Afro-Latin immigrants from these countries from our analyses of the socioeconomic status of African immigrants, as a sensitivity analysis, we repeated the analyses including persons from these Spanish-speaking countries, and did not find appreciable differences in socioeconomic status. The countries of origin that were included in the analyses are presented in Table 1.

We also used Census data to evaluate historical trends in immigration related to changes in immigration laws. The Immigration Act of 1990 increased the level of legal immigration to the U.S. by approximately 40% through a number of measures, including implemented a “diversity lottery” that allowed for 55,000 immigrants to enhance immigration from traditionally underrepresented countries (INS, 2001 Annual Report). To evaluate the impact of this legislation on immigration of African origin to the U.S., we compare select characteristics of these cohorts before and after 1990.

Table 1. Countries of Origin of Sub-Saharan African and Afro-Caribbean Immigrants to California

Eastern Africa	Western Africa	Middle Africa	Southern Africa	Caribbean
Ethiopia	Cape Verde	Angola	South Africa	Barbados
Kenya	Ghana	Cameroon	Botswana	Haiti
Somalia	Liberia	Zaire	Lesotho	Jamaica
Tanzania	Nigeria		Mozambique	Trinidad and Tobago
Uganda	Senegal		St. Helena	Antigua and Barbuda
Zambia	Sierra Leone		Swaziland	Aruba
Zimbabwe				Bahamas
				Belize
				Dominica
				Grenada
				Montserrat
				Netherland Antilles

The second data source was immigration data from the INS/DHS (Personal Communication, Nancy Rytina, 11/19/2003 and 1/20/2004). These data included information on refugees and asylees to the state of California between 1998 and 2002. Because the DHS do not collect data on the race or ethnicity of immigrants, to approximate black immigrants of African descent, as with the Census data, we restricted the analyses to the countries listed in Table 1.

The third data source was the public use data from CHIS. This is a representative sample of the non-institutionalized population living in households in every county in California (www.chis.ucla.edu) that includes information on immigration status, language, health status, and use of health services. The CHIS 2001 interviews were conducted in six languages – English, Spanish, Chinese, Vietnamese, Korean, and Khmer. Although there are limited data on immigrants of African descent in CHIS, we are able to glean some information on language characteristics and health status among African Americans who classified themselves as naturalized citizens and non-citizens in these data.

Socioeconomic Status and Language Characteristics of Area of Residence.

We describe the socioeconomic status (SES) and language characteristics of the areas of residence of immigrants of African descent in Los Angeles County using 2000 Census data (www.census.gov). Analyses are at the census tract level. The neighborhood socioeconomic status index was calculated as the mean of the standardized values of five characteristics of the census tract of residence (median family income, median housing value, percentage of the population who did not graduate from high school, percentage blue collar worker, and percentage of the population who are unemployed), with equal weight given to each variable (Winkleby, 2003). The SES index is highly correlated with each of the five variables of which it is comprised. We used this composite score because there is evidence to suggest that living in a neighborhood with a low SES index is associated with higher mortality (Winkleby, 2003), higher rates of cardiovascular risk factors (Cubbin, 2001; Lee, 2002), and lower self-rated health (Brown, 2003), even after adjustment for individual income, wealth, or other measures of social position. All analyses were performed using SAS version 8.12.

Language was evaluated using both the 2000 Census and CHIS 2001. Because we were unable to obtain specific data on the languages spoken by immigrants of African origin, we used indirect means of assessing language patterns. We were unable to use census data to obtain stable estimates of rates of “Other language” isolation in the areas with high concentrations of immigrants of African origin. We used CHIS data to evaluate the rates of English use in the households of African Americans who identified themselves as either naturalized citizens or non-citizens.

Results***Numbers, Locations, and Countries of Origin of Immigrants of African Descent***

We identified 102,655 persons in California who claimed Sub-Saharan Africa or the Caribbean as their country of origin on the 2000 U.S. Census – 74.2% from Sub-Saharan Africa and 24.8% from the Caribbean. Table 2 shows the population of foreign-born African Americans in the regions of California where they are most populous as well as in the state as a whole. Los Angeles County, the largest county, with 9.5 million residents, also has the highest numbers of residents who reported being of African origin in the 2000 U.S. Census, and is followed by the Bay Area (comprised of San Francisco, Santa Clara, and Alameda Counties), San Diego County, and Orange County. By contrast, statewide, there are 4.8 million Latino immigrants (over 2 million in Los Angeles County) and 2.5 million Asians and Pacific Islanders (790,000 in Los Angeles County). The majority (58%) of immigrants of African descent in California are not naturalized.

