Understanding the Healthcare Experiences and Needs of African Immigrants in the United States: A Scoping Review

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Abstract

Background: Africans immigrants in the United States are the least-studied immigrant group, despite the research and policy efforts to address health disparities within immigrant communities. Although their healthcare experiences and needs are unique, they are often lumped into the “black” category, along with other phenotypically-similar groups. These challenges stifle the means of accurately utilizing research data to make critical healthcare decisions regarding African immigrants. The purpose of this Scoping Review was to examine extant information about African immigrant health in the United States, in order to develop subsequent lines of inquiry using the identified knowledge-gaps. Methods: Literature published in the English language between 1980 and 2016 were reviewed in five stages: (1) identification of question and (b) relevant studies, (c) screening, (d) data extraction and synthesis, and (e) results. Databases used included EBSCO, ProQuest, PubMed, and Google Scholar (hand-search). The articles were reviewed according to title and abstract, and studies deemed relevant were reviewed as full-text articles. Data was extracted from the selected articles using the inductive approach, which was based on the comprehensive reading and interpretive analysis of the organically emerging themes. Finally, the results from the selected articles were presented in a narrative format. Results: Culture, religion, and spirituality were identified as intertwined key contributors to the healthcare experiences of African immigrants. Also, lack of culturally-competent healthcare, distrust, and complexity, of the US health system, exorbitant cost of care, were identified as major healthcare access barriers.

Introduction

The health of African immigrants in the United States is a vastly under-studied topic, despite the rapidly increasing size of the population and its uniqueness. African
immigrants make up about 5% of the United States population, which represents a 41% increase from the year 2000 (1). More than 36% of them arrive from West Africa, followed by 29% and 17% from Eastern and Northern Africa, respectively. Over 14% of African immigrants in the United States come from Nigeria, followed by 10% from Ethiopia (2).

The contributing factors to the migration of Africans to the United States include family reunification, political disturbances, and education. Other reasons include the diversity lottery program, and brain drain (3,4). Many African physicians and nurses migrate to the United States for higher-paying opportunities, leaving behind dilapidated health systems in their home countries (5,6).

Also, the healthcare experiences needs of African immigrants are not universal. Research has shown there is considerable variation in healthcare experiences across populations (7,8). Immigrants are twice as likely as their US-born counterparts to lack health insurance. They are also more likely to utilize healthcare at significantly lower rates than whites (9,10). Prior to their arrival in the United States, many African immigrants face severe health threats such as war, extreme poverty and mental health challenges, in their countries of origin. Consequently, many of them already carry significant health vulnerabilities upon arrival in the US, which can only worsen without proper healthcare access (11).

The paucity of knowledge regarding the healthcare experiences and needs of African immigrants in the United States is largely due to two main factors: the absence of research or funding focused on this population, and “black-boxing.” Majority of research on immigrant healthcare in the United States has been concentrated on populations from Latin and some Asian countries. When data involving African immigrants have been examined, they were inapplicable, and the analyses were often based on retrospective extrapolations (12,13). The healthcare needs and experiences of other immigrant
populations cannot be assumed to be identical to those of African immigrants. Also, African immigrants are put in the “Black” category, which primarily comprises African Americans and Caribbean immigrants (14-18). The issue with this however, is that while an Africa-born immigrant and a US-born African American may be phenotypically similar, they may differ significantly in health beliefs and health outcomes (19,20). For instance, babies born to Africa-born Black mothers were found to have higher birth weights than those born to US-born Black mothers (21). Also, African immigrants have shown lower prevalence of cardiovascular risk factors, including hypertension and diabetes, than African Americans (18). Merging these groups obscures the unique behavioral and lifestyle distinctions within the, and healthcare problems faced by, African immigrant groups in the United States (16-18,22). The current scoping review assesses extant data on the healthcare experiences and access barriers of African immigrants in the United States. Knowledge-gaps are also discussed following the presentation of the study findings.

Methods

A Scoping Review is ideal for the initial step in understanding African immigrant health due to its usefulness for exploring an issue that has not been well studied (23,24).

Following Arksey and O’Malley’s Scoping Review framework, the review was carried out in five stages: (a) research question identification, (b) identification of relevant studies, (c) screening of studies, (d) data extraction and synthesis, and (e) presentation of results(23). This study was approved by the Indiana University Institutional Review Board (IRB).

Identification of research questions

The specific questions this scoping review attempted to answer are: (1) What do we currently know about the healthcare experiences and needs of African immigrants in the United States? (2) What are the knowledge-gaps to guide the development of subsequent
inquiries about African immigrant health in the United States?

**Identification of relevant studies**

Four databases were accessed for relevant studies, namely: EBSCO, ProQuest, PubMed, and Google Scholar. A hand-search in Google Scholar was done to identify some key literature, which underwent snowball backward search, leading to other pertinent articles. The following keywords were used: african immigrants OR african immigration; african emigrants OR african emigration. Table I contains a full list of the inclusion criteria. The year 1980 was chosen as the starting point for included articles because it coincided with the increased influx of African immigrants due to favorable modifications to the United States immigration laws (25). The included articles were peer-reviewed, with research focus on the healthcare experiences of African immigrants in the United States. Studies from secondary data were excluded, due to the absence of necessary identifiers of African immigrants in those databases, which made accurate analyses less likely. Studies focused on African immigrant refugees were excluded, due to the unique migratory experiences of those types of subjects.

