

**THE PROCESS OF AFRICAN IMMIGRANT INCORPORATION AND SOCIAL
MOBILITY AND ITS IMPACT ON HEALTH CARE ACCESS AND UTILIZATION**

by

Senayit Kidane Haile

BA, Health Information Management, Temple University, 2006

Submitted to the Graduate Faculty of
the Graduate School of Public Health in partial fulfillment
of the requirements for the degree of
Master of Public Health

University of Pittsburgh

2010

UNIVERSITY OF PITTSBURGH
GRADUATE SCHOOL OF PUBLIC HEALTH

This thesis was presented

by

Senayit Kidane Haile

It was defended on

April 8, 2010

and approved by

Thesis Advisor:

Patricia Documet, MD, DrPH
Assistant Professor Doctoral Program Coordinator
Behavioral and Community Health Sciences
Graduate School of Public Health
University of Pittsburgh

Committee Member:

Wesley Rohrer, PhD
Assistant Chair, Health Management Education
Assistant Professor of Health Policy & Management
Graduate School of Public Health
Secondary Appointment Department of Health Information Management
School of Health & Rehabilitation Science
University of Pittsburgh

Committee Member:

Martha Ann Terry, PhD
Senior Research Associate
Department of Behavioral and Community Health Sciences
Graduate School of Public Health
University of Pittsburgh

Copyright © by Senayit Kidane Haile

2010

THE PROCESS OF AFRICAN IMMIGRANT INCORPORATION AND SOCIAL MOBILITY AND ITS IMPACT ON HEALTH CARE ACCESS AND UTILIZATION

Senayit Kidane Haile, MPH

University of Pittsburgh 2010

Abstract

African immigrants are arguably the most underserved subgroup within the United States. They have to date been largely ignored by researchers and public health agencies. While the number of African immigrants is relatively small they are one of the fastest growing groups in the United States and are likely to change the demographic makeup of the black American population. Even as there has been growing interest in African immigrant groups, existing literature does not recognize the heterogeneity within this diverse population. The result is an incomplete understanding of the factors that influence health, access and utilization of services among African immigrant groups.

In this thesis, the dynamics of social and economic mobility of African immigrants' are examined to determine what effect they have on their ability to gain access to much needed public health services. Additionally, and of particular relevance to public health, factors that enable acclimation and quicken opportunities for social and economic mobility are discussed as they are predictors for health care access and utilization in both the short and long term.

Results from a search of published research shows that inadequate acclimation to the various US systems can result in a protracted immigrant period and delayed economic and social incorporation. The result is reduced access and utilization of health and social services. Evident in the literature is the need for comprehensive immigration programs accompanied by

educational curricula that facilitate the highest level of acclimation thereby enhancing knowledge, opportunities for economic mobility, access and utilization of health and social services. Recommendations are given to quicken immigrant acclimation and improve access and utilization of health and social services.

TABLE OF CONTENTS

1.0	INTRODUCTION.....	1
2.0	MODE OF INCORPORATION.....	5
2.1	ACCULTURATION AND ASSIMILATION.....	5
2.1.1	Straight Line Assimilation	7
2.1.2	Segmented Assimilation theory	8
3.0	FOREIGN-BORN BLACKS.....	10
3.1	AFRICAN IMMIGRANT PROFILE AND HISTORY IN THE US.....	10
3.2	INCORPORATION INTO AMERICAN SOCIETY.....	14
3.2.1	Race	15
3.2.2	Economy.....	17
3.2.3	Port of entry and residential settlement.....	18
3.2.3.1	Non-traditional gateways	19
3.2.3.2	Traditional gateways.....	20
3.2.3.3	Spatial segregation	21
3.2.3.4	The impact of inner city street culture.....	22
4.0	ADAPTIVE STRATAGIES	25
4.1	ROLE OF THE COMMUNITY.....	26
4.1.1	Ethnic communities	27

4.1.2	Faith-based communities.....	28
4.2	SELECTIVE ASSIMILATION	29
4.3	SOCIAL BONDING THEORY.....	30
5.0	SOCIAL BARRIERS TO INCLUSION AND ACCESS.....	32
5.1	DISCRIMINATION	32
5.2	IDENTITY AND IDENTITY FORMATION.....	35
5.3	DISPARITIES IN ACCESS TO HEALTH CARE	36
6.0	HEALTH STATUS OF AFRICAN IMMIGRANTS.....	39
6.1	EXPLANATION FOR BETTER IMMIGRANT HEALTH.....	39
6.2	EFFECTS OF ACCULTURATION ON HEALTH.....	41
6.2.1	Chronic disease.....	41
6.2.1.1	Obesity.....	42
6.3	INFECTIOUS DISEASE	45
6.3.1	HIV/AIDS	45
6.3.1.1	Gaps in HIV/AIDS research.....	47
6.4	MENTAL HEALTH.....	48
6.5	ACCESS AND UTILIZATION.....	49
7.0	DISCUSSION	53
7.1	FACTORS THAT PROMOTE ACCLIMATION	53
7.2	POSSIBLE INTERVENTIONS	56
7.2.1	Uniform identification	56
7.2.2	Host program in Canada.....	56
7.2.3	Universal health care; universal access.....	57

8.0	CONCLUSION.....	59
	APPENDIX: FIGURES AND TABLES	60
	BIBLIOGRAPHY.....	63

LIST OF TABLES

Table 1 Refugee seekers granted entry by decade and region of birth. Adapted from the 2006 year book on US immigration statistics (Office of Immigration Statistics 2006).	62
---	----

LIST OF FIGURES

- Figure 1** Percent Distribution of Foreign-Born Population by World Region of Birth: 2000. Adapted from 2000 US census (US Census Bureau 2000)..... 60
- Figure 2** African immigrant population by region of birth adapted from Gany and Venters, 2009 (Gany and Venters 2009)..... 61
- Figure 3** Refugee seekers granted entry by country-of-origin. Adapted from the 2006 year book on US immigration statistics (Office of Immigration Statistics 2006). 62

PREFACE

I dedicate this to my family for inspiring my research and supporting me in my endeavors.

1.0 INTRODUCTION

The United States (US) 2000 Census Bureau counted the foreign-born immigrant population at 31 million (US Census Bureau 2000) with the top two-thirds originating from Latin America, Asia or the Caribbean (Shepard, 2008). The African immigrant share of that 31 million is approximately 881,300, or 2.8 percent (Baluja, Costanzo, Davis, & Malone, 2003; US Census Bureau 2000; Perry & Schachter, 2003). In spite of the small number of African immigrants, their numbers have tripled between 1990 and 2000 alone. As the number of foreign-born blacks continues to grow they are likely to change the demographic makeup of the black American population (Djamba, 1999). Of the African born immigrant population, 35 percent are of West African origin, 26 percent are of East African origin, 20 percent are of North African origin, 7 percent are of South African origin, and less than 3 percent are from central African origin (Gany & Venters, African Immigrant Health, 2009).

The foreign-born black population has long been ignored by researchers. This is evident by the limited number of articles that study African born groups. While there has been growing interest in this population (Shepard, 2008), the existing data tend to treat blacks in general and foreign-born blacks in particular as a homogenous group. There is a tendency on the part of researchers to recognize variation among subgroups within the black population but still not gather country-of-origin data. The reason cited for the exclusion country-of-origin data is the relatively small number of African immigrant participants. Homogenizing all blacks as one

group with no attention to variations leads to incomplete understanding of the factors that influence mobility, health, access, and utilization of services (Gany & Venters, African Immigrant Health, 2009). Additionally, existing research on foreign-born blacks looks primarily or only at those individuals from the Caribbean and primarily by cross comparison between the foreign-born and the black American population (Dodoo, 1997). As a result, African immigrants and blacks from other parts of the world are excluded.

In this thesis, the dynamics of social and economic mobility of African immigrants' are examined to determine what effect they have on their ability to gain access to much needed public health services. Additionally, factors that enable acclimation and ultimately incorporation are examined.

It is important to state that although the African population is diverse, and it is the purpose of this thesis to show the need for the collection of country-of-origin data, there is to this point limited information on African immigrants as a whole with even fewer studies that distinguish between national, ethnic or religious African communities. Literature review on the subject revealed that existing research does not distinguish by country-of-origin or ethnicity making it impossible to provide details along national or ethnic lines. For this reason a general analysis of African immigrants in the US is given rather than specific data on national and ethnic African groups.

Furthermore, throughout this thesis the term *African* will be used exclusively to refer to persons who have voluntary immigrated to the United States through the use of a visa or as asylum seekers (refugees) from any of the fifty-three countries in Africa. The term *black American* or *native-born blacks* will be used to describe persons of African ancestry who were brought to the United States as involuntary immigrants through the trans-Atlantic slave trade.

Other persons of African ancestry will be described by their national origin (.e.g. Brazilian, Dominican, Jamaican). Additional terminology used includes: *first generation*, which refers to individuals who were born outside the US and immigrated as adults. The term *1.5 generation*, refers to individuals who were born overseas but immigrated to the US as young children, typically before the age of thirteen. The latter have spent the majority of their life in the US as well as received their education exclusively or primarily in the US. The 1.5 generation is distinguished from the first generation because their relative youth at immigration put them at greater similarity with second generation immigrants. *Second generation* refers to US born individuals whose parents were born abroad. Each successive generation experiences greater level of assimilation as children raised in households headed by first generation immigrants are exposed to different family and community dynamics than those raised in households headed by second or third generation immigrants. Their levels of integration differ greatly and therefore so do their likely outcomes. For the reasons mentioned, a clear distinction is being made between 1.5 and second generation immigrants.

As US policy on immigration continues to change and civil unrest forces more Africans to emigrate, public health agencies, health care providers and school administrators in the host society must be prepared to address the needs of these communities. If these individuals, refugees in particular, are not adequately acclimated in an inclusive manner, they are at risk of a downward assimilation with limited mobility channels. The result would be increased strain on health and human service agencies as well as on public school system.

Chapter two examines two notable theories on immigrant incorporation, *straight-line assimilation* and *segmented assimilation*. Straight-line assimilation describes the absorption of European immigrant into American society following the turn of the last century. Segmented

assimilation considers the varying factors that impact the incorporation of racial immigrant minorities.

Chapter three provides data on source countries of African immigrants in the US and the acts of government which facilitated their legal entry. Additionally, African immigrant settlement concentration upon arrival is also discussed.

Chapter four examines the influence that port of entry has on acclimation, acculturation and barriers experienced by African immigrants.

Chapter five discusses adaptive strategies employed by African immigrant communities in order to anchor community members and facilitate opportunities for upward mobility and support.

Chapter six looks at social barriers such as discrimination, the process of identity and identity formation as well as structural barriers to health care access.

Chapter seven looks at the health profile of African immigrants and the effects of assimilation and duration in the US on health outcomes. Chronic disease, obesity, HIV/AIDS and mental health are discussed as well as health care access and utilization.

Chapter eight is a discussion of the above findings. Recommendations are made to increase greater access and utilization of health care services.

2.0 MODE OF INCORPORATION

Assimilation is the process whereby culturally dissimilar groups come together and create a common culture (Arthur, 2000). This experience is romanticized in popular images and stories of European immigrants' assimilation into US society. However, not all immigrants undergo the same process or path to incorporation (Alba & Reynolds, 2002) nor are they uniformly assimilated (Arthur, 2000), or are equally incorporated. Successful incorporation is the result of appropriate acclimation upon arrival. Factors that promote acclimation include the mode of entry and reception upon arrival; physical characteristics; social and economic context of the host society; human and social capital; and port of entry and eventual place of settlement (Alba & Nee, 1997; Dodoo, 1997; Portes & Zhou, 1999; Portes, Fernandez-Kelly, & Haller, 2005).

2.1 ACCULTURATION AND ASSIMILATION

Acculturation refers to a process in which the beliefs, practices, names and other aspects of two or more cultures interact and are mutually influenced by one another (Dictionary.com, 2009). Each group maintains aspects of its own indigenous culture, while adapting to the foreign culture in other ways (Dictionary.com, 2009). The end result may be regarded as a cohabitation of cultures. Assimilation, on the other hand, is the cultural absorption of a minority group by the dominant group (Dictionary.com, 2009). It is important to note that current theory on immigrant

incorporation asserts that visible minorities like African immigrants are not likely to fully assimilate into the dominant majority culture because of their ascribed racial status (Alba, 1999; Alba & Nee, 1997; Alba & Reynolds, 2002; Bean & Brown, 2006; Carter, Lee, & Neckerman, 1999; Dadoo, 1997; Feliciano & Waldinger, 2004; Freeman, 2002). That said they are more likely to acculturate or experience a segmented assimilation process rather than fully assimilate as Europeans have (Portes & Zhou, 1999; Portes, Fernandez-Kelly, & Haller, 2005).

Measures of acculturation/assimilation include but are not limited to the rate of intermarriage, ability to speak the dominant language (in this case English), language spoken at home (whether English, other or both), naturalization status, beliefs, practices, and behaviors (Alba, 1999; Alba & Nee, 1997; Alba & Reynolds, 2002; Arthur, 2000; Baluja, Costanzo, Davis, & Malone, 2003; Bean & Brown, 2006; Jimenez & Waters, 2005). English proficiency has been shown to positively impact immigrants' experience in the US labor market. Those that are able to speak English are better able to acquire institutional knowledge which quickens their acclimation and broadens their social network to include native-born Americans (Akresh, 2006). In as far as public health is concerned, understanding the acculturation process of various immigrant groups can help in identifying culturally appropriate strategies to acclimate them into existing programs or in tailoring new programs to meet their specific needs (Goodman, 2000; Fisher, Sallis, & Owen, 2008; Kasprzyk & Montano, 2008).

Measures of acculturation/assimilation are primary tools used to assess health seeking behaviors and to explain differences in health profiles, and access and utilization of services. However, the single greatest evidence of the relevance of acculturation/assimilation to public health is the volume of foreign-born individuals who have made the US their home. As the birth rate of native-born Americans continues to drop, the number of immigrant children continues to

climb. According to the 2000 US census, one in every five children in the US has either immigrated to the US or has at least one immigrant parent (Behraman & Shields, 2004).

Whatever their reason for leaving their home land, immigrants come in hopes of better quality of life (Arthur, 2000). Differences in social class, physical characteristics, and the manner in which they are received all influence their access to resources and opportunities for upward mobility (Baluja, Costanzo, Davis, & Malone, 2003; Bean & Brown, 2006; Carter, Lee, & Neckerman, 1999; Cunningham, Hargraves, & Hughes, 2001; Dadoo, 1997; Dolfin, Buchmueller, Lurie, & Lo Sasso, 2007; Emerson, Read, & Tarlov, 2005; Foley, 2005; Freeman, 2002; Gordon, 1999). Those who are inadequately acclimated experience a protracted immigrant period, and are at risk of economic exclusion which decreases their access and utilization of health and social services and increases their reliance on government programs.

