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Abstract

Background

African immigrants and refugees experience unique mental and physical health care needs that may be a result of pre-migration history and the acculturation process. The purpose of this project was to collaborate with African immigrant and refugee communities to identify health needs of the communities and lay a foundation for future action.

Methods

Key-informant interviews with five West, East and Central African immigrant and refugee communities included community leaders (n=10) and listening sessions with larger groups of community members totaling approximately 150 participants to identify health care needs. Content analysis was employed to identify themes related to immigrant and refugee health.

Results

Meetings with community leaders and members were conducted at community venues often immediately following or during a planned event. Six general themes emerged: mental health/trauma; sexual health; nutrition; chronic disease prevention; insurance coverage; and youth empowerment.

Discussion

Chronic mental and physical health issues were of primary concern. One key lesson learned in building successful partnerships was having members of the research team who were born into partnering African immigrant and refugee communities and were passionate about working with their communities.

Keywords

Africa Immigrant, Mental Health, Physical Health, Community-Based Research

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ABSTRACT

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INTRODUCTION

The influx of sub-Saharan African (SSA) immigrants and refugees to the United States has been steadily increasing over the past several decades. By 2015 there were over 1.7 million SSA immigrants in the US (Derose, Escarce, & Lurie 2007). The majority arrive through sponsorship by family members, refugee status or through diversity visas (Caps, McCabe, & Fix, 2012). SSA immigrants and refugees face a variety of challenges including discrimination and perceived stigma (Dhalimi, Wright, Yamin, Jamil, & Arnetz, 2018; Othieno, 2007; Mehta et al., 2018) challenges accessing health care and social services (Zong & Batalova, 2017), and communication barriers for those who arrive in the US without English language proficiency (Read et al., 2005). Assimilating and acclimating to life in their new country can be compounded by challenges negotiating housing, employment opportunities, health care, social networks, and cultural norms (Perreira, Chapman, & Stein, 2006) which are often starkly different from their native countries.

St. Louis has seen a large increase of immigrants and refugees with many fleeing war-torn countries (Hume, 2015). It is estimated that over 125,000 immigrants live in the St. Louis area (Simeone-Casas, 2016). Sub Saharan African immigrants and refugees relocating to greater St. Louis include but are not limited to newcomers from Congo, Liberia, Nigeria and Sierra Leone. There is limited information on the needs, challenges and barriers regarding the health and well-being of African immigrants in the greater metropolitan St. Louis area. Our project sought to fill this knowledge gap by collaborating with African immigrant and refugee communities to identify their health needs and lay a foundation for future action.

METHODS

We used community-based participatory research (CBPR) methods to conduct a formative qualitative assessment of the needs of African immigrants and refugees residing in the greater metropolitan St. Louis area.

CBPR is a methodology that falls under action research and emphasizes joining with the community as equal partners in every aspect of the research process (National Institute of Minority Health & Health Disparities, 2018). It is collaborative and recognizes the strengths of all partners and ensures that the interventions developed meet the needs of the community. CBPR principles were honored in this project by 1) including community members on the research team and allowing the community to tell the research team how they defined their community and identity, 2) Honoring community knowledge and culture by participating in community events and activities, 3) Conducting all research processes in community venues, decided upon by the community, and 4) working with community members to identify the best ways to keep the community informed about all research processes and results. (Smith et al., 2015)

In this project, the partnership building process was key in the CBPR approach and the first step. Partnership building began with engaging community partners in a research project by reaching out to African Immigrant and Refugee community leaders. Our St. Louis University (SLU) team was composed of both graduate student and faculty researchers. Notably, several student members of the SLU team were also members of and raised in our local refugee and immigrant partnering communities. Utilizing these existing relationships engendered trust and improved participation from the communities, namely Ogoni and Liberian communities. For other communities, the research team utilized personal connections and engagement with community service organizations to begin the partnership building process. Once community leaders were

identified, we conducted key informant interviews and worked with them to identify a time and place to conduct listening sessions to understand the health needs of the community to work collaboratively to develop a pathway forward. Community leaders chose who from their community would attend the initial meetings.