Table 2. Population of African Americans in the Most Populated Counties in California by Place of Birth

County	Total Population	African Americans	U.S. Born African Americans	Foreign-born African Americans: Naturalized	Foreign-born African Americans: Non-Citizen
Los Angeles County	9,519,338	916,907	865,469	16,430	20,781
Bay Area Counties	3,903,059	316,578	299,598	8,052	11,126
San Diego County	2,813,833	153,371	148,734	4,364	7,638
Orange County	2,846,289	44,356	39,427	2,227	5,139
Other Counties	14,789,129	783,078	755,511	11,795	15,103
Total: California	33,871,648	2,219,190	2,108,739	43,583	59,072

The proportion of immigrants of African origin from each of these regions is presented for the largest counties in Figure 1. There is substantial variation in the percentage of the total African American population represented by immigrants of African descent. Throughout the state, 4.6% of all blacks are foreign-born. African immigrants comprise 4% of the African American population in Los Angeles County, 6.1% in the Bay Area Counties, 7.8% in San Diego County, 16.6% in Orange County, and 3.4% in other California counties. The larger percentage of representation of foreign-born African Americans in Orange County, relative to other counties, is accounted for by the relatively small number of African Americans in the county.

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Figure 1. Sub-Saharan African (SSA) and Afro-Caribbean (AC) Immigrants in California by Region

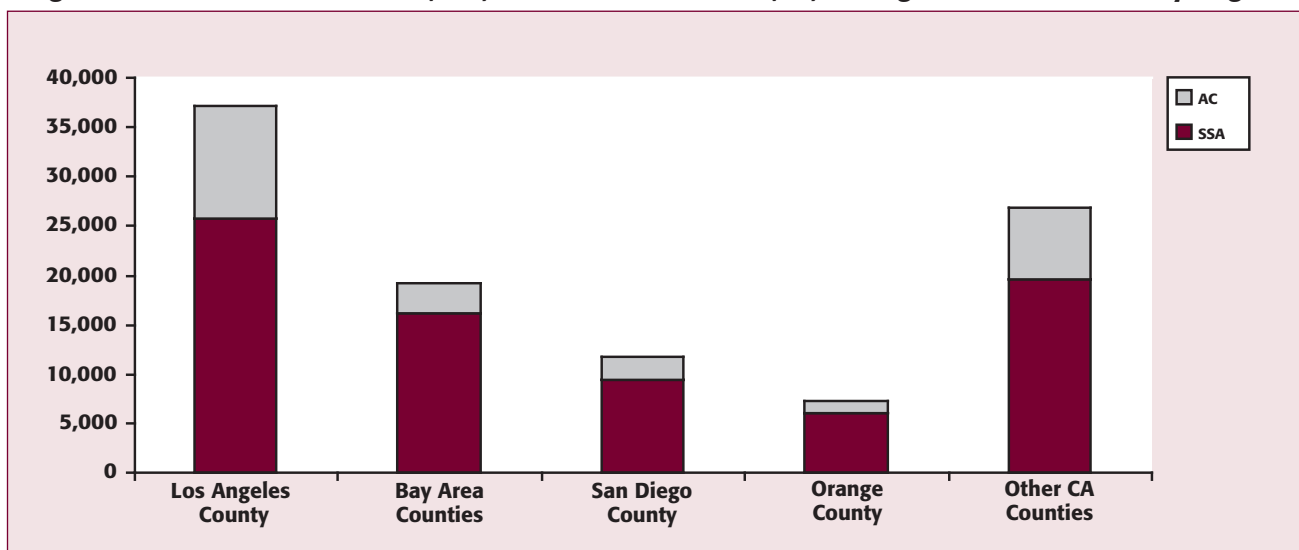


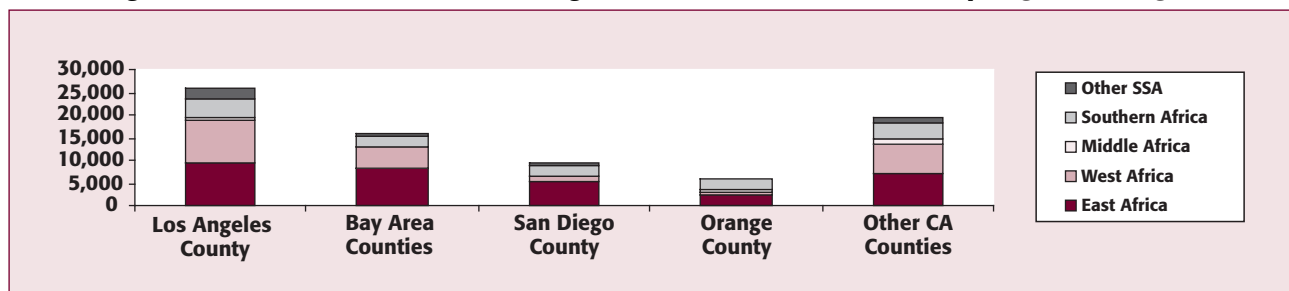
Table 3 shows the region of origin of foreign-born immigrants to California, comparing African to Caribbean immigrants. There is variation in region of origin by county. The highest concentration of Caribbean immigrants relative to immigrants from Sub-Saharan Africa is in Los Angeles County.