The following chapter discusses two notable theories on assimilation, *straight line assimilation* and *segmented assimilation*.

2.1.1 Straight Line Assimilation

The straight line assimilation model asserts that with each successive generation, immigrants shed their ethnicity and cultural background as they adopt the culture and language of the host society (Alba, 1999; Carter, Lee, & Neckerman, 1999; Perlmann & Waldinger, 1997; Portes & Zhou, 1999; Portes & Zhou, 1999). Increased economic prosperity provides immigrant families and individuals with the opportunity to move out of ethnic enclaves and reside in greater proximity to US-born Americans (Baluja, Costanzo, Davis, & Malone, 2003; Behraman & Shields, 2004; Feliciano & Waldinger, 2004; Freeman, 2002). With each generation these groups become increasingly mobile and experience higher rates of assimilation and intermarriage

with members of the host culture (Gordon, 1999; Yetman, 1999). For those individuals and groups who undergo this process of assimilation, in time ethnic identification becomes more of a symbolic process in that one does not identify him or herself for instrumental purposes but rather as a mode of self expression (Alba, 1999; Gans, 1999; Brown & Rong, 2007). Immigrants who ascribe to symbolic ethnic identification tend to have higher socioeconomic status (SES) and no longer depend on their ethnic community for social or economic networks. These groups or individuals are considered to have become completely incorporated into American mainstream society (Brown & Rong, 2007). Symbolic ethnic identification is synonymous with European immigrant groups who over the course of multiple generations have been incorporated in this manner (Carter, Lee, & Neckerman, 1999; Feliciano & Waldinger, 2004; Portes & Zhou, 1999; Portes, Fernandez-Kelly, & Haller, 2005).

2.1.2 Segmented Assimilation theory

The segmented assimilation model predicts that the children of immigrant minorities will be blocked from accessing mobility channels provided to European immigrants because of their racial or ethnic status (Portes & Zhou, 1999). Segmented assimilation asserts that key factors such as race, changes in the economy and place of residence block or limit contemporary immigrants from accessing mobility channels (Portes & Zhou, 1999). First, racial discrimination compartmentalizes immigrants into minority racial categories with ascribed negative stereotypes (Alba, 1999; Portes & Zhou, 1999; Portes, Fernandez-Kelly, & Haller, 2005). As a result, they will face the same difficulties encountered by domestic racial and ethnic minorities. Second, the bifurcation of the US labor market has blocked opportunities for middle-class aspirations by eliminating or reducing low-skill, medium-paying jobs. The result is a bilateral partitioning of

the labor market, dividing the highly skilled and educated upper class from a low-skilled, low-wage lower class with limited opportunities in between (Alba, 1999; Portes & Zhou, 1999; Portes, Fernandez-Kelly, & Haller, 2005).

Newly arriving immigrants with limited skills saturate these low-wage positions while their children aspire for greater opportunities (Portes, Fernandez-Kelly, & Haller, 2005). Economically and socially disadvantaged 1.5 and second generation immigrants experience what is termed in the literature as a “mismatch” between their aspirations and reality (Alba & Nee, 1997; Alba & Reynolds, 2002; Portes, Fernandez-Kelly, & Haller, 2005). With few medium-paying, low-skill jobs, immigrant families face increasing difficulties in providing resources that enable 1.5 and second generations to become upwardly mobile.

This brings us to the third point: poverty, crime and residence. Contemporary immigrant communities close proximity to low-income inner city communities’ predisposes them to the ills e.g. crime, poverty, inadequate amenities, that plague these existing neighborhoods (Portes, Fernandez-Kelly, & Haller, 2005; Alba & Nee, 1997; Portes & Zhou, 1999; Feliciano & Waldinger, 2004).

3.0 FOREIGN-BORN BLACKS

Thanks to sweeping immigration reform that eliminated quotas and preference for person from Western Europe, many Africans have been able to enter the US. Those who arrived in the 1980s represent the single largest group of Africans to enter the US in over two hundred years (Arthur, 2000). Between 1974 and 1995 the number of Ethiopians increased from 276 to 5,960 and Nigerians from 670 to 6,818, representing an increase of 2000 and 900 percent respectively (Arthur, 2000).

Today, the largest African immigrant groups come from Egypt (133, 818), Nigeria (158,436), Cape Verde (71,816) followed by Ethiopia (66,822), Ghana (49,434), South Africa (41,422), Somalia (35,977), Morocco (33,402), Liberia (25,140), and Kenya (16,918) (Arthur, 2000; U.S. Census Bureau, 2000). Most of these individuals arrived as a result of immigration policy passed in the 1980s (Arthur, 2000).

3.1 AFRICAN IMMIGRANT PROFILE AND HISTORY IN THE US

Foreign-born blacks are a growing subgroup within the US black population. Those of African origin represent the largest segment of foreign-born blacks after Caribbean immigrants (Dodoo, 1997). Foreign-born blacks generally have higher levels of education, income and employment rates than their American counterparts (Arthur, 2000; Djamba, 1999; Dodoo, 1997).

Of those who immigrate to the US from Africa, approximately 88 percent of the adult population has a high school education or higher as compared to only 77 percent among native-born American adults regardless of race (Arthur, 2000). Additionally, with one-quarter of the African immigrant population holding an advanced degree, they are (as a whole) one of the most highly educated groups in the US (Arthur, 2000). Nonetheless, 50 percent of all US immigrants including Africans experience occupational downgrade upon arrival (Akresh, 2006). In general, foreign degrees and experience are undervalued by US employers and accrediting bodies, which existing literature suggests is a contributing factor for high rates of “self-employed” among certain segments of the immigrant population (Akresh, 2006). It also results in the creation of ethnic enclaves (Akresh, 2006) that provide an economic niche in low-paying labor markets and in creating businesses that cater to ethnic communities (Arthur, 2000). That said, individuals who are self-employed are less likely to have health care coverage than wage employees, and immigrants have greater likelihood of being self-employed than native-born Americans (Dolfin, Buchmueller, Lurie, & Lo Sasso, 2007) which means they are at greater risk of being uninsured.

While foreign-born blacks have the highest rate of migration from state to state of any immigrant group, their population is greatly concentrated in large metropolitan centers of traditional gateway cities and states like Chicago, northwestern Indiana, Dallas-Fort Worth and Arlington area, Washington DC, Philadelphia, Wilmington (Delaware), Trenton, Newark (NJ), New York, Atlanta, San Francisco-Oakland area, and the Boston region (Arthur, 2000). Generally speaking, African immigrant concentration follows black American residential concentration. Recent trends following government settlement policy show an increase in the number of African immigrants in non-traditional gateway locations. As of 2000 the states with the largest African populations included Minnesota (which had the largest East African

population) with 13.2 percent of all Africans living there, District of Columbia with 12.5 percent, and Maryland with 12.1 percent (Baluja, Costanzo, Davis, & Malone, 2003).

Increased African immigration to the US has been facilitated largely by four acts of government: the Immigration and Nationality Act of 1965, otherwise known as the Hart-Celler Immigration Bill, the Refugee Act of 1980, the Immigration Reform and Control Act (IRCA) of 1986, and the Immigration Act of 1990 (Alegria, Jackson, Takeuchi, & Williams, 2007; Arthur, 2000; Djamba, 1999; Congressional Budget Office, 2006; Shepard, 2008)

The Immigration and Nationality Act of 1965 eliminated the national quota system and established categorical preference based on skill and family reunification for US citizens and legal residents (Arthur, 2000; Congressional Budget Office, 2006). While this is to date considered the most important legislation on immigration, it did not abolish numerical restriction on immigrants from Eastern Europe, Asia, Africa or Australia (Congressional Budget Office, 2006). It did, however, give way to other pieces of legislation in 1976 and 1978 that would eliminate preference (Arthur, 2000) to immigrants from Western Europe as well as increase the cap for legal entry for all groups to 290,000 per year (Congressional Budget Office, 2006).

The 1980 Refugee Act gave the president and congress the power to determine the number of refugees on a year by year basis (Congressional Budget Office, 2006). The 1980 Refugee Act also aligned US policy on refugees with the 1969 protocol of the United Nations Refugee Convention thereby adapting the universally accepted definition of a “refugee” (Arthur, 2000; Congressional Budget Office, 2006). Working with the Organization of African Unity (OAU) Convention the US expanded the number of people believed to be refugees (Congressional Budget Office, 2006). Africans greatly benefited from the restructuring of immigration policy on refugees. Between 1946 and 1950 a total of 1,788 Africans were granted

asylum in the US. Between 1961 and 1970 5,486 were granted refugee status; between 1971 and 1980, 2,991 were granted asylum; following the refugee Act of 1980, from 1981 to 1990, 22,149 were granted refugee status; between 1991 and 2000, 51,469 were granted entry as refugees; 65,601 between 2001 and 2005; and in 2006 44,808 African were permitted entry under refugee status (Office of Immigration Statistics, 2006).

Originally created to address the issue of illegal immigrants, the Immigration Reform and Control Act of (IRCA) of 1986 created two amnesty programs allowing illegal immigrants legal status (Congressional Budget Office, 2006). The amnesty programs allowed 2.7 million illegal immigrants to become legal permanent residents (Congressional Budget Office, 2006).

The Immigration Act of 1990 allowed for an increase in the total number of immigrants based on skills for employment in the US and diversity. Africans benefited tremendously, as the diversity program promoted the legal entry of persons whose nationality was underrepresented in the US population (Arthur, 2000). The result was 131,603 Africans immigrating between 1997 and 2004 (Congressional Budget Office, 2006). The 1990 Act also allowed for a more flexible cap on the number of immigrants granted entry, so while 650,000 was the stated limit it could be extended if needed (Congressional Budget Office, 2006).

Increased political strife around the world and on the African continent has created an explosion of people seeking asylum in the US. In 2005 there were 8.4 million refugees from around the world, 2.7 million of which were from countries in Africa (Akinsete, et al., 2007). The US accepted 492,735 (Office of Immigration Statistics, 2006) of which, 207,187 came from Europe, 113,632 from within North America, 97,388 from Asia, and only 65,601 from Africa (Office of Immigration Statistics, 2006). The majority of African refugees arrived between 1997 and 2006 (U.S. Census Bureau, 2000) and tended to come from a handful of countries: Ethiopia,

Somalia, Liberia, Ghana, Sierra Leone, and Nigeria (Arthur, 2000; Office of Immigration Statistics, 2006).

Most African immigrants are transnational migrants, sojourning elsewhere before coming to the US (Arthur, 2000). The vast majority of the African immigrants in the US are from previously British held territories like Nigeria, Kenya, Egypt and Ghana (Arthur, 2000). Common continental heritage notwithstanding, these groups are divided along linguistic, cultural, ethnic, class, nationality and educational lines. Strongly kinship-oriented, many Africans maintain strong ties with family members back home and often send remittance in order to share whatever economic prosperity they have gained in the US (Arthur, 2000; Apraku, 1991; Arthur, 2000; Baluja, Costanzo, Davis, & Malone, 2003; Djamba, 1999; Dodoo, 1997; Grant & Obiakor, 2002; Holtzman, 2008; Robert K. Ream, 2007; Shepard, 2008).

3.2 INCORPORATION INTO AMERICAN SOCIETY

Given the US social context, the notion of a cultural and social melting pot is not representative of reality. Different groups and individuals experience varying degrees of acculturation/assimilation (Alba, 1999). Additionally, immigrant groups do not uniformly undergo the same process of incorporation into American society (Alba & Reynolds, 2002; Portes, Fernandez-Kelly, & Haller, 2005). The question here is not whether or not the current stock of immigrants (African immigrants in particular) will be incorporated, but rather into what stratum of American society will they be acculturate/assimilate into. Will they enter mainstream Middle America or will they join the multitude of racialized and disenfranchised individuals at the bottom of the social ladder (Aljandro Portes, 2005). There are several factors that affect the

pattern of immigrant incorporation into American society. They include race, economics and residential settlement (Dodoo, 1997; Portes, Fernandez-Kelly, & Haller, 2005; Portes & Zhou, 1999).

3.2.1 Race

Race is not a biological characteristic that can be identified through science; rather it is a social reality that cannot be ignored (Yetman, 1999). Race underlies the social context in which American minority groups and immigrants alike live. Race and racial categories are dynamic and change with time. In the early part of the twentieth century Irish along with southern and eastern Europeans were not considered to be “white” (Yancey, 2003). Bogus “scientific” claims pointing to difference in skin color as well as other physical distinctions were made to discredit their “whiteness” from that of earlier European immigrants (Perlmann & Waldinger, 1997; Yancey, 2003). The advantages afforded to the Irish and south and eastern Europeans are their common European ancestry which dulled the prejudicial edge.

Blacks on the other hand have the distinction of being the traditional “other” in American society and must contend with the ubiquitous nature of racism whether overt or systematic (Freeman, 2002). Sadly, skin color has been a discriminatory marker throughout American history and blacks have been the primary target of racial prejudice based on skin color for as long as they have existed on the North American continent. The extreme extent of their circumstance was codified in law and practiced as policy. While the institution of slavery and racial segregation of Jim Crow laws has ended, the resulting stereotypes, economic and social marginalization, disparities in health and health care access have continued to impact the lives of all persons of African ancestry in America.

It has been well documented that persons of African ancestry receive inferior health care; have fewer options for invasive procedures and less access to high-tech medical therapies in comparison to whites, even under comparable insurance like Medicare and the VA system (Mayberry, Mili, & Ofili, 2000; Mechanic, 2006). Blacks including African immigrants are also more likely to be treated by physicians who are not well trained and who are inadequately positioned to provide access to additional health care services (Mechanic, 2006). It has also been shown that health insurance and SES are the two greatest predictors for health care access. Blacks are more likely to be unemployed, less likely to have employer-sponsored insurance, more likely to rely on government health care programs, and are more likely to be in a lower SES. Blacks face the greatest health disparities in health coverage, access and treatment as well as carrying the greatest burden of morbidity and mortality (Mechanic, 2006). To merely identify overt racial prejudice as the underlying cause of disparities is too simplistic. The issue of health disparities relates to residential geography, state of the physical environment, poverty and crime, poorly developed or underdeveloped infrastructure and cultural orientation, which all contribute to a systemic problem rooted in historical indifference (Cunningham, Hargraves, & Hughes, 2001; Mayberry, Mili, & Ofili, 2000; Mechanic, 2006).