Data Collection

Data collection was completed in two phases from January 2018-May 2019. In phase one key informant interviews (KII) were conducted with community leaders to 1) Identify the best way to communicate with and engage their community members and 2) to develop a deeper understanding of the community before engaging community members. In phase two following the KIIs, we worked with the community leaders to assemble the larger community for listening sessions and discussions about their perspectives on community health and social issues.

Key Informant Interviews

Over a six-month period, we conducted semi-structured key informant interviews (n= 10) with community leaders representing five communities and listening sessions with other groups in the community. Two community leaders from each of the five communities participated in one-on-one interviews with the research team. The interviews were audio recorded and field notes taken by the researchers during the sessions. Interviews lasted for 30 minutes to an hour. The interview locations were selected by participants.

Listening Sessions

After the key informant interviews, we held five community listening sessions with 8-25 members in each session. Listening sessions are a qualitative research method that brings together people from diverse groups into a shared space where study participants are allowed to share their views openly (Erves et al., 2017). Typically, these sessions are facilitated by community members themselves making it a more community-centric approach to CBPR. Community leaders recruited participants for the listening sessions. Listening sessions were held in community venues following regularly held events such as religious services or community meetings. Our listening sessions were informal meetings held in community selected gathering spaces and usually included a mix of men and women between ages 25-75. The exceptions were the Ogoni and the Congolese ethnic groups where in the former group we met with the women and men separately, and in the latter, we met with only the men's group. Participants provided written informed consent. This research was approved by the Institutional Review Board of the lead authors institution. No incentives were given for this study. Graduate student researchers who spoke the local languages were trained in qualitative research methods and assisted with the interviews and data collection. Questions for KII and listening sessions can be found in the appendix.

Analysis

All interviews were audio recorded. Interviews were transcribed verbatim by two or three members of the research team. Transcribed interviews were cross-checked with the audio recordings to ensure correctness. Data were analyzed by three members of the research team via an inductive qualitative content analytical inductive This method was used to allow meaning in the participants words to emerge from the data (Creswell and Creswell, 2017). First, each member read and line-by-line coded two or three interviews independently and then met to agree on a coding scheme and emerging themes. Any disagreement on codes on were discussed and agreement achieved. Afterwards, two members coded responses into emerging themes. The third team member served as a corroborator. Field notes were taken during all interviews. Field notes

were used to provide contextual information. Health and well-being concerns and interests were assessed between and within each community.

RESULTS

Participants

Participants included persons from the Congo, Kran and Grebo tribes from Liberia, the Ogoni tribe from Niger Delta of Nigeria, Kenya, and Sierra Leone. Congolese participants spoke English, French, Lingala and Swahili. Kenyan participants spoke Swahili and English. Liberia, Nigeria and Sierra Leone are Anglophone countries and participants from those countries spoke English. The average years lived in the US for over 80% of the study's participants were 10 years.

Community leaders who completed Key Informant Interviews (KI)

There was a total of two community leaders from the Liberian Community, two from the Ogoni Community, two from the Congolese community, two from the Sierra Leonian Community and two from the Kenyan Community (n =10). Each community leader had a high school diploma or higher. The community leaders were all men, however women's group leaders who managed an all-woman subset of the larger community organization (n=5) participated in the key informant interviews. For some of the communities (Liberian, Sierra Leonean, Kenyan), these women were interviewed alongside the men, and for others (the Ogoni, Congolese), the women were interviewed separately.

Community Members who participated in Listening Sessions

The listening sessions were open to the larger community and participants included community leaders (n =10) for a total number of participants (N=150). There was a total of five participants from Liberia, thirty from Sierra Leone, fifteen from the Ogoni tribe of Nigeria, forty from Kenya, and sixty from Congo. Participants who were not community leaders, had a mix of formal education (high school diploma and higher) or informal education (trade training).

Community Leader Key Informant Interview Feedback

Meeting Location Preferences. Most meetings took place during or after scheduled community events or religious services at community members' homes, at regularly used meeting spaces and places of worship.

Community Membership. Community leaders unanimously defined their communities as those coming from their homeland despite some communities being geographically dispersed around the city.

Collaboration and Partnership Preferences. Several communities agreed that partnering with other communities for future health sessions would be beneficial. The Sierra Leonean and Liberian communities have a history of partnering on multiple activities due to cultural connections in Africa and the US. The Ogoni community requested meetings with male leaders and the women's leadership group separately. Community leaders believe that the listening session as an opportunity to invite and unite ethnic groups among the community in cases where collaborations and between-ethnic group unity was currently challenged.