Table 3. Foreign-born African Americans from Africa and the Caribbean in the Most Populated Counties in California

	Foreign-born African Americans		
	Total	From Africa	From Caribbean
Los Angeles County	37,211	25,829 (69%)	11,382 (31%)
Bay Area Counties	19,178	16,111 (84%)	3,067 (16%)
San Diego County	12,002	9,623 (80%)	2,379 (20%)
Orange County	7,366	6,098 (83%)	1,268 (17%)
Others	26,898	19,493 (72%)	7,405 (27%)
Total: California	102,655	77,154 (75%)	25,501 (24%)

Figure 2 shows the population of Sub-Saharan African immigrants to California by region of origin.

Figure 2. Sub-Saharan African Immigrants in California Counties by Region of Origin*



* Eastern Africa includes: Ethiopia, Kenya, Somalia, Tanzania, Uganda, Zambia, Zimbabwe;
 Western Africa includes: Cape Verde, Ghana, Liberia, Nigeria, Senegal, Sierra Leone;
 Middle Africa includes: Angola, Cameroon, Zaire;
 Southern Africa includes: South Africa, Botswana, Lesotho, Mozambique, St. Helena, Swaziland.
 Caribbean includes: Jamaica, Trinidad & Tobago, Haiti, Barbados, Antigua and Barbuda, Aruba, Bahamas, Barbados, Belize, Dominica, Grenada, Montserrat, Netherlands Antilles. Cuba is excluded.

Tables 3a and 3b show the country/region of origin of African immigrants to California. The majority of SSA immigrants are from South Africa, Nigeria, and Ethiopia.

Table 3a. Foreign-born from Africa by Country of Origin - Eastern and Western Africa

County	Eastern Africa			Western Africa				
	Total	Ethiopia	Other Eastern Africa	Total	Ghana	Nigeria	Sierra Leone	Other Western Africa
Los Angeles	9,424	4,501	4,923	9,359	1,336	6,682	389	952
Bay Area	8,197	3,891	4,306	4,505	459	2,678	482	886
San Diego	5,383	1,289	4,094	911	67	514	14	316
Orange	2,479	506	1,973	692	140	340	82	130
Others	7,039	1,631	5,408	6,564	1,101	3,725	337	1,401
Total: California	32,522	11,818	20,704	22,031	3,103	13,939	1,304	3,685

Table 3b. Foreign-born from Africa by Country of Origin - Middle and Southern Africa

County	Middle Africa	Southern Africa			Others: Africa
	Total	Total	South Africa	Other Southern Africa	Africa: Others
Los Angeles	806	4,190	4,171	19	2,050
Bay Area	525	2,306	2,273	33	1,119
San Diego	261	2,437	2,437	0	631
Orange	134	2,353	2,301	52	440
Others	837	3,270	3,177	93	1,242
Total: California	2,563	14,556	14,359	197	5,482

Table 4 shows the proportion of immigrants from Caribbean by countries. In order of representation in California are immigrants from Cuba, Jamaica, Trinidad and Tobago, the Dominican Republic, Haiti, and Barbados. There is, however, some variation in these frequencies by county, particularly for persons from the Dominican Republic, Haiti, and Barbados.

Table 4. Foreign-born from the Caribbean by Country of Origin in the Most Populated Counties in California

County	Jamaica	Trinidad and Tobago	Haiti	Barbados	Other Caribbean*
Los Angeles	5,856	2,329	1,198	325	1,674
Bay Area	1,265	873	312	147	470
San Diego	920	546	292	118	503
Orange	492	345	147	27	257
Others	3,136	1,661	1,057	291	1,260
Total: California	11,669	5,754	3,006	908	4,164

* Other Caribbean includes Antigua and Barbuda, Aruba, Bahamas, Barbados, Belize, Dominica, Grenada, Montserrat, Netherlands Antilles. Cuba and the Dominican Republic are excluded.

Historical Trends – Foreign-Born by Year of Entry

Table 4a shows the numbers of Foreign-born African Americans by year they report entering the U.S. Among foreign-born African American residents of California, 21.7% report immigrating to the U.S. before 1980, 34.4% in the 1980s, and 43.9% in the 1990s. The 1990 visa lottery may have contributed to the high numbers who report entering the U.S. between 1990 and 2000.

Table 4a. Foreign-Born by Year of Entry

	Foreign-born AA (Year of Entry Before 1980)	Foreign-born AA (Year of Entry 1980-1989)	Foreign-born AA (Year of Entry 1990 to March, 2000)
Los Angeles County	8,196	12,679	16,336
Bay Area Counties	4,061	6,698	8,419
San Diego County	2,538	4,195	5,269
Orange County	1,657	2,475	3,233
Other Counties	5,758	9,331	11,808
Total: California	22,263	35,326	45,065

Immigration, Refugees, and Asylees

Between 1998 and 2002, there were 28,704 legal immigrants from the countries identified in Table 1. The numbers of immigrants to the largest counties over this time period are presented in Table 5, and rates of asylum seekers and refugees are presented in Table 6.