Foreign-born blacks, regardless of national origin, are not sheltered from this reality. The unique quality of racism experienced by persons of African origin not only impacts their ability to enter the US but also their life outcomes once they have arrived. Regardless of their SES, foreign-born blacks and native-born blacks are equally spatially segregated (Freeman, 2002). The literature also indicates that foreign-born blacks have disproportionately higher rates of unemployment and underemployment in spite of greater educational attainment when compared to other immigrant and minority groups (Arthur, 2000; Apraku, 1991; Bueker, 2006;

Djamba, 1999). They are thus, the least rewarded for their educational attainment of any group in the US.

3.2.2 Economy

The second source of vulnerability has to do with current economic conditions. Communities and individuals, immigrants or not, must contend with the available resources in order to sustain themselves (Aldrich & Waldinger, 1990). In the past, the US industrial economy provided a diversified labor market that produced employment niches for incoming immigrants. This created opportunities for subsequent generations to gradually work up the pay ladder while remaining part of the working class (Barondess, 2008; Portes & Zhou, 1999; Portes, Fernandez-Kelly, & Haller, 2005). Assimilation of past immigrant groups, was directly related to the availability of high-paying jobs that required minimum education (.e.g., construction, manufacturing and transportation). Over the past several decades, the US economy has gone through a process of deindustrialization, limiting these sorts of job to industries in which there are increasing pressure to reduce wages (Akresh, 2006; Alba & Nee, 1997; Alba, 1999; Hernandez, 2004; Portes & Zhou, 1999; Portes, Fernandez-Kelly, & Haller, 2005; Perlmann & Waldinger, 1997). A consequence of the above changes is the creation of an hourglass economy in which there are limited medium-paying, low skilled jobs that can provide economic growth. While there is a demand for jobs at both ends of the labor market (highly-skilled and low-skilled), there is a notable decline in middle-earning job opportunities. It is feared that those in the bottom half of the hourglass will become part of a growing permanent underclass (Dadoo, 1997; Portes & Zhou, 1999; Portes, Fernandez-Kelly, & Haller, 2005).

The advent of the hourglass economy has reduced economic opportunities which in the past were available to European immigrants (Alba, 1999; Alba & Reynolds, 2002; Portes & Zhou, 1999; Portes, Fernandez-Kelly, & Haller, 2005). This impacts not only African immigrants, but all immigrants and ethnic communities including American-born lower classes as they are overrepresented in industries that have been most impacted by the economic shift (Aldrich, Waldinger, & Ward, 1985).

Another consequence of changes in the economy relates to the education of 1.5 and second generation immigrant children. The US educational system is such that communities essentially pay for their children's education through their tax dollars (Portes & Zhou, 1999; Portes, Fernandez-Kelly, & Haller, 2005). This has major adverse implications for public schools in most urban settings, which are major ports of entry. Pressure to control public school funding threatens to eliminate programs that are increasingly ineffective in preparing students for 21st century jobs (Portes & Zhou, 1999). Particularly for jobs that require advanced training and greater education (Alba & Nee, 1997; Portes & Zhou, 1999; Portes, Fernandez-Kelly, & Haller, 2005). In the absence of well-paying jobs, immigrant families are less likely to afford their children the level of education needed to stay competitive with middle class children. Furthermore, immigrant families are more likely to live in inner cities and their children attend inner city schools, which do not have the resources available to compete with suburban and private school systems.

3.2.3 Port of entry and residential settlement

Gateways or port of entry plays an important role in shaping how immigrant groups are acclimated and what sort of resources will facilitate their acclimation (Freeman, 2002).

Gateways determine immigrant settlement pattern and concentration in a given location; they have the potential to impinge on how well and how long it will take foreign-born persons to become incorporated into mainstream society. Resource rich cities and states can afford to provide greater assistance and opportunities to growing immigrant communities. Immigrants who settle into existing co-ethnic communities or areas that have had previous waves of immigrants have the benefit of gaining from the experience and resources established for their predecessors. However, they are also at risk of experiencing a protracted immigrant period as they may unintentionally limit their interaction with native-born Americans versus co-ethnics. Further, as new immigrants arrive to replenish existing ethnic communities, they inadvertently slow down the acculturation/assimilation process of members of the existing co-ethnic community as they again, limit their interaction with native-born Americans (Jimenez & Waters, 2005).

3.2.3.1 Non-traditional gateways

Traditional gateway states include California, Florida, Illinois, New York and Texas; all have historically been the destination point for multitudes of newly arriving immigrant groups (Hernandez, 2004; Jimenez & Waters, 2005). However, recent changes in settlement policy have shifted settlement from traditional gateway cities and states to non-traditional location in the southern and Midwest states (Jimenez & Waters, 2005). Additionally, secondary migration necessitated by work or the desire to join existing co-ethnic communities or families has contributed to growing immigrant presence in non-traditional cities and states (Arthur, 2000; Holtzman, 2008).

The benefit of new gateway cities and states is that they provide new immigrant groups an opportunity to define their position as they have no history in the community. New

immigrant groups and individuals may be less affected by long held beliefs of class, racial stereotypes and ethnic hierarchies already established in traditional gateway cities (Jimenez & Waters, 2005). New gateways are also less likely to have large ethnic enclaves that promote isolation and reduce interaction between immigrant groups and native-born Americans (Gee, Holt, Laftlamme, & Ryan, 2006). It is important to note however, that visible minorities, like African immigrants, are entering into a social context in which long held beliefs about blacks are already established; and regardless of their port of entry, they are more likely to experience ethnic or racial discrimination as a result (Gee, Holt, Laftlamme, & Ryan, 2006). Additionally, new gateways may not have adequate resources to facilitate health care access for immigrant populations who experience cultural and linguistic barriers (Cynthia Garcia Coll, 2004; Hernandez, 2004; Jimenez & Waters, 2005).

3.2.3.2 Traditional gateways

In contrast, the benefit of traditional gateways is their experience with refugees and the immigration process as a whole. Traditional gateways have established services .e.g., language line, translators and interpreters necessitated by previous immigrant groups (Jimenez & Waters, 2005). Unfortunately, traditional gateways are often crowded urban centers with potentially hazardous environmental conditions (Barondess, 2008). Over the course of their history many inner city locations were abandoned as residents migrated to suburbs taking with them much of the economic resources resulting in the hollowing out of the urban core and consequent decline in inner city economic opportunities (Barondess, 2008). The migration of the American-born white population to the suburbs increased residential segregation which created and reinforced differentials in quality of education and availability of services for those living in these areas (Barondess, 2008).

It is important to point out that in the case of African immigrants, existing literature states that regardless whether they are in traditional or non-traditional gateway cities, they are often overlooked and underserved (Hausman, Lidicker, Simbiri, & Wadenya, 2009). So, in dealing with these communities social services agencies in both traditional and new gateway locations must be made aware of the African immigrant presence and specific needs of their communities.

3.2.3.3 Spatial segregation

Desirable neighborhoods are those that provide access to good schools, environments that promote healthy behaviors, and access to services that facilitate the highest level of inclusion. Integration either culturally or spatially is contingent on racial and ethnic background. For African immigrants regardless of country-of-origin being “black” (Freeman, 2002) limits their likelihood for spatial assimilation into white middle class neighborhood. Persons of African ancestry are likely to live primarily among or in close proximity to black Americans as they are comparably segregated. Unfortunately, spatial segregation creates inequitable access to amenities that provide a higher quality of life. Even as black Americans and foreign-born blacks become move into middle class status, their neighborhoods are disproportionately exposed to higher rates of poverty, crime and dilapidated housing (Freeman, 2002) with less access to health services (Mechanic, 2006). This is in stark contrast to white middle class neighborhoods which provide better housing, schools, health care services and overall amenities (Freeman, 2002; Mechanic, 2006).

3.2.3.4 The impact of inner city street culture

For newly arrived immigrants neighborhood selection is determined by economics; the result is that most newly arriving immigrants reside in low-income, inner city neighborhoods (Portes & Zhou, 1999). Residing in inner city neighborhoods exposes 1.5 and second generation immigrants to an oppositional street culture that promotes values and attitudes inimical to upward mobility (Arthur, 2000; Shepard, 2008; Portes & Zhou, 1999; Portes, Fernandez-Kelly, & Haller, 2005).

Adversarial in nature, this inner city street culture is not unique to contemporary inner-city minority youth. It is a phenomenon experienced time and time again by disenfranchised youth on the fringe of mainstream society (Perlmann & Waldinger, 1997). Marginalized youth have historically been likely to ascribe to a sub-culture that is reluctant to submit to Middle American norms (Perlmann & Waldinger, 1997). It is marked by an antagonistic attitude, poor grades, and a rejection of mainstream society's rules and codes of behavior as well as attributes of success. European youth of the early twentieth century were criticized for revolting against mainstream society, viewing good grades and professional success as symbol of "selling out" one's community and self (Feliciano & Waldinger, 2004).

Adversarial culture, while not clearly defined in the literature, can be interpreted as a culture that arises from a history of "playing it by the book" and finding that the existing rules of meritocracy do not always apply (Grant & Obiakor, 2002). That is, racism and prejudice produce additional barriers to success that cause marginalized youth to develop a counter culture in order to protect themselves (Yancey, 2003). For example, students who do not equate greater schooling with increased opportunity for upward mobility may choose to drop out and pursue activities they perceive as more advantageous (Portes, Fernandez-Kelly, & Haller, 2005).

The difference between the “youth revolts” of the past and the adversarial culture adopted by African youth today is that European immigrant youth were attempting to preserve their community from what they perceived as hostile environment. Further, the European youth were integrated into communities that managed to promote their own heritage, which sustained and enabled community members. While immigrant youth of the past may have rejected mainstream standards of success, their communities’ social networks provided economic opportunities for their future. And while they rejected mainstream society they did not reject their communities, which instilled a sense of pride in their heritage and culture that worked to buffer against negative stereotypes.

With regard to African youth, many of the African cultures represented in the US are those that promote education and respect for authority regardless of the source of authority (Arthur, 2000). Doing well in school and becoming successful in society (even white American society) means that you are in a better position to help your family and community as a whole; it is not perceived as selling out. Living in such close proximity to inner-city youth, African 1.5 and second generation are at risk of ascribing to the same adversarial culture adopted by their neighbors and previous immigrant youth in similar low-income neighborhoods. However, in this case adopting an oppositional stance is not in reaction to their communities’ history of oppression in the US. The youth culture to which they are ascribing is in reaction to black American social history which is uniquely different from African history.

This “adversarial culture” hinders academic progress and increases immigrant youth’s awareness of racial stigma and class divide. Couple that with current economic trends and the result is greater risk of a downward assimilation towards the lowest economic sectors of society (Alba & Nee, 1997; Alba & Reynolds, 2002; Feliciano & Waldinger, 2004). In which case,

having strong community ties would help protect against. These protective factors have the potential to buffer the effects of exposure to mainstream inequalities and discrimination from local minorities and society as a whole. This is especially important considering the negative stereotypes of Africa and Africans in the media (Abdullah, 2009; Foley, 2005). Furthermore, extreme racial categories expose African youth to increased levels of minority status inequalities (e.g. social, economic and health disparities) making them acutely vulnerable to psychological stress and illness, which amplifies their chances for risky behavior and adverse outcomes (Baldimarsdottr, et al., 2009).

4.0 ADAPTIVE STRATEGIES

The term community can be used to describe a variety of relationships as well as geographical space. For the purpose of this thesis the term community is referring to community based on identity. The communities discussed in this thesis are not limited to any particular geographical location; membership is based on religion but mostly ethnic and national identity. Not all communities function and provide the same benefits. The amount of resources a community can have is based on how established the community is. Newer communities are not as likely to have the same amount of social capital as more established communities (Foley & Hoge, 2007). Social capital refers to resources provided by networks (Foley & Hoge, 2007) created through increased interactions with a variety of institutions, US systems and individuals. Communities that emphasize community-building by employing a variety of programs and activities increase membership participation which fosters socialability (Foley & Hoge, 2007), and thus increase member network and communities social capital.

4.1 ROLE OF THE COMMUNITY

If there is one thing that the literature is clear on, as it relates to African immigrants, it is the importance that the community plays in the lives of Africans (Akinsete, et al., 2007; Apraku, 1991; Arthur, 2000; Baker, et al., 2003; Foley, HIV/AIDS and African immigrant women in Philadelphia: Structural and cultural barriers to care, 2005). Ethnic/national and religious communities provide access to extended social support and networks for adults and youth (Foley & Hoge, 2007). These communities assist their members in navigating through the American landscape and facilitating the acclimation of newly immigrated community members. Increased community involvement can be seen as an adaptive strategy used to offset the harmful effects of immigration and long-term residence in the US. Strong community ties reinforce cultural identity and provide stability during times of instability (Shepard, 2008). By maintaining strong ties to one's ethnic community, families and individuals are able to feel a sense of control and pride in their life that is related to their culture (Arthur, 2000; Shepard, 2008). They tend to measure their financial success based on standards of life in their country-of-origin rather than with middle class American standards (Arthur, 2000; Djamba, 1999; Portes, Fernandez-Kelly, & Haller, 2005). As a result they are able to maintain a sense of optimism given the long journey and difficulties they have endured. Ethnic communities provide a sense of belonging and companionship (Shi & Stevens, 2004), where community members are able to share experiences and receive emotional support. Additionally, is an environment where immigrants are not a minority but part of a community of peers who look, sound and act as they do.

4.1.1 Ethnic communities

Choosing to immigrate to another country is a major risk-taking endeavor. Upon arrival many African immigrants find that their education and credentials are not recognized (Arthur, 2000). For those with an education and professional background emigration means letting go of the benefits they once enjoyed in their country-of-origin. In addition to loss of credentials, they may also experience a loss in status and a reduction in income proportional to their education (Grant & Obiakor, 2002). This reduction in status and mobility can have detrimental psychological impact especially where gender roles and cultural beliefs are threatened (Arthur, 2000). This initial downward mobility, lower employment rates (Akresh, 2006) and changes in gender roles is softened when strong ethnic and kinship ties make resources for housing, employment and financial investment opportunities available (Arthur, 2000). Various African communities, in addition to reinforcing cultural and ethnic beliefs and practices, also provide direct economic support during periods of crisis, such as a death or legal problems; they also provide psychological, cultural and political support (Arthur, 2000). In other words, individuals with greater social capital e.g. community of social networks, are better able to rebound from the difficulties associated with immigrating to a new environment (Akresh, 2006).

An additional difficulty associated with immigration is the impact that assimilation has on 1.5 and second generation youth. This is made evident by the number of African families that opt to send their children back to their country-of-origin in order to preserve ethnic culture and minimize assimilation (Arthur, 2000; Warner, 1998). For those families who are unwilling or unable to send their children to their country-of-origin, local ethnic communities play an important role in anchoring African youth to their culture and in providing greater access for

opportunities (Arthur, 2000; Jackson, et al., 2007; Portes & Zhou, 1999; Portes, Fernandez-Kelly, & Haller, 2005).