Acceptable and Taboo Topics. Non-communicable diseases such as diabetes and hypertension and access to care were high priority topics across communities. The Sierra Leonean, Kenyan, Liberian, and Congolese leaders expressed concerns about mental health among youth and families.

Cultural Practices and Community Preferences. Leaders did not express concern regarding cultural practices that the research team needed to keep in mind or adhere to when it came to engaging their communities. However, community leaders wanted to make sure that their communities would not be merely 'research subjects' and wanted to be sure of our motives.

Community leaders thought it would be best to hold listening session when the weather was favorable (e.g., no extreme cold or snow) to get maximum attendance. Community leaders worked with their communities to identify appropriate dates for listening sessions and the research team worked around those dates.

Themes from Community Listening Sessions

Five major themes emerged: 1) diabetes (DM) and hypertension (HTN) prevention and management, 2) mental health awareness and access 3) diet and nutrition education 4) youth sexual health education 5) access to health insurance. Table 1 illustrates participant quotes related to these themes.

Diabetes and Hypertension Prevention and Management. All groups were concerned about the perceived increase in diabetes and hypertension among their community members. All communities requested information sessions on how to prevent DM/HTN, how to recognize the signs and how to manage the disease (e.g., diet) if diagnosed. Participants thought that a future blood sugar/hemoglobin A1c and blood pressure screening would be helpful. However, gender differences emerged in the Ogoni community where the men thought that screening would be an invasion of privacy and the women thought it was necessary for community members to be aware of the DM/HTN status.

Mental Health Awareness and Access. Community members indicated that having a mental health provider available to talk at health fairs would be beneficial. Notably, there were conflicting views on mental health needs and the value of increased awareness and screening. The Kenyan and Sierra Leonean's identified this as a need within their community and were open to receiving mental health awareness training. Gender differences emerged between the Ogoni men and women. The Ogoni (men) felt that this was not a need and were strongly opposed to such trainings. The Ogoni women stated that this was a need especially for their youth. There was consensus among all community's that mental health services, especially for youth, was as a major health need. A request was made for a list of mental health resources or related contacts, to ensure privacy among the community members. Among the Ogoni community, men stated this was not a health need in their community while the women felt strongly that it was, which highlighted conflicting views on perceived need for mental health interventions among the community's youth. All communities expressed the need for a creative support system in the community to raise awareness of mental health issues. Several communities reported youth suicides and youth anxiety and depression related to acculturation and living between two worlds (traditional African parents and community and US schools and peers). The Sierra Leonean community especially cited the stresses of assimilating into a new culture and a desire to fit in as potential contributing factors to youth disengagement in the classroom and at home, and engagement in crime. They expressed a need for education on coping with the stress of assimilating and thriving in an environment where crime rates and youth engagement in crime are high. The Sierra Leonean and Liberian (Kran) communities expressed the need for community engagement of the youth to deter participation in crime and potential gun-related violence.

Diet and Nutrition Education. Men from the Ogoni community stated a need for education on portion control, and healthy modifications to traditional meals. The Ogoni women were more concerned with the quality of food in America and the ways it differs from what they are used to back home. Additionally, there were concerns about access to quality produce and what they should be purchasing. The Liberian (Kran and Grebo Tribes), Kenyan, and Sierra Leonean communities both expressed a need for training on portion control and methods for incorporating healthier options into the daily diet especially for diabetic community members. Among the Congolese a primary concern was the need for knowledge on healthy American food options to feed their families. All groups wanted to preserve their traditional foods and methods of preparation and sought knowledge on how they would adapt their traditional diets to make them healthier. The Sierra Leoneans for example, highlighted that fufu is a staple cultural meal in their homes, therefore removing it completely from their diet would be difficult. However, they were receptive to learning more about portion control.

Sexual Neath. Among both the Kran and Grebo Liberian communities, sex education was mentioned at both meetings, however the Kran leaders thought it would be better to separate education session by gender. This was also a health need expressed by the Sierra Leonean community. The French-speaking Congolese explicitly expressed a need for accessing women's health services. All other communities did not identify this as a health need for their youth. The Liberians and Sierra Leoneans were interested in pregnancy prevention due to a number of teenage pregnancies in their community in the recent years.