Table 5. Documented Immigrants to California from SSA* or AC Countries 1998-2002*****

Area	1998	1999	2000	2001	2002	1998-2002
Los Angeles County	1,255	1,029	1,214	1,616	1,679	6,793
Bay Area Counties	739	670	697	872	895	3,873
San Diego County	425	194	352	398	601	1,970
Orange County	203	180	302	375	349	1,375
Total: California	5,100	4,478	5,402	6,611	7,113	28,704

* Sub-Saharan Africa as identified in Table 1

** Afro Caribbean Countries as identified in Table 1 (Note: excludes immigrants from Cuba, Puerto Rico, and the Dominican Republic)

*** Source: Data from the Department of Homeland Security, personal communication from Nancy Rytina

Table 6. Documented Refugees and Asylees to California from SSA* or AC Countries 1998-2002*****

Area	1998	1999	2000	2001	2002	1998-2002
Los Angeles County	58	30	19	116	88	311
Bay Area Counties	85	61	58	56	163	423
San Diego County	235	49	136	99	250	769
Orange County	72	9	12	3	26	22
Total: California	704	485	589	750	1,196	3,724

* Sub-Saharan Africa as identified in Table 1

** Afro Caribbean Countries as identified in Table 1 (Note: excludes immigrants from Cuba, Puerto Rico, and the Dominican Republic)

*** Source: Data from the Department of Homeland Security, personal communication from Nancy Rytina

Country of origin varied for refugees/asylum seekers by county, however, among the most commonly represented countries were Ethiopia, Eritrea, Nigeria, Somalia, Kenya and Liberia.

SES and Language Characteristics of the Areas of Residence of Immigrants of African Origin in Los Angeles County

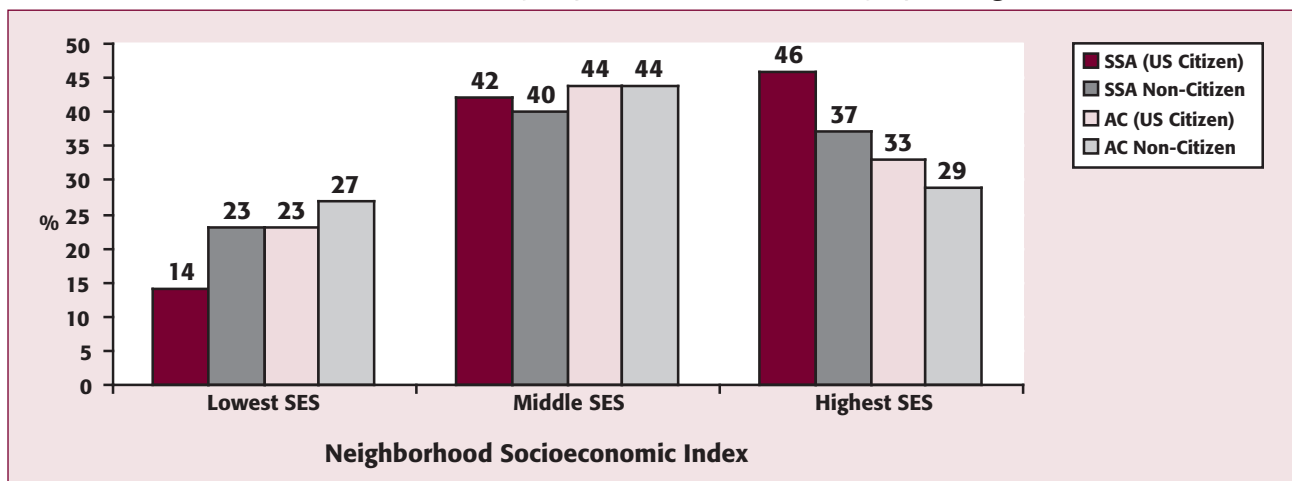
We describe the SES and language characteristics of the areas of residence of immigrants of African descent in Los Angeles County using 2000 Census data (www.census.gov). Analyses are at the census tract level. (It was determined that the data for San Diego was not as comprehensive and that any comparable analysis would have demanded more time and resources than were available for this preliminary study).

The SES of communities or neighborhoods is strongly associated with characteristics such as availability and accessibility of health services, inadequate infrastructure, prevailing attitudes toward health, stress, social support, and environmental conditions, all of which may influence general health outcomes (Diez-Roux, 1998; Pickett, 2001; Yen, 1999).