According to the literature, immigrant groups who network primarily among co-ethnics, and minimize their interaction with the host society ultimately reduce their chances for economic inclusion (Aldrich, Waldinger, & Ward, 1985; Yancey, 2003). This puts African immigrants who must contend with the double burden of being racialized and alien, in a precarious position. On the one hand data on immigrants' mobility show that overdependence on ethnic ties decreases chances for upward economic mobility. However, ethnic community ties are fundamental in protecting against the negative aspects of assimilation, as well as forging an identity within a new society.

4.1.2 Faith-based communities

For many African immigrant groups religion plays an important role, perhaps more so than it did prior to emigrating (Abdullah, 2009; Warner, 1998; Shepard, 2008). Faith-based organizations hold a multifaceted position in the community. In addition to providing religious guidance, they become key in maintaining ethnic solidarity by reinforcing values, beliefs and practices from the country-of-origin (Abdullah, 2009; Foley & Hoge, 2007; Shepard, 2008). Religious bonds can foster increased interaction with larger religious community of the same persuasion, e.g. Muslims of varying ethnic and national backgrounds attend the same Mosque and can benefit from the social network that individuals bring.

For many Africans religious identity may be more salient than even national or ethnic identity. For example, many African Muslims who experienced intense anti-Islamic sentiments following September 11, 2001 counteract negative stereotypes about Muslims by embracing a

strong religious identity (Shepard, 2008). In the same way that ethnic communities reinforce positive self image and boundaries, religious communities bolster religious boundaries of acceptable conduct and positive identity (Abdullah, 2009; Abusharaf, 1998).

All communities, but especially religious communities, provide universal codes of conduct that guide day-to-day actions (Shepard, 2008) that may include dietary habits, and even financial transactions (Abdullah, 2009). Unlike cultural practices, however, religious expectations are clearly defined and their meaning unequivocal, thus religious identity and boundaries are more likely to be strictly maintained (Shepard, 2008) regardless of ethnic or national background. Furthermore, religion can also help to bolster cultural identity in the diaspora as community members restructure their collective identity in the US (Abusharaf, 1998).

Both co-ethnic and religious communities provide structural resources that include opportunities for employment, housing, education and connections with social service networks (Foley & Hoge, 2007) that include knowledge or access to public health programs.

4.2 SELECTIVE ASSIMILATION

Selective assimilation happens when immigrant groups retain some aspects of their culture (.e.g. beliefs, religion, certain codes of conduct) while assimilating in other ways (.e.g. views and practices regarding employment) towards mainstream American culture (Carter, Lee, & Neckerman, 1999; Shepard, 2008). Rather than assimilate they are choosing acculturate. For example, some traditional Ethiopian culture provide clear gender roles where women are relegated to household duties (e.g. cooking, cleaning and child rearing) and are excluded from

family financial matters and decision making (Arthur, 2000). However, economic necessity following immigration to the US required that families adapt egalitarian approaches to family decision making and financial contribution (Arthur, 2000). Furthermore, cultures that previously restricted male-female interaction prior to marriage or practiced arranged marriage may adapt western style courtship.

4.3 SOCIAL BONDING THEORY

In addition to the concept of selective assimilation, the Social Bonding theory provides practical and appropriate constructs in facilitating youth bicultural or selective acculturation. Originally formulated as a tool in preventing adolescent delinquent behavior, the premise behind the theory is that individuals become delinquent because they have failed to establish or maintain strong ties with society (Griswold, Roberts, & Wiatrowski, 1981). The four constructs include: *Attachment*, *Commitment*, *Involvement*, and *Beliefs* (Chriss, 2007; Griswold, Roberts, & Wiatrowski, 1981).

- Attachment refers to affective relations that youth establish with significant others. The family is the primary source of attachment, and parents are the primary models who teach children socially acceptable behavior.
- Commitment is associated with ambition to attain a specific desired goal like attending university and or becoming professionally successful. Youth who have goals are less likely to participate in risk-taking behavior that might hinder their ability to achieve their goals.

- Involvement refers to participation in activities and how they relate to future goals, for example, doing homework versus going out drinking with friends.
- Beliefs refer to the acceptance of and adherence to social moral codes of behavior which is relevant because “rule-bound” individuals are less likely to take part in delinquent activities (Chriss, 2007; Griswold, Roberts, & Wiatrowski, 1981) .

The ideas behind social bonding is that individuals who feel invested in society and have strong connections within their community, and especially with their families, are less likely to participate in deviant acts. Deviant acts are those that are incongruent with society or community mores. Those who are poorly integrated in their community and family in particular, do not benefit from the social support they provide, and are likely to exhibit deviant behavior. External societal pressures and prejudices reinforced by local environmental failings e.g., inadequate housing, resource starved educational systems, and limited access to social services, can foster feelings of alienation and encourage deviance as a coping mechanism. In such cases, strong social ties can anchor at-risk youth from risk-taking behaviors. Families and community that foster positive, goal-oriented behavior should result in greater long term success for all community members but especially the youth (Cynthia Garcia Coll, 2004; Hernandez, 2004). In short, increased attachment results in community members’ belief in community and family held values and a decrease in the likelihood of adopting adversarial attitudes and behaviors (Barondess, 2008; Chriss, 2007; Portes, Fernandez-Kelly, & Haller, 2005; Shepard, 2008).

5.0 SOCIAL BARRIERS TO INCLUSION AND ACCESS

As previously stated, the assimilation process is not entirely the same for all immigrants or individuals. The particular experience of an immigrant group or an individual is determined by social forces that predate their arrival to the US. The social context, while ever-changing, is rooted in history of racial hierarchy that has the potential to impact opportunities for upward mobility. Issues of discrimination have been discussed in earlier chapters; however, they cannot be overstated as they are relevant factors that persons of African origin must contend with on a daily basis. American racial constructs help to define how African immigrants are perceived and self identify within the US social framework. For blacks in general, discrimination, systemic or overt, dramatically affects access to a wide range of resources including health care services. The social barriers created by discrimination or past discriminatory patterns of behavior continue to influence the lives and health outcomes of all persons of African ancestry.

5.1 DISCRIMINATION

Racism and discrimination yield a large impact the psychological and ultimately on the physiological state of anyone exposed to this treatment (Jackson, Neighbors, & Williams, 2003). Consequences of exposure to perceived racism and discrimination include induced stress, internalized oppression, health care barriers and structural disadvantages. (Gee, Holt, Laftlamme,

& Ryan, 2006). Often covert, discrimination may take the form of systemic organizational practices and discrete life events or overt observable stressors. It may be expressed through daily hassles or sporadic irritants like single incidents of discrimination (Jackson, Neighbors, & Williams, 2003). These instances may be interrelated or independent of one another. In either case, it is difficult to pinpoint life-long exposure to discrimination as an attributable cause for disease and poor health. This is especially true when considering negative effects of spatial segregation and blocked opportunities (Jackson, Neighbors, & Williams, 2003).

Key characteristics of stressful experiences include “the domain in which the event occurs, the magnitude of the event, the temporal characteristics of the event, and the nature of the relationship between the stressor in question and other race-related and non-race related stressors” (Jackson, Neighbors, & Williams, 2003; Shi & Stevens, 2004). The consequences of racism and discrimination become increasingly more important as immigrant groups become assimilated. Existing literature states that in time foreign-born persons begin to resemble their US counterparts in terms perceptions and lifestyle habits that include an increase in foods high in fat, smoking and living a more sedentary lifestyle (Alegria, Jackson, Takeuchi, & Williams, 2007; Deepika L. Koya, 2007; Baldimarsdottr, et al., 2009). First and 1.5 immigrants can escape some of the harmful effects associated with discrimination by insulating themselves within their ethnic community. Yet, successive generations that will have become increasingly more Americanized and further removed from their ethnic community will not have that benefit. Since discrimination has been identified as a catalyst for stress induced negative health outcomes, and that increased residency increases exposure, it is likely that the health of second generation and potentially 1.5 African immigrants will be impacted (Foley, 2005; Gee, Holt,

Laftlamme, & Ryan, 2006; Jackson, Neighbors, & Williams, 2003; Jackson, et al., 2007; Jing Fang S. M., 1996; Jing Fang S. M., 1997; Jing Fang S. M., 1997; Kaushal, 2009)

Recent political change, i.e., the election of a black president does not negate the fact that being “black” in the US is associated with poor health and health outcomes. This is due largely to historical inequities that have produced systemic barriers to access (Mayberry, Mili, & Ofili, 2000) and create additional sources of stress for which risk-taking behaviors are used as coping mechanisms. Persons of African ancestry entering the US require additional public health efforts that address the unique combination of both recent immigrant status and racial marginalization so as to prevent their uptake of risk-taking life style habits that induce negative health outcomes.

While there is a substantial amount of literature discussing the topic of discrimination and health, few studies examine the impact of discrimination on immigrant minorities in areas where there numbers are relatively small (Gee, Holt, Laftlamme, & Ryan, 2006). Other areas that require increased focus deal with the extent to which perceived discrimination increases risk of disease, circumstances in which this would happen, and what mechanisms are employed in such cases (Jackson, Neighbors, & Williams, 2003). Furthermore, current research is unclear on whether there is a dose-response relationship between discrimination and disease outcome; if discrimination amplifies exposure to other sources of stress; or leads to habitual risk taking behavior to the point where discrimination is not recognized as a catalyst for the behavior (Jackson, Neighbors, & Williams, 2003). Of the studies conducted on the subject, few have employed psychometric tools in the design, administration, and interpretation of quantitative tests for measures of psychological variables and data in measures of discrimination (Jackson, Neighbors, & Williams, 2003).

5.2 IDENTITY AND IDENTITY FORMATION

Identity and identity formation is the result and processes of multiple factors working on different levels. It is shaped through interactions with individuals, communities and society (Shepard, 2008). People are dynamic and complex; depending on their social surroundings, certain identities may become more prominent within a particular context (Shepard, 2008). For example, many Dominicans who previously considered themselves to be white are shocked to realize, upon arrival in the US, they are considered black (Hernandez, 2004). The question with regards to Africans is, “to what extent is race salient?” since they have not historically been a part of the “African-American” diaspora (Arthur, 2000). For a considerable portion of 1.5 and second generation African immigrants, the adoption of a black American identity is relatively natural as they undergo “Americanization”. Common racial identity (within the US social context), and close residential concentration make it easier for African immigrant youth to more readily assimilate to popular black American culture. African youth will emulate black American styles of dress, popular music and use black American vernacular English (AAVE) (Shepard, 2008).

Existing literature suggests that racial identification occurs through one of three processes: *reactive*, *selective*, and *symbolic* identification.

Reactive identification is the result of exposure to experiences related to discrimination and is associated with individuals in a lower socioeconomic position (Bean & Brown, 2006). This form of identification would represent minority groups who may feel socially and economically disenfranchised and overlooked by policy makers. Racial and ethnic identities are reinforced by social and economic exclusion. The result is a strong ethnic identification necessitated in part by economic and social needs that foster networks to address these matters.

An example of reactive identification would include pan-ethnic identification used to lobby for increased services that address collective racial or ethnic community needs.

Selective ethnic identification occurs among the more affluent members of society. It is used to facilitate opportunities for advancement through social networks in which case ethnic identification is advantageous. (Bean & Brown, 2006; Gans, 1999). Symbolic identification, which occurs among ethnic groups that have already been (at least economically) incorporated, ethnicity is used as an outlet of personal expression. Like selective identification, it too is most common among those in higher socioeconomic positions (Bean & Brown, 2006; Gans, 1999).

The impact of racialization can have long lasting effects as exposure, particularly lifelong exposure, to discrimination impacts health outcomes. For immigrants it compounds an already stressful situation caused by the immigration processes and struggles with identity. In addition to facing prejudices from mainstream society, Africans also perceive their being African as a source of prejudice. In light of the media's portrayal of Africa only in times of political, environmental or social upheaval, Africa is often perceived as antiquated and chronically impoverished (Arthur, 2000; Foley, 2005; Grant & Obiakor, 2002). Additionally, controversial findings that places the origin of AIDS in Africa creates additional stigma on Africans (Foley, 2005; Hausman, Lidicker, Simbiri, & Wadenya, 2009).

5.3 DISPARITIES IN ACCESS TO HEALTH CARE

Health disparities are an enormous concern. Systemic causes of health disparities are due in part to previous patterns of behavior and beliefs founded upon racial and ethnic stereotypes that continue to impacted the level of services provided to visible minorities, in

particular those of African ancestry (Arthur, 2000; Mayberry, Mili, & Ofili, 2000; Fu & van Rye, 2003).

It has been well documented that racial minorities receive lower quality of care regardless of insurance. Black Americans in particular have been found to receive lower quality prenatal care (Fu & van Rye, 2003; Doescher, Fiscella, Franks, & Saver, 2002; Mayberry, Mili, & Ofili, 2000), are less likely to receive counseling regarding smoking and alcohol cessation as well diet and exercise (Doescher, Fiscella, Franks, & Saver, 2002; Fu & van Ryn, 2003); are also more likely to receive fewer pediatric prescriptions, fewer and lower quality care for hospital admissions for chest pain, and inferior management of congestive heart failure and pneumonia. Furthermore, black Americans have less access to preventative treatments including mammograms (Doescher, Fiscella, Franks, & Saver, 2002; Mayberry, Mili, & Ofili, 2000; Mechanic, 2006), vaccination among elderly (Fu & van Ryn, 2003) and are less likely to receive access to advance therapeutic health care services (Mayberry, Mili, & Ofili, 2000; Mechanic, 2006) including access to particular treatment for HIV/AIDS (Mayberry, Mili, & Ofili, 2000) as well as differentials in mental health services (Mayberry, Mili, & Ofili, 2000).

Research shows that physicians spent more time and give more attention to patients with whom they shared the same racial and ethnic background (Lenny Lopez, 2008). Conversely, patients expressed greater comfort discussing any health related matters including pressing questions and concerns with physicians of the same racial and or ethnic background as their own (Lenny Lopez, 2008; Cadoret, Garcia, & Henshaw, 2008).

This is not to say that physicians knowingly and purposefully provide inferior care to patients based on race and ethnicity. On the contrary, physicians are not immune from historical

stereotypes about minority groups and whether they are aware of it or not, studies show that it does in fact, impact the level of care they provide (Fu & van Rye, 2003).

In spite of the benefits of selective assimilation and or acculturation and community involvement, the reality is that African immigrants are also exposed to the same subpar level of care that is being provided to black Americans. Additionally, structural barriers related to language, culture and unfamiliarity with the US health system further exacerbate the circumstance that African immigrants are likely to face.