Access to Health Insurance. Communities unanimously expressed a need for information on options for accessing health insurance coverage and general health care. This was of particular concern among the newly immigrated Lingala speaking Congolese. Members expressed that they did not understand how to obtain coverage and how to interpret what services were covered by their insurance plans once they obtained coverage. Additionally, all communities requested information on ways to access affordable healthcare without insurance especially for dental and optical care. Community members were concerned about health insurance for individuals who were un- or under-employed.

Conflicting Opinions. Several communities were conflicted about their health needs and the required resources to address these needs. For instance, the Ogoni men and women differed in their perceptions of urgent community health needs. Results from the men and women's sessions showed that the two groups continually held opposing views on the need for mental health focused trainings for community youth. Women leadership was open to acknowledging and discussing barriers to accessible mental health care due to stigma among the community and highlighted the toll this has had on their youth in recent years.

Table 1. Emerging themes from Listening Sessions

Theme	Selected Quotes
Diabetes and hypertension management and prevention	It would be helpful to have a diet/nutrition portion that focuses specifically on what diabetics should be Consuming *(Liberian Community)*
Mental health awareness	Mental health is of major importance for both adults and youth in our community, especially the youth *(Sierra Leonean Community)*
	I came here as a teenager, and it was hard to communicate with my parents about what I was going through at school and adapting to my new environment.... because of this I went down the wrong path for some time *(Sierra Leonean Community)*
	Yes, we need mental health services. Also, mental health education for mothers to recognize things that are going on with their children *(Ogoni Community – Women's group)*
Diet and nutrition training	We don't use measurements when we cook... *(sierra Leonean Community)*
	We want more information on eating healthy for us and our children *(Congolese community)*
Sexual health	Sex education will be good for our young people *(Liberian Community)*
	..... we also want sexual health education for our youth *(Sierra Leonean Community)*
Access to health insurance	I would like to know more about health insurance for people without jobs *(Sierra Leonean Community)*
	What option do I have for health insurance if I don't have a job or make enough money...? Where can I go for free health checkup? *(Congolese Community)*

DISCUSSION

Listening sessions reviled, behavioral and physical and sexual health concerns.

Diet and Related Health Conditions

Like our results, Jakub and colleagues (2018) found that among a sample of second-generation African immigrant young adults valued the cultural meaning of African foods and that community and peers influenced both food preferences and physical activity. Similarly, African Immigrant women residing in high income countries also valued the cultural and communal meaning of food and physical activity however, also felt hat they needed to maintain a balance between Western and African cultural norms.

Sexual Health

Our listening sessions indicated that African immigrant community partners requested sexual health education out of the need for pregnancy prevention for both adolescent girls and boys (conducted separately). The current literature shows that abstinence is a commonly reinforced concept (Agbemenu, 2018a, b) and that sexual health education is more acceptable for older adolescents. The development of programming for African immigrant communities should include

a component for both parents and adolescent children to offer evidenced based sexual health components that respect cultural norms.

Access to Care

Ahad et al. (2019), and Wafula & Snipes (2014) found that factors such as cultural preferences, and religion and spirituality were associated with health care access. In addition, perceptions of healthcare experience and cost, lack of culturally grounded health care and the complexity of negotiating health care system are all barriers to accessing health care. Community partners who participated in the listening sessions were particularly concerned about health insurance for unemployed or self-employed individuals. Partnering with local safety-net health care providers and insurers to discuss availability and need for culturally grounded care for African immigrant communities.

Youth Mental Health Program Development

The prevalence of mental health issues among African immigrants varies widely among published report (Boise et al., 2013). This is likely a result of under-reporting of mental health issues among African Immigrant youth due to stigma associated with mental health in these communities. Acculturation for the youth and social pressures to fit in can cause different levels of trauma that can manifest in the form of rebellion, and engagement in criminal activity. While youth mental health is becoming a more acceptable topic of discussion, among certain communities the importance of addressing this issue remains a point of contention. (Kataoka et al., 2003). This was evidenced by the members from the Movement for the Survival of the Ogoni People who were strongly opposed to the idea of a mental health intervention. Reasons for this opposition could be due to the stigma associated with mental health and not wanting that stigma associated with their people. When addressing youth mental health in communities where it remains stigmatized, our results suggest that it might be important to assess perceived severity and perceived susceptibility among community members. In addition to this, using a culturally grounded approach to address the concerns of the community could be the best avenue for youth mental health program development going forward.