Immigrants from Sub-Saharan Africa were slightly more likely than Afro-Caribbean immigrants to reside in neighborhoods with higher socioeconomic status (Figure 3). Immigrants of African descent were much less likely than Latino immigrants to reside in low SES neighborhoods, but had patterns of residential SES that were comparable to Asian/Pacific Islander immigrants in Los Angeles County (Figure 4). Comparison with non-immigrant African Americans suggest that Sub-Saharan African and Afro-Caribbean immigrants are more likely to reside in areas of higher socioeconomic status. For both Sub-Saharan African and Afro-Caribbean immigrants, non-citizens resided in lower SES areas than naturalized citizens.

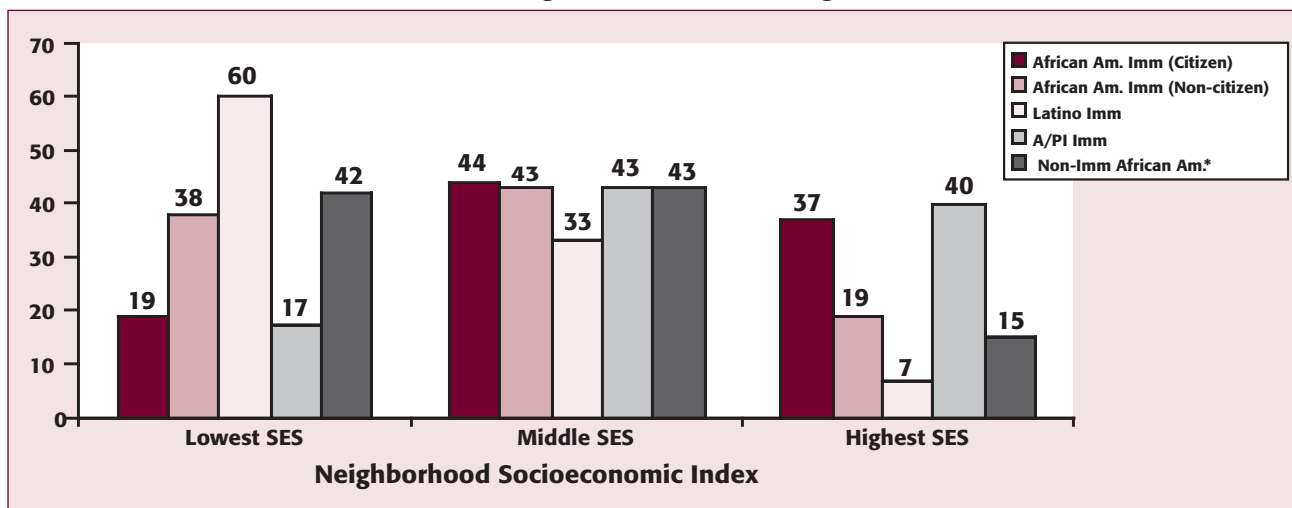
40

Figure 3. Socioeconomic Index* of the Neighborhoods of Residence of Sub-Saharan African (SSA) and Afro-Caribbean (AC) Immigrants



* Neighborhood socioeconomic index is an unweighted average of median family income, median housing value, percentage of the population who did not graduate from high school, percentage blue collar worker, and percentage of the population who are unemployed, measured at the census tract of residence: (Winkleby, 2003).

Figure 4. Socioeconomic Index of the Neighborhoods of Residence of African, Latino, and API Immigrants and Non-Immigrant African Americans*



* Non-Immigrant African Americans is used here and throughout the Appendix to describe what has come to be thought of as the traditional African American community. Legally, children born in the United States to African immigrant parents are also non-immigrant African Americans, but this is not the population referenced in the data presented here.

The percent of foreign-born residents who live below the poverty line is illustrated in Figures 5 and 6. Sub-Saharan African and Afro-Caribbean immigrants have comparable rates of living in neighborhoods at each level of poverty, and similar rates to Asian/Pacific Islander immigrants and non-immigrant African Americans. All the comparison groups had substantially lower rates of living in neighborhoods of the highest levels of poverty than Latino immigrants. Naturalized citizens were less likely to reside in poverty areas than non-citizen Sub-Saharan African and Afro-Caribbean immigrants.