6.0 HEALTH STATUS OF AFRICAN IMMIGRANTS

Studies of immigrant populations (regardless of country origin) indicate that immigrants are generally in better health than the American born population. Life expectancy among immigrants is between two to four years longer than among the US born population. Foreign born blacks have a life expectancy that is seven to nine years longer than their American counterparts. Further, foreign born blacks over the age of 25 have the lowest age adjusted mortality rates of any immigrant group in the US (Gany & Venters, 2009). Overall, foreign born blacks have a lower mortality rate than black Americans and white Americans (Emerson, 2005). However, the black foreign born populations vary significantly among themselves. For example, of all black immigrant groups, African immigrants have the best health status, followed by Caribbean and lastly, Europeans (Emerson, 2005).

6.1 EXPLANATION FOR BETTER IMMIGRANT HEALTH

The superior health status of immigrant groups can be attributed to a number of factors that include a culture and lifestyle in the country-of-origin that promoted physical activity and healthy eating habits. In addition to a healthier lifestyles, selective migration and the majority-minority status (Emerson, 2005) all greatly impact the health quality of individuals that

immigrate to the US. Healthier life styles may include healthier diets that were low in processed sugars, sodium and caloric intake as well as greater physical activity, and more social support.

US immigration policy is such that a selective process is employed where by only the healthiest are permitted legal entry. In other words, only those who are more likely to be successful and contribute to the US economy are permitted to emigrate (Emerson, Read, & Tarlov, 2005).

The notion of majority-minority relates to an immigrant group status in their country-of-origin. There is evidence in the literature that lifelong minority status, minority in the political sense rather than numerical minority, negatively impacts a person's health. Within the US social context, political minorities or racial minorities, blacks in particular, are politically and socially underserved as well as face the greatest disparity of any group in the country. The negative experiences associated with the above described minority status impacts all phases of life, development and health (Emerson, Read, & Tarlov, 2005). Within this context, African immigrants and blacks in general would experience greater burden of disease and lower quality of life. Research has shown strong association with perceived discrimination and higher blood pressure, decreased mental health and overall poor health status (Emerson, Read, & Tarlov, 2005; Gee, Holt, Laftlamme, & Ryan, 2006; Jackson, Neighbors, & Williams, 2003). In contrast, African immigrants coming from their country-of-origin may not have had to contend with the same level of marginalization experienced by native-American blacks. Positive experiences associated with political and social majority status early in life produce greater resilience and health throughout the life course (Emerson, Read, & Tarlov, 2005).

6.2 EFFECTS OF ACCULTURATION ON HEALTH

Unfortunately, the advantage of superior health that immigrant groups experience is diminished with increased length of stay and acculturation/assimilation (Emerson, 2005). Assimilation and acculturation both involve more than merely learning the language along with other positive cultural mores; it often involves adopting risk taking behaviors such as smoking and poor dietary habits that promote obesity and other chronic conditions (Homer Venters, 2009). As the health profile of African immigrants (Shi & Stevens, 2004) shifts from healthy to unhealthy, there is a growing need to consider the impact that chronic disease will have on this community (Gany & Venters, 2009).

6.2.1 Chronic disease

Statistically, black immigrants experience lower mortality related to chronic conditions such as cardiovascular disease, respiratory disease and cancer when compared to both white and black Americans (Gany & Venters, 2009). However, as mentioned above, the limited amount of data on chronic disease within the foreign-born black population, and specifically the African-born population, makes it difficult to understand the impact that chronic conditions are having on this group (Gany & Venters, 2009). One important problem that requires more study is the preexistence of diabetes among African immigrants. While diabetes has not been well studied among African immigrants in the US (Gany & Venters, 2009), European and Israeli studies found higher rates of diabetes among African immigrants than any other immigrant population (Gany & Venters, 2009). This points to need for collection of country-of-origin data on studies of diabetes among the black population. In addition, a study of pregnant women in Washington

State found that of all participants, Somali women suffered from a higher rate of gestational diabetes than white and black American women (Apraku, 1991; Shi & Stevens, 2004; Gany & Venters, 2009). Some African advocacy organizations have pointed to hypertension and anxiety in addition to diabetes as major health concerns of Africans, for example, the Liberian community in Los Angeles (Gany & Venters, 2009). This concern is notable given the data suggesting that Africans suffer low rates of hypertension and hypertension related conditions as well as stroke in comparison to black Americans (Gany & Venters, 2009). These studies emphasize the lack of research into the status of foreign-born African groups.

6.2.1.1 Obesity

Most immigrant groups have lower rates of obesity than US born groups. Healthier behaviors that reduce the risk of obesity are determined by the country-of-origin, selective migration (as mentioned above with regards to other chronic conditions), and cultural factors that buffer immigrants from risky health behaviors (Askew, Bennett, Emmons, Wolin, & Fletcher, 2007). Unfortunately, immigrant health status begins to mirror that of the general American population with increased residency (Askew, Bennett, Emmons, Wolin, & Fletcher, 2007; Gany & Venters, 2009; Kaushal, 2009).

Factors that influence this process include, for example, limited access to a healthy diet and opportunities to learn about healthy eating habits within the US context (Gany & Venters, 2009). This relates to residential location of immigrant groups in inner city, low-income neighborhoods as they have limited access to grocery stores that provide fresh foods (Gany & Venters, 2009; Latetia V. Moore, 2006). Further, immigrant groups may not consider the benefits of eating fruits and vegetables (Gany & Venters, 2009) or the health effects of processed American foods. In short, economic constraints, geographical location and limited

knowledge of the US food choices and nutritional guidelines may reduce access to healthy foods and increase consumption of fast foods and prepackaged goods that are high in processed sugars and sodium. Risk for obesity has been found to be highest in the first five years following arrival to the US (Kaushal, 2009) which might be the result of unfamiliarity with US products and lack of availability of ethnic foods.

Country-of-origin influences the diet consumed, the level of physical activity and health outcomes like overweight and obese as well as risk factors for other chronic conditions (Kaushal, 2009). The lifestyle practiced in the country-of-origin may or may not promote certain health practices like exercise or eating fruits and vegetables. Communities and families that selectively acculturate thereby maintaining a great deal of their indigenous culture are better able to resist the negative aspects of US culture that they deem undesirable. This is done through strong community ties and networks that promote cultural behaviors (.e.g., diet, recreation, faith-based activities etc.) that protect immigrants from larger society. Considering trends in childhood obesity and immigrant demographic composition consisting of greater numbers of 1.5 generation, immigrants are at greater risk of obesity since obesity is linked to age and increased time spent in the US (Kaushal, 2009). This means that with each successive generation the risk of obesity increases.

Existing literature points to a forty percent (Askew, Bennett, Emmons, Wolin, & Fletcher, 2007) lower rate of obesity among second generation immigrants as compared to third generation (Shi & Stevens, 2004). This is consistent with the discussion above regarding the diminishing effect of the “healthy immigrant” status over time. It also points to the benefits of having foreign born parents in contrast to US born parents (Askew, Bennett, Emmons, Wolin, & Fletcher, 2007).

Other factors that influence the risk for obesity include education level and economic integration. Obesity is most frequent among less educated immigrants especially those without a university degree (Kaushal, 2009). Higher educational attainment generally is associated with greater opportunities for employment and economic integration. In turn, immigrants have expanded choices of residence that in turn increase their access to resources that promote better health behaviors (Freeman, 2002; Israel, James, Schulz, Wilson, & Zenek, 2005). Those less educated are more likely to be from a lower socioeconomic sector and are less likely to have access to high quality health care including counseling on healthy behaviors and physical activity (Kaushal, 2009). Immigrants from lower socioeconomic backgrounds are also more likely to live in areas that do not promote physical activity and provide limited access to resources like grocery stores that sell fruits and vegetables (Freeman, 2002).

Conversely, some data suggests that occupational status (which is linked to education) does little to influence risk for obesity in the African population (Askew, Bennett, Emmons, Wolin, & Fletcher, 2007) though this relationship is likely due to changes in the demographic makeup of the African immigrant population. Until recently, most African immigrants came from primarily English speaking countries and had some education (Foley, 2005). However, recent immigrants from Africa have included increasing numbers of rural and non-English speaking populations. Those with limited education and who do not speak English are at a greater risk of poverty (Askew, Bennett, Emmons, Wolin, & Fletcher, 2007). In short, those most at risk of obesity within the African immigrant population are those from lower socioeconomic background and the young, who are most likely to adapt to US risky behaviors.

6.3 INFECTIOUS DISEASE

Existing public health statistics on African immigrants may result in underestimating health problems following immigration (Adair & Nwaneri, 1999). The absence of published data makes it difficult to appreciate the full extent of the disease burden in this population. In contrast to chronic conditions, infectious disease has been comparatively well studied, in particular tuberculosis (TB) and the human immunodeficiency virus (HIV) (Gany & Venters, African Immigrant Health, 2009). However, there is lack of US based research as most studies are either Canadian or European and often not in English (Adair & Nwaneri, 1999).

6.3.1 HIV/AIDS

In regards to HIV infection, Africans have a lower rate of infection in comparison to black Americans; still, that rate has substantially increased since the 1990's (Gany & Venters, African Immigrant Health, 2009). Nevertheless, there is limited prevalence data on HIV among African immigrants. European studies have identified variation in HIV genetic diversity as well as unique characteristics among African-born populations (Akinsete, et al., 2007). A similar study in Minnesota identified new genetic variations in the virus not yet registered (Akinsete, et al., 2007). Genetic variations have tremendous implications for surveillance and treatment of HIV/AIDS (Akinsete, et al., 2007).

Barrier to treatment of HIV/AIDS is the stigma associated with the disease. Cultural beliefs and attitudes carried over from the country-of-origin dictate to a great extent an individual's willingness to get tested and seek treatment (Akinsete, et al., 2007; Gany & Venters, 2009; Foley, 2005). Fear of isolation and rejection from community and family members is

perceived as equally devastating as the disease itself (Foley, 2005) that being said, the associated stigma of HIV/AIDS is major barrier in providing not only treatment but even screening programs.

Structural barriers in accessing health care services include immigration status that can block employment opportunities in formal sectors that are likely to provide health care benefits; and eligibility for government health programs for the uninsured or underinsured (Foley, 2005; Hernandez, 2004). Structural barriers that impact treatment-seeking behavior include language and cultural misunderstandings, racism, lack of information about testing and treatment as well as perception of risk for contracting HIV/AIDS, and limited knowledge and understanding of US health care system (Adair & Nwaneri, 1999; Akinsete, et al., 2007; Foley, 2005; Baker, et al., 2003). In particular, the inability to speak English and the unavailability of translators or access to translators, are cited as being sources of perceived mistreatment of medical staff and are linked to feelings of insecurity regarding documentation status and quality of health care received (Akinsete, et al., 2007; Foley, 2005). Health care providers, in turn, perceived patients lack of knowledge about the US health system as lack of confidence in the providers (Foley, 2005). Consequently, a 2005 study found that health care providers openly admitted that staff members were rude and intentionally created additional barriers to access for African patients (Foley, 2005).

From a national perspective, African immigrants comprise a small portion of the overall HIV positive population in the US. However, self perceived risk, delayed diagnoses and acceptance of use of antiretroviral treatment, and less knowledge of HIV treatment options in the US, put them at greater risk (Foley, 2005). African women are particularly vulnerable because

they have lower participation in formal employment and social support systems that provide access to health care and social services (Foley, 2005).

6.3.1.1 Gaps in HIV/AIDS research

Further research is needed to understand determinants of health care-seeking behavior, fear of the US health care system, the stigma associated with HIV/AIDS, and the structural barriers that reduce access for African immigrants in the US (Gany & Venters, 2009). Studies must address the heterogeneity of the African immigrant population in order to create public health programs that better facilitate culturally appropriate education and outreach initiatives. It is not enough to create culturally appropriate programs. Instead, interventions must consider economic barriers to access .e.g. lack of health insurance and access to basic services (Akinsete, et al., 2007; Foley, 2005).

Furthermore, there is a need for increased surveillance to monitor the rate of infection pre and post immigration; the rate of testing in comparison to other immigrant groups; the impact of educational interventions (what works and what does not); and most importantly, whether African immigrants visit travel clinics (to address any health concerns and to prepare for trips abroad) prior to traveling outside of the country. It is important to keep in mind that international visitors, students or business visa holders are not required to undergo HIV testing prior to entry and so this further crystallizes the importance of effective surveillance (Foley, 2005).

6.4 MENTAL HEALTH

Mental health problems in the African immigrant community may be the result of the journey to the US or they may have preceded the emigration process. Experienced trauma leaves long lasting effects that are further exacerbated by the immigration and resettlement process. Inimitable sources of stress present uncommon depressive or somatoform symptoms that worsen with time (Gany & Venters, 2009). Adding to the problem is the US medical model for treating mental illness and the US social-cultural environment which may contradict with traditional practices of dealing with mental illness. Refugees are particularly vulnerable to mental health issues. A 2005 US-based study found that among detained refugees, of whom 77% were African, 86% showed clinical signs of depression, 77% signs of anxiety, and 50% post traumatic stress disorder (PTSD) (Gany & Venters, 2009). While there is considerable amounts of literature on mental health issues, prevalence rates are vary from study to study (Gany & Venters, 2009). In addition, there is limited information regarding the effectiveness of western medical approach in diagnosing, treating and screening for mental health issues among African immigrants (Gany & Venters, 2009).

Although the literature review did not uncover research that compared rates of mental illness across African groups or genders, it did point to high rates of stigma associated with mental health (Gany & Venters, 2009; Lange, Miranda, & Nadeem, 2009). An unfortunate consequence of stigma is that it shrouds the need for care and perpetuates the belief that mental health issues do not require medical treatment (Lange, Miranda, & Nadeem, 2009). Current research suggests that African women typically do not perceive a need for medical care in dealing with mental health issues especially since they often may not know of anyone in their social circle that has sought treatment for mental health issues or that there are treatment options

available (Lange, Miranda, & Nadeem, 2009). Moreover, African women have a high rate of somatization in spite of low rates of alcohol or drug use in comparison with other immigrant groups (Gany & Venters, 2009).

Important questions regarding rates of depression, suicidality and anxiety among African immigrants are unknown. It is also unknown as to how if at all do these rates change with length of residency. While stigma is associated with reluctance to seek treatment, lack of health care access and mental health status influence health seeking behavior (Gany & Venters, 2009).

6.5 ACCESS AND UTILIZATION

Issues of health disparity are complex, however, there are number of factors that inhibit access and utilization to health care services. They include access to employer-sponsored coverage, eligibility for government health programs and knowledge and perspective regarding the US health care system. The US Foreign-born population is more likely to be uninsured than the general US population (Barr-Anderson, Kington, & Lucas, 2003; Dolfin, Buchmueller, Lurie, & Lo Sasso, 2007). Uninsured rates for foreign-born persons in the US are 32 percent versus 13.4 percent for the general US public (Dolfin, Buchmueller, Lurie, & Lo Sasso, 2007). The higher proportion of uninsured among US immigrants is largely due to lower likelihood for employer-sponsored insurance. Lack of coverage not only minimizes overall use of health care services but it also accounts for low rates of screenings and other preventative treatments (Dolfin, Buchmueller, Lurie, & Lo Sasso, 2007). The result is greater reliance on “safety net” services such as the emergency department (Gany & Venters, 2009).