CONCLUSION

While we were able to obtain rich information in collaboration with our community partners, our study is not without limitations. First there are several immigrant communities whose voices were not heard. Due to the convenience sample, our results are not generalizable to African immigrant communities outside of our local community. As a follow-up to the listening sessions, partnering communities have requested education sessions on each topic at a starting point. These education sessions will be in collaboration with key stakeholders that represent each area of concern, for example, safety net health care providers, nutritionists, mental health providers, in order to identify sustainable strategies for effective and culturally grounded interventions.

A study on Cambodian refugees in Lowell Massachusetts utilized the ‘whole community model’ to address health disparities and develop community-based interventions (Grigg-Saito et al., 2010). The model utilized a culturally centered approach that recognizes that trust and relationship building, and change are processes occurring over time through repeated doses of information (Grigg-Saito et al., 2010). Similarly, we used CBPR to ensure engagement with our community partners. CBPR was utilized in another study to collect data on how to improve the health of the African community in the Portland area, and helped in identifying and prioritizing

the needs of the African community (Boise et al., 2013; Venters & Gany, 2011). To understand the health needs of immigrant communities, it is important to consider the sociocultural context and barriers to learning about the health status and practices of African immigrants. Recruitment strategies need to include the identification of community leaders, communication channels, ‘‘safe spaces’’ and appropriate language and knowledge of social norms before initiating recruitment activities (Shedlin, Decena, Mangadu, & Martinez 2011). Best practices for community engagement should include a community based participatory approach to ensure that the community’s voice is included in program planning, implementation, and evaluation. We identified several areas for intervention.

Note that community members were consulted as we identified the results for publication and are represented in the authorship. We are currently working collaboratively with all stakeholders on community and culturally driven strategies to address the issues identified in this study. This includes working with community members to prioritize health issues, develop follow-up projects, and identify funding opportunities.

Working with community partners required commitment and desire to engage in multiple aspects of community life including religious services, large community meeting and smaller meetings and community partners’ homes. One key factor in the success of building the partnerships was having student members of the research team that were born into communities and were passionate about working with their communities.

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APPENDIX

Questions for Community Leaders Key Informant Interviews

1. How do you define your community?
2. How do you engage your community?
3. If your community were to participate in these events, where would the best place to hold these events be?
4. To what extent would we need a translator? What languages?
5. Can we use written materials?
6. Are there cases where we need a women/man to deliver information? Any other social dynamics to take into consideration?
7. Any holidays/dates to avoid end of November / beginning of December
8. Are there any cultural practices to take into consideration?
9. What other community organizations do you engage with?
10. Do you think your community would be willing to talk about mental health?
11. From your knowledge and experience in the community, what are some of the most and least effective strategies or programs you have heard of to reach, involve, and motivate immigrant and refugee families?
12. What special challenges are faced when trying to reach immigrant and refugee families who struggle with NCDs and mental health?

Questions for Community Listening Sessions

13. What are your overall social concerns? Health concerns?
14. What types of concerns do you see in your community? Diabetes? Mental health? Hypertension?
    a. What suggestions do you have in terms of how we might meet these challenges?
    b. What, in your opinion is the best way to reach immigrant and refugee families with an NCD/physical/mental health message? i.e., community talks, sermons, educational videos, etc
    c. What do you think are the keys to successfully reaching immigrant and refugee families *with* an NCD/physical/mental health message*?* Why do you feel that way?
    d. What do you think are the keys *to reducing mental health and physical health problems among immigrant and refugee families?* Why do you feel that way?
15. Do you have any thoughts or ideas about programs, strategies, or activities that you think would be particularly effective for communicating health messages to immigrant and refugee families?
16. Is there anyone else (individuals, organizations, churches, etc) in the community that I should speak with about this issue, who may have some ideas for reaching immigrant and refugee families with a health message?
17. Do you have any other thoughts, comments, or ideas that you would like to share with us?