Figure 5. Sub-Saharan African and Afro-Caribbean Immigrants by the Rates of Foreign-born Citizens Living in Poverty

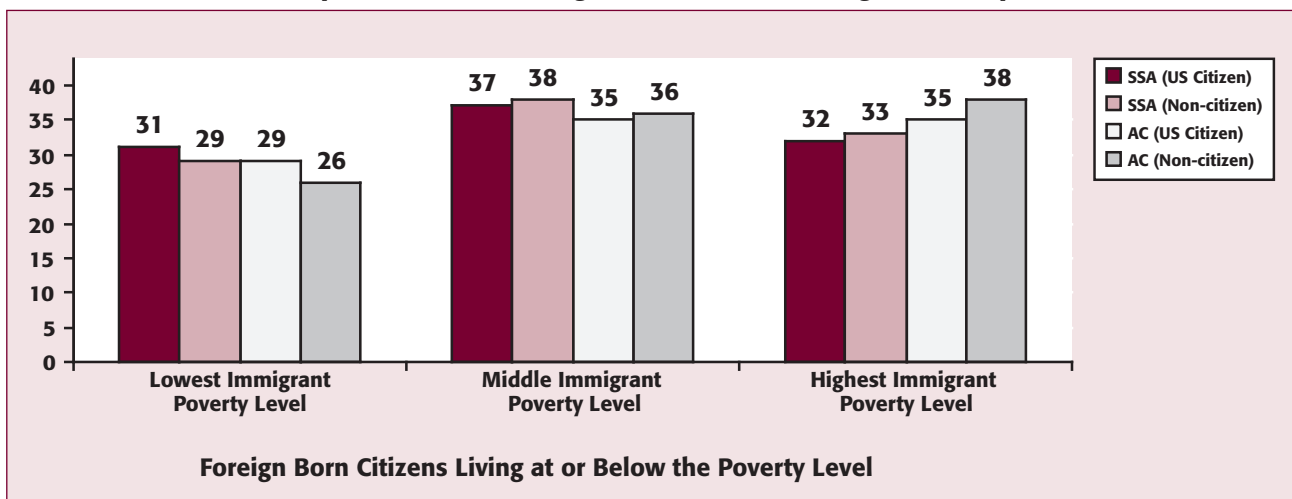
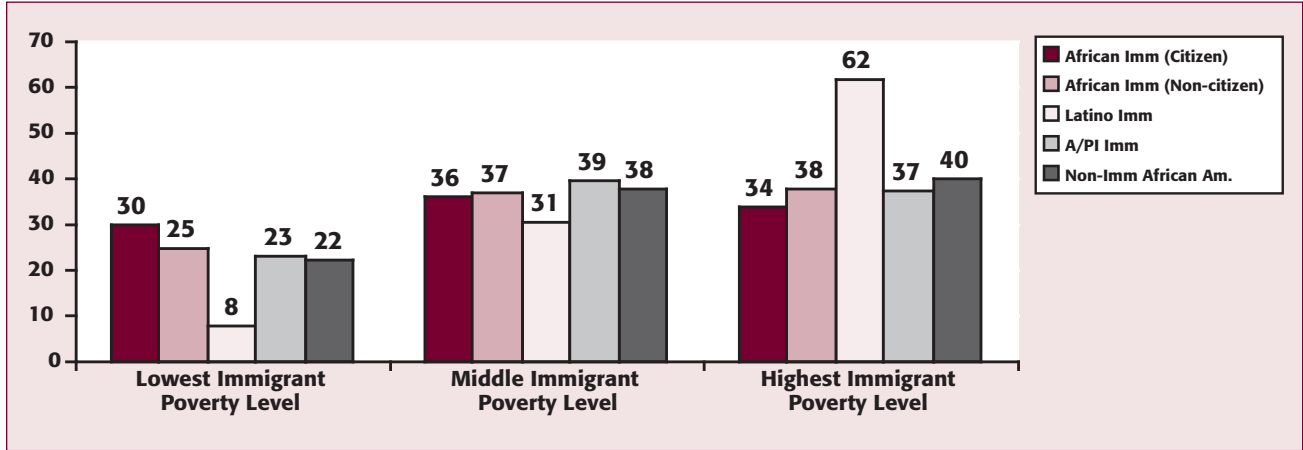


Figure 6. African, Latino, and A/PI Immigrants and Non-Immigrant African Americans by Rates of Foreign-born Citizens Living in Poverty



CHIS 2001 suggests that there are slightly lower rates of poverty among immigrant African Americans. While 78% of native born African Americans are at or above the poverty level, 86% of non-citizen immigrant African Americans and 94% of naturalized African American citizens are above the poverty level. These numbers should be interpreted with caution, however, because they do not take into account factors such as age and sex that may influence poverty levels.