A higher rate of uninsurance among African men in particular is due in part to difficulty in qualifying for government sponsored insurance (Barr-Anderson, Kington, & Lucas, 2003). Notwithstanding higher rates of education and employment, foreign born black men are considerably more likely to be uninsured than both black and white American-born individuals (Barr-Anderson, Kington, & Lucas, 2003). While education has been cited as the number one predictor for the likelihood of having employer-sponsored insurance (Dolfin, Buchmueller, Lurie, & Lo Sasso, 2007), African immigrant men, regardless of educational attainment are more likely to work for employers that do not provide health benefits (Gany & Venters, 2009). The prospect of having employer-sponsored health insurance is even lower for foreign born black men from non-English speaking countries (Barr-Anderson, Kington, & Lucas, 2003).

Another important factor related to health care coverage is citizenship status, as noncitizens tend to have lower rate of coverage, and naturalization is positively associated with not only access to health care but also to improved wages and wage increases (Dolfin, Buchmueller, Lurie, & Lo Sasso, 2007). Citizenship opens opportunities to employment sectors e.g. companies that hold government contracts or government jobs (Dolfin, Buchmueller, Lurie, & Lo Sasso, 2007), which are more likely to provide employer-sponsored coverage. Additional factors that influence the type of jobs held by immigrants are country-of-origin, year of arrival and age of arrival (Dolfin, Buchmueller, Lurie, & Lo Sasso, 2007). As mentioned above, those who emigrate from non-English-speaking countries are less likely to have employer-sponsored health coverage. Year of arrival is relevant in as far as economic trends in employment and cost of living which varies over time. Age at arrival distinguishes 1.5 from first generation immigrants. While both are technically first generation, 1.5 are likely to speak English with greater proficiency, and culturally adapt quicker and have the benefit of attaining a US education

which is widely accepted versus foreign degrees, diplomas and accreditations which are seldom recognized.

Although it is understood that SES affects access to health care coverage, reliable data on employment and wages-related disparities and their impact on the health status of immigrants is lacking. In fact, the greatest data gap on the subject relates to foreign-born black men (Barr-Anderson, Kington, & Lucas, 2003).

Lack of knowledge and trust in the US medical system also work to inhibit utilization. (Baker, et al., 2003; DeShaw, 2006; Foley, 2005; Shi & Stevens, 2004). Cultural incongruence (DeShaw, 2006) and linguistic barriers (Biddle, Carey, DeFrieze, Lambrew, & Ricketts, 1996; Doescher, Fiscella, Franks, & Saver, 2002) coupled with the complexities of insurance policies, eligibility criteria for government programs (Dolfin, Buchmueller, Lurie, & Lo Sasso, 2007; Foley, 2005), and US medical and public health approach to treatment and prevention (DeShaw, 2006; Foley, 2005) can be overwhelming and easily misunderstood. Additionally, mistrust in the health care system stemming from discrimination, low quality care and previous negative experiences discourage utilization (DeShaw, 2006; Shi & Stevens, 2004; Foley, 2005). Past negative experiences, both personal and historical, also reduce patient empowerment in demanding access to adequate care (Mechanic, 2006; Shi & Stevens, 2004).

Factors that have been found to enable and predict health care utilization include having a regular source of care (e.g. a doctor's office or clinic) and the ability to speak English or have access to interpreters (Biddle, Carey, DeFrieze, Lambrew, & Ricketts, 1996; Doescher, Fiscella, Franks, & Saver, 2002; Mayberry, Mili, & Ofili, 2000; Cunningham, Hays, & Ponce, 2006). Individuals with primary care physicians are more likely to have preventative procedures like cancer screenings, clinical breast examination as well as improved management of chronic

illness (Mayberry, Mili, & Ofili, 2000). Those who did not have regular source of care are likely to be racial and ethnic minorities (Cunningham, Hargraves, & Hughes, 2001), are uninsured, have a family income below US average and are more likely to use ER for health services (Cunningham, Hays, & Ponce, 2006; Mayberry, Mili, & Ofili, 2000). Consequently, not having a regular source of care puts individuals at greater risk of receiving less time and attention as well as inappropriate care (Mayberry, Mili, & Ofili, 2000).

7.0 DISCUSSION

African immigrant acclimation upon arrival determines what process of acculturation/assimilation they will undergo. It is understood that those with greater personal and social capital are better able to access opportunities for employment and needed social services. Those that receive better economic opportunities for upward mobility are more likely to gain access to health and social services aimed at preventing health behaviors that result in negative health outcomes. If resources are plentiful, then opportunities for education, employment and access to health care are increased. Social service programs that provide appropriate acclimation to the various US systems in the initial years following immigration can increase opportunities for individual and community social capital in both the short and long term.

7.1 FACTORS THAT PROMOTE ACCLIMATION

Factors that impact acclimation include mode of entry and reception upon arrival; immigrant physical characteristics; social and economic context of the host society; their human and social capital; and port of entry and eventual place of settlement (Alba & Nee, 1997; Dodoo, 1997; Portes & Zhou, 1999; Portes, Fernandez-Kelly, & Haller, 2005).

Mode of entry refers to immigrant status e.g. refugee, student visa, workers visa, and or arrival under the family reunification program. Those that arrive as refugees are granted additional services to assist in their adjustment. Those who arrive with a work or student visa may not be privileged to the same programs as asylum seekers, however, it is presumed they are arriving with personal capital e.g. they are educated or are granted entry based on skills desired in the US. Individuals who enter through family reunification programs are presumed to have social capital as they are likely moving into co-ethnic communities in addition to having established family members. Physical characteristics are especially important for African immigrants as race and racial discrimination are part of the US social context. Racial disparities impact every facet of life for persons of African ancestry including quality of life. Human and social capital relates to mode of entry and refers to educational attainment, professional background and the existence of co-ethnic communities that are able to provide networks that foster structural opportunities. Port of entry and place of residence determine what types of resources are available for immigrants. Resource rich environments are better able to provide a wide range of services to aid in the acclimation process. Additionally, cities and states with past experience in dealing with immigrant communities may already have existing social service programs that can address the needs of newly arriving individuals and communities. The social and economic context of the host society determines the availability of jobs and opportunities at any given time. Those who immigrate during times of prosperity are more likely to receive greater access to social services and employment versus those who arrive during a recession.

If well acclimated, then individuals and communities of immigrants are better able to access and utilize health care services because not only do they have the structural resources to obtain health care, but more importantly they have the knowledge on how to access it. We know

that factors that enable access include employer-sponsored coverage and eligibility for government programs. Social services that emphasize opportunities for education including English proficiency and promote naturalization would increase immigrant likelihood for employment in industries that provide employer-sponsored coverage. Additionally, they also increase individual eligibility for government-sponsored coverage regardless of age and time of arrival or country-of-origin. Thus, increased coverage would help to offset some of the deteriorating affects associated with increased duration in the US e.g. poor dietary habits, smoking, sedentary lifestyle. Unfortunately, discrimination cannot be addressed through adequate acclimation. The systemic nature of racial prejudice make it formidable obstacle, in which case current adaptive strategies e.g. ethnic community involvement are still the best methods for insulating African immigrant community members.

7.2 POSSIBLE INTERVENTIONS

7.2.1 Uniform identification

Uniform identification method should be established so that more accurate and reliable surveillance data can be captured (Gany & Venters, 2009). This means gathering consistent documentation that includes national origin and language in medical settings which would alleviate the ambiguity that comes with inconsistent identifiers like “foreign-born blacks”, “African born blacks”, and “non-Caribbean blacks” (Gany & Venters, 2009). Inconsistent identifiers make it difficult to compare findings as well as identify variations in health practices and profiles of different African immigrant groups. Gathering country-of-origin data is also likely to increase community visibility and greater opportunity for public health agencies to tailor programs that meet the demographic needs of the various communities.

7.2.2 Host program in Canada

The Canadian Host program is a federally funded program designed to welcome and engage new arrivals and to provide diverse social networks that newcomers can employ in their adjustment to Canadian society. While Host is funded through Citizenship and Immigration Canada (CIC) it is facilitated by independent agencies that provide services to immigrant groups and incorporate Host into their existing programs. Initially, Host was a pilot program created in 1985 to quicken the acclimation of Indo-Chinese refugees who immigrated to Canada (Anisef, Farr, Poirier, Poteet, & Wang, 2007; Baldacchino, Chilton, Chung, & Mathiang, 2008-2009). However, after a 1986 study found that immigrants that receive greater social support acclimate

at a faster rate, the program expanded to include all government-sponsored refugees and eventually all immigrants (Baldacchino, Chilton, Chung, & Mathiang, 2008-2009).

The name Host comes from the term “host society” referring to the society on the receiving end of the immigration process. The program matches new immigrants (individuals or families) with volunteers that will aid the new comers in adjusting to life in Canada (Baldacchino, Chilton, Chung, & Mathiang, 2008-2009). Host volunteers provide new immigrants with access to social networks and information on various social services. In addition, the program also sensitizes the wider society to the specific needs and difficulties faced by newly arrived immigrants. The program is not meant to replace the job or need for traditional resettlement programs nor does it disqualify new immigrants from participating in other services being offered. Instead the Host program supplements existing programs.

7.2.3 Universal health care; universal access

Existing literature states that SES, personal characteristics, ethnic community or coverage status and insurance type alone or in conjunction do not explain current rates health disparities (Cunningham, Hargraves, & Hughes, 2001; Mayberry, Mili, & Ofili, 2000). Natural human tendency to assign subjective characteristics to individuals’ based on patient behavior, race and ethnicity effects physicians decision making (Fu & van Rye, 2003). Racial and ethnic stereotypes shape physicians belief regarding patient likelihood to adhere to treatment regiment or to be able to maintain healthy lifestyle following invasive procedures (Cadoret, Garcia, & Henshaw, 2008; Fu & van Rye, 2003). Research on the subject states that racial differences in access to at least primary care are reduced under universally accessible systems such as the Department of Defense (DoD) health care system and the Veterans Affairs (VA) medical system

(Mayberry, Mili, & Ofili, 2000). While studies on the VA and other social systems of care have shown that disparities exist regardless of coverage status, patient access is dramatically improved, and physician bias is decreased (Biddle, Carey, DeFriese, Lambrew, & Ricketts, 1996) (Cohen, Betancourt, Lopez, Vranceanu, & Weissman, 2008; Cunningham, Hargraves, & Hughes, 2001; Doescher, Fiscella, Franks, & Saver, 2002; Biddle, Carey, DeFriese, Lambrew, & Ricketts, 1996; Mechanic, 2006; Fu & van Ryn, 2003). Much like fluoridation of water or installing air bags and seatbelts or fortifying food is more likely to reduce tooth decay or reduce rates of fatal car crashes, ensuring health care coverage to the entire population is more likely to reduce health disparities than to let individuals try and access the same services on their own (Mechanic, 2006). Compared to other developed nations the US has the lowest rates of health care utilization among immigrant groups. Possible explanation cited is the lack of a strong primary care system which provides equitable access for vulnerable groups like immigrants (Mechanic, 2006).

8.0 CONCLUSION

Undoubtedly, newly arriving immigrants face tremendous challenges. The notable absence of data on African immigrant groups provides limited understanding of how social and economic mobility impacts their burden of disease and what barriers they face to access and utilization of health and social services. Ultimately, it is their personal and collective capital that will determine their long-term success. Acclimation to the various US systems supplemented by educational curricula and life skills courses would increase feelings of self-agency and knowledge to make informed decision regarding health and lifestyle choices. Additionally, this would amplify employment opportunities which increase the potential for upward mobility, access and utilization of health and social services.

APPENDIX: FIGURES AND TABLES

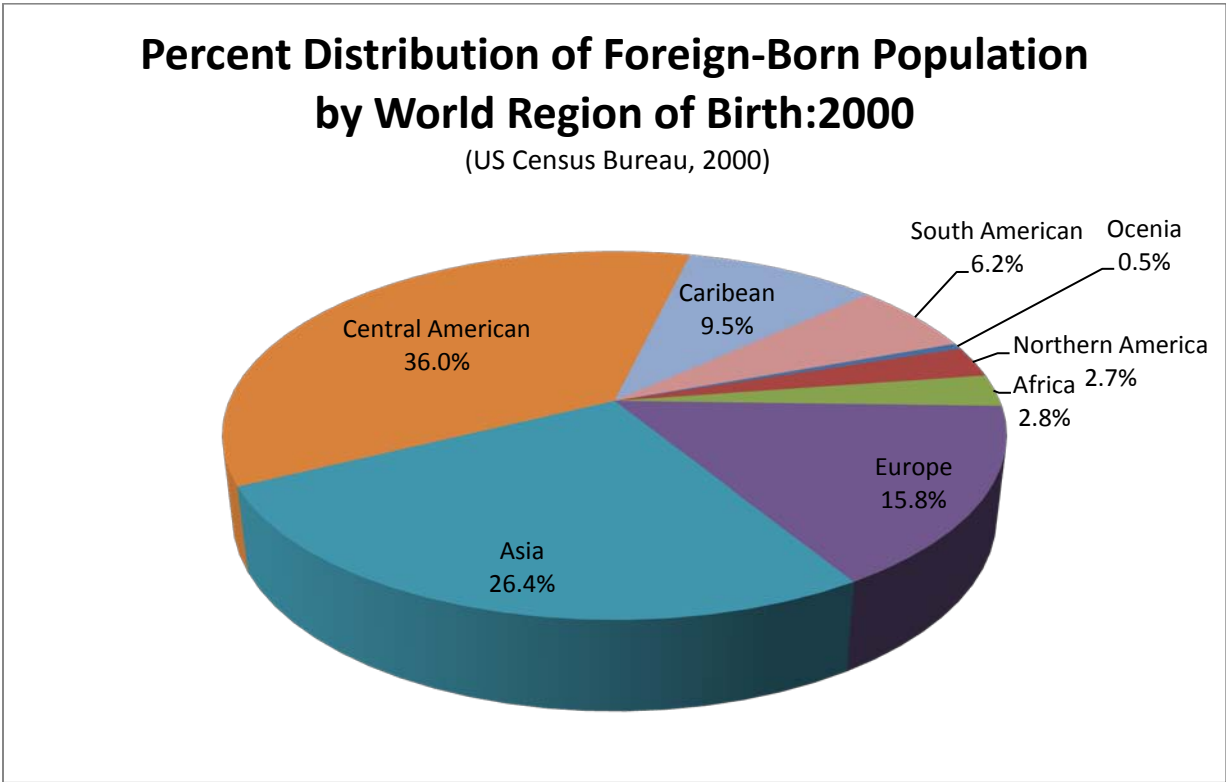


Figure 1 Percent Distribution of Foreign-Born Population by World Region of Birth: 2000. Adapted from 2000 US census (US Census Bureau 2000).

African Immigrant Population by Region of Birth

(Gany & Venters, 2009)

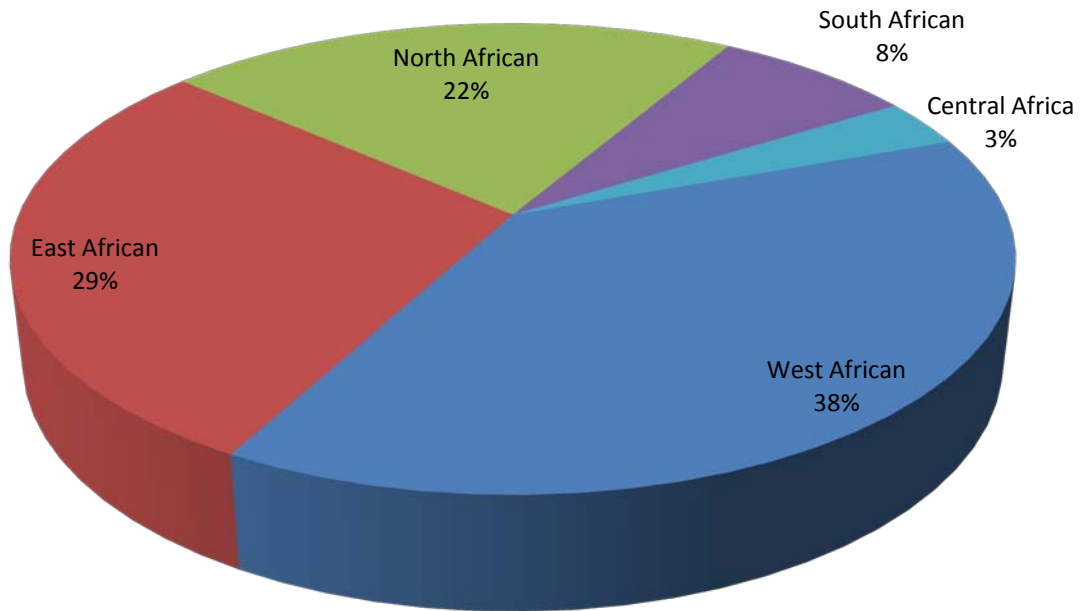


Figure 2 African immigrant population by region of birth adapted from Gany and Venters, 2009 (Gany & Venters, 2009).

Table 1 Refugee seekers granted entry by decade and region of birth. Adapted from the 2006 year book on US immigration statistics (Office of Immigration Statistics, 2006).

Refugee Seekers Granted Entry by Decade and Region of Birth								
(Office of Immigration Statistics, 2006)								
Region and country of birth	1946 to 1950	1951 to 1960	1961 to 1970	1971 to 1980	1981 to 1990	1991 to 2000,	2001 to 2005,	2006
Total	213,347	492,371	212,843	539,447	1,013,620	1,016,820	492,735	216,454
Europe	211,983	456,146	55,235	71,858	155,512	425,047	207,187	35,689
Asia	1,106	33,422	19,895	210,683	712,092	350,702	97,388	67,011
Africa	20	1,768	5,486	2,991	22,149	51,469	65,601	44,808
Oceania	7	75	21	37	22	291	153	678
North America	163	831	132,068	252,633	121,840	183,251	113,632	51,031
South America	32	74	123	1,244	1,986	5,840	8,124	16,857

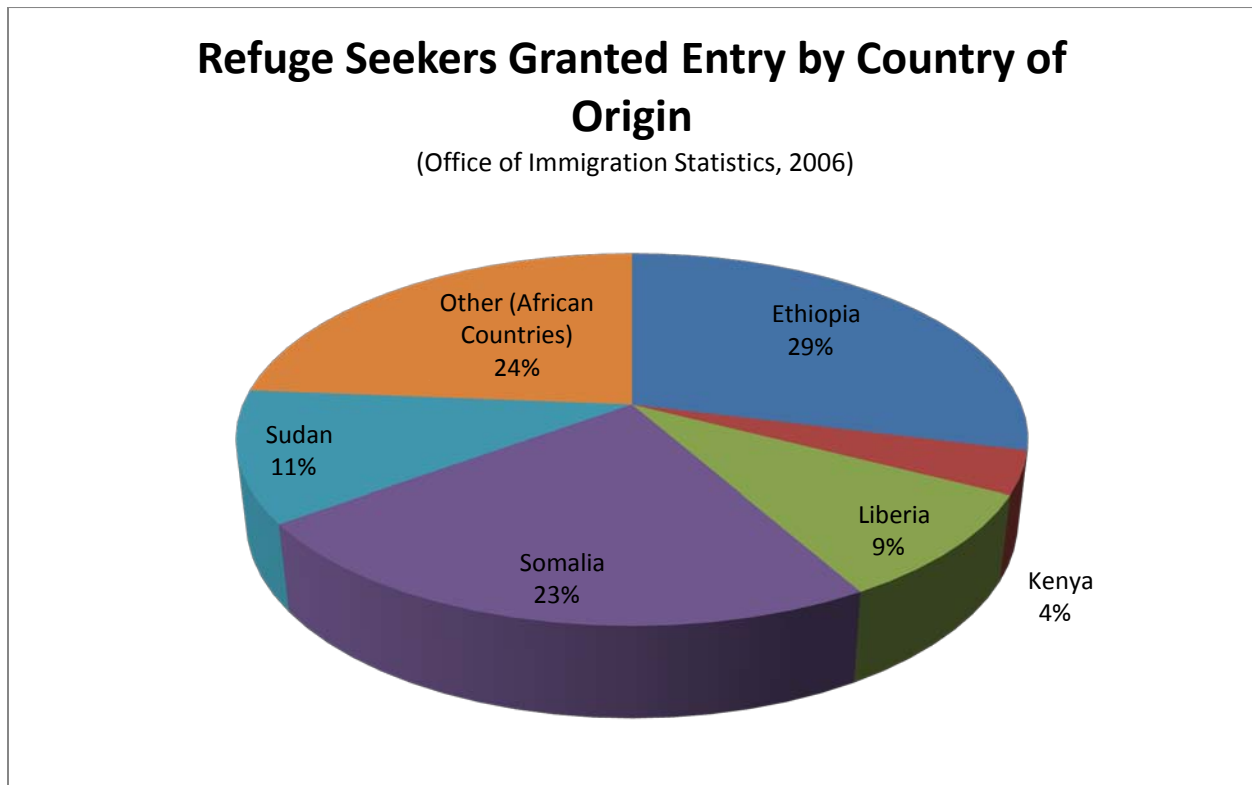


Figure 3 Refugee seekers granted entry by country-of-origin. Adapted from the 2006 year book on US immigration statistics (Office of Immigration Statistics, 2006).

BIBLIOGRAPHY

Abdullah, Z. (2009). African "Soul Brother" in the 'Hood: Immigration, Islam, and the Black Encounter. *Anthropological Quarterly* , 37-62.

Abusharaf, R. M. (1998). Structural Adaptaion in an immigrant Muslim cogregation in New York. In R. S. Warner, & J. G. Wittner, *Gathering in the diaspora: religious communities and the new immigration* (pp. 235-264). Philadelphia: Temple University Press.

Adair, R., & Nwaneri, O. (1999). Communicable Disease in African Immigrants in Minneapolis. *American Medical Association Publication* , 83-85.

Akinsete, O. O., Cartwright, C., Boraas, C., Davey, C., Sides, T., Hirigoyen, D., et al. (2007). Demographic, Clinical, and Virologic Characteristics of African-Born Persons with HIV/AIDS in a Minnesota Hospital. *AIDS Patient Care and STDs* , 356-364.

Akresh, I. R. (2006). Occupational Mobilty Among Legal Immigrants to the United States. *International Migration Review* , 854-884.

Alba, R. (1999). Assimilation's Quiet Tide. In N. R. Yetman, *Majority and Minority: The Dynamics of Race and Ethnicity in American Life* (pp. 327-335). Toronto: Allyn and Bacon.

Alba, R., & Nee, V. (1997). Rethinking Assimilation for a New Era of Immigration. *The Centre for Migration Studies of New York, Inc.* , 826-874.

Alba, R., & Reynolds, F. (2002). The New Second Generatin in the Unite States. *International Migration Review* , 669-701.

Aldrich, H. E., & Waldinger, R. (1990). Ethnicity ane Entrepreneurship. *Annual Review Social* , 111-135.

Aldrich, H., Waldinger, R., & Ward, R. (1985). Trend Report - Ethnic Business and Occupational Mobility In Advanced Society. *Sociology* , 586-597.

Alegria, M., Jackson, D. R., Takeuchi, D. T., & Williams, D. R. (2007). Immigration and Mental Health: Diverse Findings in Asian, Blacks, and Latino Populations. *American Journal of Public Health* , 11-12.

Andrew Moran, A. V. (2007). Acculturation Is Associated With Hypertension in Multiethnic Sample. *American Journal of Hypertension* , 354-363.

Anisef, P., Farr, G., Poirier, C., Poteet, M., & Wang, H. (2007). *Issues confronting Newcomer Youth In Canada: Alternative Models For A National HOST Program*. Toronto: Centre of Excellence for Research on Immigration and Settlement (CEERIS).

Apraku, K. K. (1991). *African Emigres in the United States*. New York: Praeger.

Arthur, J. A. (2000). *Invisible Sojourners: African Immigrant Diaspora in the United States*. London: Praeger Publishers.

Askew, S., Bennett, G. G., Emmons, K. M., Wolin, K. Y., & Fletcher, R. (2007). Immigration and Obesity Among Lower Income Blacks. *Obesity* , 1391-1394.

Baker, A., Kellela, Z., Lahai-Momoh, J., Momoh, M., Rosenthal, L., Ross, M. W., et al. (2003). Assessing The HIV/AIDS Health Services Needs of African Immigrants to Houston. *AIDS Education and Prevention* , 570-580.

Baldacchino, G., Chilton, L., Chung, S.-J. Y., & Mathiang, B. M. (2008-2009). *The Host Program and Immigrant Retention on Prince Edward Island*. Charlottetown: University of Prince Edward Island.

Baldimarsdottr, H. B., Bovbjerg, D. H., Brown, K., Tiffany, E., Forman, A., Kapil-Par, N., et al. (2009). The influence of acculturation and breast cancer-specific distress on perceived barriers to genetic testing for breast cancer among women of African descent. *Psychology* , 945-955.

Baluja, K. F., Costanzo, J. M., Davis, C. J., & Malone, N. (2003). *The Foreign Born Population: 2000*. U.S. Census Bureau.

Barondess, J. A. (2008). Health Through the Urban Lens. *Journal of Urban Health: Bulletin of the New York Academy of Medicine* , 787-801.

Barr-Anderson, D., Kington, R. S., & Lucas, J. W. (2003). Health Status, Health Insurance, and Health Care Utilization Patterns of Immigrant Black Men. *American Journal of Public Health* , 1740-1747.

Bean, F. D., & Brown, S. (2006). *New Immigrants, New Models of Assimilation*. Washington DC: Migration Policy Institute.

Behraman, R. E., & Shields, M. K. (2004). Children of Immigrant Families: Analysis and Recommendations. *The Future of Children* , 4-16.

Biddle, A. K., Carey, T. S., DeFries, G. H., Lambrew, J. M., & Ricketts, T. C. (1996). The Effects of Having Regular Doctor on Access to Primary Care. *Medical Care* , 138-151.

Brown, F., & Rong, X. L. (2007). Educational Attainment of Immigrant and Non-Immigrant Young Blacks. In H. J. Susan J. Paik, *Narrowing the Achievement Gap: Strategies for Education Lation, Black, and Asian Students* (pp. 91-108). Chicago: Springer.

Bueker, C. S. (2006). *From Immigrant to Naturalized Citizen*. New York: LFB Scholarly Publishing LLC.

Cadoret, C., Garcia, R. I., & Henshaw, M. (2008). Multicultural Issues in Oral Health. *Dent Clin North Am.* , 319-331.

Carlotta M. Arthur, E. S. (2006). Making a Case for the Examination of Ethnicity of Blacks in the United States Health Research. *Journal of Health Care for the Poor and Underserved* , 25-36.

Carter, P., Lee, J., & Neckerman, K. M. (1999). Segmented assimilation and minority cultures of mobility. *Ethnic and Racial Studies* , 945-965.

Chriss, J. (2007). The Functions of The Social Bond. *The Sociological Quarterly* , 689-712.

Cohen, A. P., Betancourt, J., Lopez, L., Vranceanu, A.-M., & Weissman, J. S. (2008). Personal Characteristics Associated with Resident Physicians' Self Perceptions of Preparedness to Deliver Cross-Cultural Care. *Journal of General Internal Medicine* , 1953-1958.

Congressional Budget Office. (2006). *Immigration Policy In The United States*. Washington D.C.: Congress of the United States.

Crista E. Johns, K. E. (2008). Cervical Cancer Screening Among Immigrants and Ethnic Minorities: A Systematic Review using the Health Belief Model. *Journal of Lower Genital Tract Diseases* , 232-241.

Cunningham, P. J., Hargraves, L. J., & Hughes, R. G. (2001). Racial and Ethnic Differences in Access to Medical Care in Managed Care Plans. *Health Service Resarch* , 853-868.

Cunningham, W. E., Hays, R. E., & Ponce, N. A. (2006). Linguistic Disparities in Health Care Access and Health Status Among Older Adults. *Journal of Gernal Internal Medicine* , 786-791.

Cynthia Garcia Coll, L. A. (2004). The Multiple Contexts of Middle Childhood. *The Future of Children* , 81-98.

Dana Edelman, A. L. (2009). Association of Acculturation Status With Beliefs, Barriers, and Perceptions Related to Cardiovascular Disease Prevention Among Racial and Ethnic Minorities. *Journal of Transcultural Nursing* , 278-285.

Deepika L. Koya, L. E. (2007). Association Between Length of Residence and Cardiovascular Disease Risk Factors Among an Ethnically Diverse Group of United States Immigrants. *Society of General Internal Medicine* , 841-846.

DeShaw, P. J. (2006). *Clinical and Health Affair: Use of Emergency Department by Somali Immigrants and Refugees*. Minnesota.