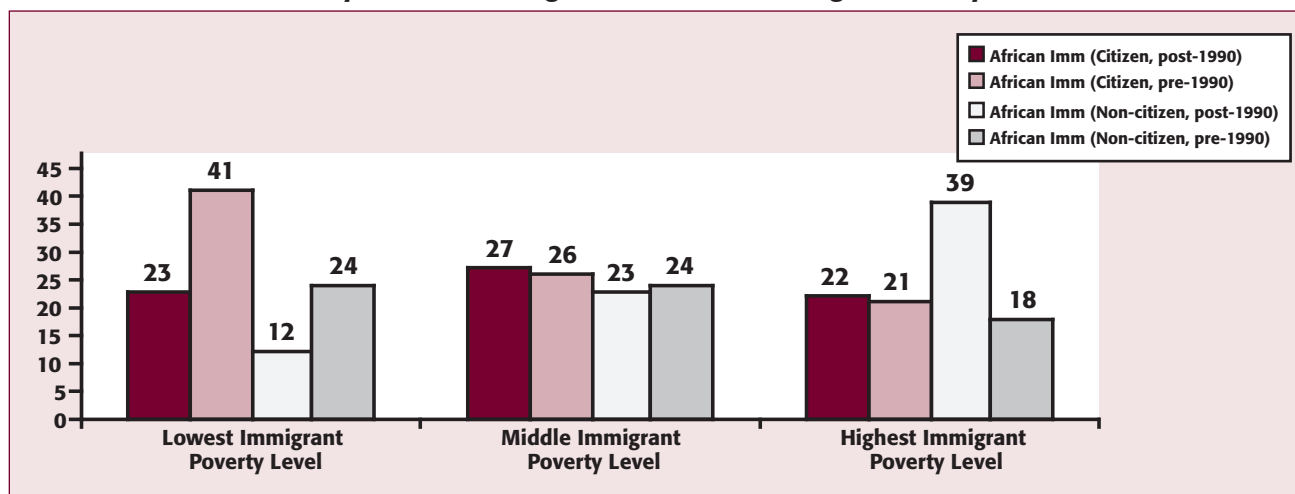
42

Because CHIS was not conducted in any African languages, we cannot use these data to assess rates of English fluency among the respondents. However, the existing data suggest high rates of use of languages other than English in the households of the immigrant African Americans in the survey. Among the African Americans in CHIS, 92% of U.S.-born citizens reported speaking English at home, compared to 42% of the naturalized U.S. citizens and 54% of the non-citizens. Additionally, 32% of naturalized citizens and 19.5% of non-citizens reported using English and one other language (excluding Spanish, another European language, or an Asian language) at home, compared to only 1.6% of the U.S.-born African American citizens.

Historical Trends – Area of Residence and Language Isolation of African Immigrants

Figure 7 shows the area of residence of immigrants of African descent in California. Not surprisingly, naturalized citizens who immigrated prior to 1990 have the lowest rates of residing in poverty areas, and the highest rates of poverty area residence are among non-citizens who immigrated after 1990. Similar patterns are seen for linguistic isolation.

Figure 7. African American Immigrants (Pre- & Post 1990) by Rates of Foreign-born Citizens Living in Poverty



Conclusions

- Immigrants of African origin have SES that is comparable on many measures to Asian/Pacific Islander groups and have comparable or better SES than U.S.-born African Americans, and generally better SES than immigrant Latinos.
- SES data, while providing a useful framework for analysis, may not convey a totally accurate portrait of a community's real economic status. This is more likely true in cases of population subsets – refugees, for example. Therefore, SES data should be evaluated cautiously.

Limitations of the Analyses

- Census tract level data were used, thus we were unable to evaluate the socioeconomic and language characteristics of individual immigrants of African descent or of the groups to which they were compared.
- The census reports on individuals and households who have immigrated to the U.S.; however information on some important groups may not be captured and may lead to an underestimate of the numbers of immigrants of African descent in California. Among these groups at risk for being undercounted are undocumented immigrants and second generation immigrants who were born in the U.S. but still have strong cultural or other ties to countries in Sub-Saharan Africa or the Caribbean.

Future Efforts

- The heterogeneity of their countries of origin suggests that Sub-Saharan African and Afro-Caribbean immigrants, similar to different groups of Asian/Pacific Islander immigrants may have substantially different language and health care needs. In order to better identify the needs and focus efforts to improve care for these populations, further work is needed to identify immigrants of African origin, where they receive health care, the quality of that care, and whether there are language barriers to the receipt of health care.
- An assessment of immigrants of African origin in California is needed to evaluate the varied groups in the state, where they reside, and their health care and health status.
- Further work is needed to determine whether patterns observed in these ecologic analyses are consistent with individual-level effects. Additionally, further information on individual level characteristics may play an important role in evaluating the relative influence of individual SES, neighborhood SES, and other individual and health care system factors in influencing health outcomes for these populations.