Deville, W., Foets, M., Groenewegen, P. P., Spreeuwenberg, P., & Uiters, E. (2009). Differences between immigrant and non-immigrant groups in the use of primary medical care; a systematic review. *BMC Health Service Research* .

Dictionary.com. (2009, September 23). Retrieved September 23, 2009, from Dictionary.com: <http://dictionary.reference.com/browse/acclulturation>

Djamba, Y. K. (1999). *African Immigrants in the United States: A Socio-Demographic Profile in Comparison to Native Blacks*. Austin: Population Research Centre, University of Texas.

Dodoo, N.-A. F. (1997). Assimilatio Differences Among Africans in America. *Social Forces* , 527-546.

Doescher, M. P., Fiscella, K., Franks, P., & Saver, B. G. (2002). Disparities in Health Care by Race, Ethnicity, and Language among the Insured: Findings from National Sample. *Medical Care* , 52-59.

Doescher, M. P., Fiscella, K., Franks, P., & Saver, B. G. (2002). Disparities in Health Care by Race, Ethnicity, and Language among the Insured: Findings from National Sample. *Medical Care* , 52-59.

Dolfin, S., Buchmueller, T. C., Lurie, I., & Lo Sasso, A. L. (2007). Immigrants and Employer-Sponsored Health Insurance. *Health Research and Educational Trust* , 286-310.

Doug Brugge, M. W.-D. (2008). Community-Level Data Suggest that Asthma Prevalence Varies Between U.S. and Foreign-born Black Subpopulation. *Journal of Asthma* , 785-789.

Emerson, M. O., Read, J. G., & Tarlov, A. (2005). Implications of Black Immigrant Health for U.S. Disparities in Health. *Journal of Immigrant Health* , 205-211.

Feliciano, C., & Waldinger, R. (2004). Will the new second generation experience' downward assimilation'? Segmented assimilation re-assessed. *Ethnic and Racial Studies* , 376-402.

Fisher, E. B., Sallis, J. F., & Owen, N. (2008). Ecological Models of Health Behavior. In K. Glanz, B. K. Rimer, K. Viswanath, & T. Orleans, *Health Behavior and Health Education: Theory, Research, and Practice 4th Edition* (pp. 465-482). San Francisco: Jossey-Bass.

Folakemi T. Odedina, D. Y. (2009). Prostate Cancer Cognitive-Behavioral Factors in a West African Population. *Journal Immigrant Minority Health* , 258-267.

Foley, E. (2005). HIV/AIDS and African immigrant women in Philadelphia: Structural and cultural barriers to care. *AIDS Care* , 1030-1043.

Foley, M. E., & Hoge, D. R. (2007). *Religion and the new immigrants: How faith communities form our newest citizens*. New York: Oxford University Press Inc.

Freeman, L. (2002). Does Spatial Assimilation Work for Black Immigrants in the US? *Urban Studies* , 1983-2003.

Fu, S. S., & van Ryn, M. (2003). Paved With Good Intentions: Do Public Health and Human Service Providers Contribute to Racial/Ethnic Disparities in Health. *American Journal fo Public Health* , 248-255.

Gans, H. J. (1999). Symbolic Ethnicity: The Future of Ethnic Groups and Cultures in America. In N. R. Yetman, *Majority and Minority: The Dynamics of Race and Ethnicity in American Life* (pp. 417-431). Toronto: Allyn and Bacon.

Gany, F., & Venters, H. (2009). African Immigrant Health. *Journal of Immigrant Minority Health* .

Gary L. Kreps, L. S. (2008). Meeting the Health Literacy Needs of Immigrant Populatin. *Patient Education and Counseling* , 328-332.

Gee, G. C., Holt, J., Laftlamme, D. J., & Ryan, A. (2006). Self-Reported Discrimination and Mental Health Status Among African Descendants, Mexicans Americans, and Other Latinos in the New Hampshire REACH 2010 Initiative: The Added Dimension of Immigration. *American Journal of Public Health* , 1821-1828.

Goodman, R. M. (2000). Bridging The Gap in Effective Program Implementation From Concept to Application. *Journal of Community Psychology* , 309-321.

Gopal K. Singh, B. A. (2004). Health, Life Expectancy, and Mortality Patterns Among Immigrant Populations in the United States. *Canadian Journal of Public Health* , 14-19.

Gopal K. Singh, M. S. (2001). All-Cause and Cause-Specific Mortality of Immigrant and Native Born in the United States. *American Journal of Public Health* , 392-398.

Gopal K. Singh, R. A. (2006). Trends and disparities in socioeconomic and behavioral characteristics, life expectancey, and cause-specific mortality of native-born and foreign-born populations in the United States, 1979-2003. *International of Epidemiology* .

Gordon, M. M. (1999). Assimilation in America: Theory and Reality. In N. R. Yetman, *Majority and Minority: The Dynamics of Race and Ethnicity in American Life* (pp. 272-285). Toronto: Allyn and Bacon.

Grant, P. A., & Obiakor, F. E. (2002). *Foreign-Born African Americans: Silenced Voices in the Discourse on Race*. New York: Nova Science Publishers, Inc.

Griswold, D. B., Roberts, M. K., & Wiatrowski, M. D. (1981). Social Control Theory and Delinquency. *American Sociological Review* , 525-541.

Hausman, A., Lidicker, J., Simbiri, K. O., & Wadenya, R. O. (2009). Access Impediments to Health Care and Social Service Between Anglophone and Francophone African Immigrants Living in Philadelphia with Respect to HIV/AIDS. *Journal of Minority Health* .

Hernandez, D. J. (2004). Demographic Change and the Life Circumstances of Immigrant Families. *The Future of Children* , 17-48.

Hoffnung-Garskof, J. (2004). The Prehistory of the Cadenu: Dominican identity, social class, and the problem of mobility, 1965-78. In C. W. Donna R. Gabaccia, *Immigrant Life in the US* (pp. 31-50). New York: Routledge.

Holtzman, J. D. (2008). *Nuer Journeys, Nuer Lives*. New York: Pearson Allyn and Bacon.

Homer Venters, F. G. (2009). African Immigrant Health. *Journal of Immigrant Minority Health* .

Ilana Redstone Akresh, R. F. (2008). Health Selection Among New Immigrants. *American Journal of Public Health* , 2058-2060.

Israel De Alba, A. H. (2004). Impact of U.S. Citizenship Status on Cancer Screening Among Immigrant Women. *Journal of General Internal Medicine* , 290-296.

Israel, B. A., James, S. A., Schulz, A. J., Wilson, M. L., & Zenek, S. N. (2005). Neighborhood Racial Composition and the Spatial Accessibility of Supermarkets in Metropolitan Detroit. *American Journal of Public Health* , -667.

Jackson, J. S., Neighbors, H. W., & Williams, D. R. (2003). Racial/Ethnic Discrimination and Health: Findings From Community Studies. *American Journal of Public Health* , 200-208.

Jackson, S. A., Diez Roux, A. V., Manolio, T. A., Moran, A., Kramer, H., Shea, S., et al. (2007). Acculturation Is Associated With Hypertension in Multiethnic Sample. *American Journal of Hypertension* , 354-363.

James, D. R. (1999). The Racial Ghetto as a Race Making Situation: The Effects of Residential Segregation on Racial Inequalities. In N. R. Yetman, *Majority and Minority: The Dynamics of Race and Ethnicity in American Life* (pp. 400-416). Toronto: Allyn and Bacon.

Jessica M. Robbins, D. A. (2004). Neighborhood Poverty, Mortality Rates, and Excess Deaths among African Americans: 1999-2001. *Journal of Health Care for the Poor and Underserved* , 530-537.

Jimenez, T. R., & Waters, M. C. (2005). *Assessing Immigrant Assimilation: New Empirical and Theoretical Challenges*. Cambridge: Annual Reviews.

Jing Fang, S. M. (1997). Influence of Nativity on Cancer Mortality among Black New Yorkers. *American Cancer Society* , 129-135.

Jing Fang, S. M. (1997). Nativity, race, and mortality: favorable impact of birth outside the United States on mortality in New York City. *Human Biology* , 689-692.

Jing Fang, S. M. (1996). The Association Between Birthplace and Mortality from Cardiovascular Casus Among Black and White Residents in New York City. *The New England Journal of Medicine* , 1545-1551.

Joel Perlmann, R. W. (1997). Second Generation Decline? Children of Immigrants, Past, and Present-A Reconsideration. *International Migration Review* , 893-922.

Kamya, H. A. (2001). African Immigrants in the United States: The Challenges for Research and Practice. *Social Work* , 154-165.

Kasprzyk, D., & Montano, D. E. (2008). Theory of Resaoned Action, Theory of Planned Behavior, And Theory of Integrated Behavioral Model. In K. Glanz, B. K. Rimer, K. Viswanath, & T. Orleans, *Health Behavior And Health Education: Thory, Research,and Practice* (pp. 67-92). San Francisco: Jossey-Bass.

Kaushal, N. (2009). Adversities of Acculturation? Prevalence of Obesity Among Immigrants. *Health Economics* , 291-303.

Keller, G. (2001). The New Demographics of Higher Education. *The Review of Higher Education* , 219-234.

L.Champion, V. (1999). Revised Susceptibility, Benefits, and Barriers Scale for Mammography Screening. *Research in Nursing and Health* , 341-348.

Lange, J. M., Miranda, J., & Nadeem, E. (2009). Percieved Need for Care Among Low-Income Immigrant and U.S.- Born Black and Latina Women with Depression. *Journal of Womens Health* , 369-375.

Latetia V. Moore, A. V. (2006). Associations of Neighborhood Characteristics with Location and Type of Food Stores. *Journal of Public Health* , 325-331.

Lenny Lopez, A.-M. V. (2008). Personal Characteristics Associated with Resident Physicians' Self Perceptions of Preparedness to Deliver Cross-Cultural Care. *Journal of General Internal Medicine* , 1953-1958.

LeRoi S. Hicks, D. G. (2003). Association of Region and Immigrant Status with Hypertension, Renal Failure, Cardiovascular Disease, and Stroke, among African American Participants in the third National Health and Nutrition Examination Survey (NHANES III). *Ethnicity and Disease* , 316-323.

Lim, N. (2004). The Significance of race in the urban labor market. In C. W. Donna R. Gabaccia, *Immigrant Life in the US* (pp. 152-172). New York: Routledge.

Magnus, M. (2004). Prostate Cancer Knowledge Among Multiethnic Black Men. *Journal of National Medical Association* , 650-656.

Marian L. Neuhouser, B. T. (2004). Higher Fat Intake and Lower Fruit and Vegetables Intake Are Associated with Greater Acculturation Among Mexicans Living in Washington State. *Journal of American Dietetic Association* , 51-57.

Maurice Crul, H. V. (2003). The Second Generation in Europe. *The Centre for Migratory Studies in New York, Inc.* , 965-986.

Mayberry, R. M., Mili, F., & Ofili, E. (2000). Racial and Ethnic Differences in Access to Medical Care. *Medical Care Research Review* , 108-145.

Mechanic, D. (2006). *The Truth About Health Care: Why Reform Is Not Working In America*. London: Rutgers University Press.

Mikhail, B. (2000). Prenatal Care Utilization Among Low-Income African American Women. *Journal of Community Health Nursing* , 235-246.

Moore, L. V., & Diez Roux, A. V. (2006). Associations of Neighborhood Characteristics with Location and Type of Food Stores. *Journal of Public Health* , 325-331.

Office of Immigration Statistics. (2006). *2006 Yearbook of Immigration Statistics*. U.S. Department of Homeland Security.

Ogbu, J. U. (1999). Minority Status in Comparative Perspective. In N. R. Yetman, *Majority and Minority: The Dynamics of Race and Ethnicity in American Life* (pp. 363-375). Toronto: Allyn and Bacon.

Perlmann, J., & Waldinger, R. (1997). Second Generation Decline? Children of Immigrants, Past and Present-A Reconsideration. *International Migration Review* , 893-922.

Perry, M., & Schachter, J. P. (2003). *Migration of Natives and the Foreign Born: 1995 to 2000*. U.S.Census 2000.

Portes, A., & Zhou, M. (1999). The New Second Generation: Segmented Assimilation and Its Variants. In N. R. Yetman, *Majority and Minority: The Dynamics of Race and Ethnicity in American Life* (pp. 348-362). New York: Allyn and Bacon.

Portes, A., Fernandez-Kelly, P., & Haller, W. (2005). Segmented Assimilation on the ground : The new second generation in early adulthood' , Ethnic and Racial Studies. *Ethnic and Racial Studies* , 1000-1040.

Richard Alba, V. N. (n.d.). Rethinking Assimilation Theory for a New Era of Immigration. *The Centre for Migration Studies of New York,Inc.*

Robert K. Ream, R. D.-S. (2007). The Mobility/Social Capital Dynamics: Understanding Mexican Americans Families and Students. In H. J. Susan J. Paik, *Narrowing the Achievement Gap: Strategies for Educating Lation, Black, and Asian Students* (pp. 67-90). Chicago: Springer.

Roger Waldinger, D. F. (2004). Transnationalism in Question. *American Journal of Sociology* , 1177-1195.

Shepard, R. M. (2008). *Cultural Adaptation of Somali Refugee Youth*. New York: LFB Scholarly Publishing LLC.

Shi, L., & Stevens, G. D. (2004). Vulnerability and Unmet Health Care Needs. *Journal of General Internal Medicine* , 148-154.

Spickard, P. (2008). Asian Americans, Religion and Race. In H. D. Elliott R. Barkan, *From Arrival to Incorporatiaon* (pp. 94-117). New York: New York University Press.

U.S. Census Bureau, 2000. *Census 2000 special tabulation*.

U.S. Department of Homeland Security, Office of Immigration Statistics. (2006). *2006 Yearbook of Immigration Statistics*. U.S. Depatment of Homeland Security.

US Census Bureau 2000. *US Census Bureau Summary File 4 (SF 4)*.

W.S. Carlos Poston, V. P. (2001). Genetic bottlenecks, perceived racism, andhypertension risk among African American and firt-generation Africanimmigrants. *Journal of Human Hypertension* , 341-351.

Warner, S. R. (1998). Immigration and Religious Communities in the US. In S. R. Warner, & J. R. Witter, *Gathering in the diaspora: religious communities and the new immigration*. Philadelphia: Temple University Press.

Wild, M. (2004). Members of many gangs: childhood and ethno-racial identity on the streets of twentieth-century urban America. In C. W. Donna R. Gabaccia, *Immigrant life in the US* (pp. 99-112). New York: Routledge.

Yancey, G. (2003). *Who Is White? Latinos, Asians, And The New Black/NonBlack Divide*. London: Lynne Rienner Publishers, Inc.

Yetman, E. b. (1999). *Majority and Minority*. New York: Allyn and Bacon.