APPENDIX A

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APPENDIX B-1

Knowledgeable Observers/Centers of Influence Los Angeles

Countries of Origin:

Democratic Republic of the Congo
Ethiopia
Ghana
Haiti
Kenya

Nigeria
South Africa
Trinidad and Tobago
Uganda
United States

Individuals:

Adutwum, Yaw O.
Aiyaniol, Abraham
Akosah, Vincent
Asem, David
Chizobam, Ani
Daniel, Chancelor
Devine-Kyerematen, Elizabeth
Dymally, Mervyn
Eubuho, Solomon
Ivie, Sylvia Drew
Jimoh, Wale A.
Kauai, Joseph
Kyerematen, Samuel
Mitchell, Susan

Mukenge, Muadi
Munongo, Kalenga P.
Nibo, Jude C.
Nnabuaku, Green
Odume, Augustine
Olagunju, Joshua
Orlale, Maureen
Phama, Nonkhukumo
Tadesse, Azeb
Tesfai, Nikk
Tesfaye, Martha
Teklehaimanot, Senait
Walusimbi, Abbey

Organizations:

African Community Center
African Federation
California State Assembly
Charles R. Drew University
Citadel Church
Congoese Association
Entelechy, Inc.
Ghana Association
James Coleman International Center, UCLA
Los Angeles County Department of Health Services

Nigerian Mutual Aid Group
Nigerian Social Club
South African Consulate
T.H.E. Clinic
Vital International, Inc.

APPENDIX B-2**Knowledgeable Observers/Centers of Influence
San Diego****Countries of Origin:**

Cameroon	Nigeria
Eritrea	Somalia
Ethiopia	Sudan
Ghana	Uganda
Kenya	United States

Individuals:

Abdi, Ramo
 Abraha, Yebio
 Adams-Simms, Denise
 Antallo, Abebe
 Farah, Abdisalam
 Gatkuoth, Jacob
 Hissen, Elizabeth
 Lam, Walter
 Maani, Mohammed
 McWilson, Jimma
 Mohamed, Abdul Kadir
 Ossavou, George
 Raage, Halimo
 Tuany, Dep

Organizations:

African Immigrants Youth & Family Resource Center
 Alliance for African Assistance
 Eritrean Community Services
 Ethiopian Community Service
 International Refugee Girls Association
 Mid-City Community Project
 National Organization for Somali Benadiri
 Nile Sisters Development Initiative
 San Diego African Youth Soccer League
 San Diego Urban League
 Somali Community of San Diego
 Southern Sudan Christian Youth & Community Organization
 Southern Sudanese Community Center

APPENDIX C

SAMPLE QUESTIONS FROM FOCUS GROUP SESSIONS

- How would you describe the overall health status of the clients your organization serves?
- How much do your clients trust their doctor or health care provider to offer them high quality medical care?
- Is language a barrier to getting better health care for African and/or Caribbean immigrants?
- Has there been a change in the type of immigrants coming to the United States in the last 5 to 10 years, and do you anticipate any other changes in the future?
- What would you recommend be done to improve the health of members of the African and/or Caribbean communities, besides having additional funding and resources?

APPENDIX D**African/Caribbean Immigrant Presence in the United States**

African and Caribbean Countries Ranking Within Top 15 Countries of Origin for Foreign-born Residents for 50 States in Year 2000: Data Extract for SHIRE Study Populations⁷⁵

	Number of Individuals	Rank
Alabama		
Nigeria	1,426	13
Kenya	1,048	15
Alaska		
Haiti	578	12
Connecticut		
Jamaica	28,757	2
Delaware		
Haiti	1,368	9
District of Columbia		
Jamaica	2,409	4
Ethiopia	2,273	6
Nigeria	1,815	8
Trinidad and Tobago	1,330	14
Florida		
Haiti	166,778	3
Jamaica	127,591	5
Georgia		
Jamaica	11,845	11
Nigeria	6,482	15
Idaho		
Sudan	1,136	10
Louisiana		
Nigeria	1,880	14
Maine		
South Africa	679	11

	Number of Individuals	Rank
Maryland		
Jamaica	20,804	7
Nigeria	14,528	12
Trinidad and Tobago	12,466	13
Massachusetts		
Haiti	33,640	7
Minnesota		
Somalia	7,995	11
Nigeria	5,523	13
Ethiopia	4,435	15
Missouri		
Haiti	2,206	15
New York		
Jamaica	214,973	4
Haiti	123,737	9
Trinidad	97,073	13
North Dakota		
Somalia	1,268	2
Pennsylvania		
Jamaica	10,036	13
Rhode Island		
Haiti	2,138	15
South Dakota		
Ethiopia	2,806	1
Sudan	467	11
Tennessee		
Haiti	3,367	13
Texas		
Nigeria	22,241	13
Wyoming		
South Africa	372	8

Total Number of Individuals: 937,470

States Reporting None: 29

Arizona	Nebraska	Washington
Arkansas	Nevada	West Virginia
California	New Hampshire	Wisconsin
Colorado	New Jersey	
Hawaii	New Mexico	
Illinois	Ohio	
Indiana	Oklahoma	
Iowa	Oregon	
Kansas	Rhode Island	
Kentucky	South Carolina	
Michigan	Utah	
Mississippi	Vermont	
Montana	Virginia	

APPENDIX E

Resource Bibliography of Culturally Competent Care

Compiled by Jacquelyn Coughlan, Associate Librarian
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<http://www.sunyit.edu/library/htmlculturalmed/foreign/>

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Endnotes

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