**Table 1 – Inclusion Criteria for Article Selection**

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

**Study Screening**

The initial literature search yielded 304 articles, which were screened by applying the
search criteria to their titles. If a title contained insufficient evidence, the abstracts was reviewed, but if that step still did not offer enough evidence for inclusion, the entire article was read. This screening step resulted in 11 relevant articles. Additionally, a backwards search of nine key articles identified through a Google Scholar hand-search produced 54 articles, three of which met the inclusion criteria. Figure I represents the article screening sequences, including the number of filtered articles from each stage.

**Data extraction and synthesis**

The articles were mined from their databases using EndNote. Through an inductive approach consistent with the approach by Strauss and Corbin (26,27), themes were identified from the article results. The derivation of themes relied on interpretive analysis which entailed exhaustively reading the selected articles, paying attention to cultural meanings. For this scoping review, this step was crucial because in cases of under-studied phenomena embedded in culture, it facilitates the organic emergence of results, while also keeping in check the researcher’s assumptions (27,28).

**Data presentation**

Findings from the selected studies were synthesized into a narrative format. This form of result presentation allows a deeper insight into people’s views of themselves, especially when their experiences traverse different cultural nuances such as language and ethnicity (29,30). The results were presented from the perspective of the study participants regarding how the issues discussed affected them.

**Results**

**Description of identified studies**

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

**Characteristics of included studies**

A summary of the characteristics of the 14 included articles is presented in Table II. Seven articles focused specifically on female participants, while one article concentrated on youth and the elderly. Of the other six articles, one looked at individuals over 40 years old and five focused on the general population of African immigrants.

*Table 2 - Characteristics of Included Articles*
| Author(s)                          | Year | Location          | Study Design                                      | Study Purpose                                                                 |
|-----------------------------------|------|-------------------|--------------------------------------------------|-------------------------------------------------------------------------------|
| Adekeye et al.                    | 2014 | Greensboro, NC    | Qualitative; Photovoice; Community-based participatory research (CBPR) | Comprehend African immigrants' health and well-being, as well as healthcare access. |
| Asare & Sharma                   | 2012 | Cincinnati, OH    | Quantitative; Cross-sectional                    | Understanding sexual communication behaviors among African immigrants, (HBM) and acculturation. |
| Blanas et al.                     | 2014 | New York, NY      | Qualitative; Focus Groups                        | Assess factors that affect the health behaviors of African immigrants from different demographics. |
| Chu & Akinsulure-Smith           | 2016 | New York, NY      | Qualitative; Focus Groups & Questionnaires       | Examine the health beliefs regarding female genital cutting (FGC), across different demographics. |
| Daramola & Scisney-Matlock       | 2014 | Detroit, MI       | Quantitative; Cross-sectional (Correlational Surveys) | Examine the interaction between migration and health behaviors of African immigrant women. |
| De Jesus et al.                   | 2015 | Washington, DC    | Qualitative; Semi-structured Questionnaire        | Explore health behaviors of African immigrant women regarding HIV testing services. |
| Foley                             | 2005 | Philadelphia, PA  | Qualitative; Focus Groups                        |                                                                                |
| Kaplan, Ahmed, & Musah           | 2015 | Kaplan, Ahmed, & Musah | Qualitative; Focus Groups                        |                                                                                |
| Ndukwe, Williams, & Sheppard     | 2013 | Washington, DC    | Qualitative; Focus Groups & Questionnaires       |                                                                                |
| Opoku-Dapaah                      | 2013 | Winston-Salem, NC | Quantitative – Surveys; Qualitative – Interviews; Cross-sectional |                                                                                |
| Raymond et al.                   | 2014 | Minneapolis, MN   | Qualitative; Focus Groups                        |                                                                                |
| Sellers, Ward, & Pate            | 2006 | Madison, WI       | Qualitative; Focus Groups                        |                                                                                |

**Identified themes**

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

**Cultural Influence**

**Traditional Beliefs**

Cultural perspectives of diseases and illness determine healthcare behaviors, which in turn shape healthcare experiences. Eight articles discussed the impact of culture on the healthcare experiences of African immigrants in the United States (31–38). In African immigrant communities, diseases such as HIV and cancer are viewed as spiritual consequences. Therefore, it is not uncommon for many African immigrants to consult oracles and traditional healers in their home countries, regarding those types of health problems (34,38). The study by Kaplan et al. showed it was common for participants to delay office visits until the diseases or illnesses were certifiably irreversible or severe enough to halt daily activities (32). Results from another study showed HIV-positive African immigrant women sought treatment when the condition was already in its late stage (35). In one study, participants believed that unnecessary physician contact would lead to unwanted diagnoses. Therefore, unwarranted exam would be tantamount to tempting fate. In that regard, seeing a doctor was reserved for evidently necessary cases (33). Prior to their migration to the United States, many African immigrants utilized herbal remedies for different health problems. In the United States, the fear that such options may not be explored by healthcare providers, resulted in office visits and routine checks being viewed by some participants as waste of time and resources, especially given the high cost of healthcare (36). Participants’ deference to their culture also had dietary implications. Turk and co. (2015) discovered some participants had problems with their providers’ dietary recommendations. These participants found it difficult to replace their long-held cultural perspectives regarding food and health due their contrasting outlook on body size. Whereas a big body size was considered unhealthy in the United States, it was
regarded as a sign of healthy eating in their cultures (37). In addition, they described the fast-food culture in the United States not only as inescapable, but problematic due to its incongruence with their own cultural views of food preparation (31,32).

**Religiosity and Spirituality**

The influence of African immigrants’ religious and spiritual outlooks on health and well-being was presented in eight articles (31,33,34,38-42). In Vaughn and Holloway’s study, both the Muslim and Christian participants ascribed health status and outcomes primarily to God. They believed in spite of their efforts, their ultimate health outcomes were beyond their, or anyone’s control. Therefore, even if physicians were able to treat them successfully, that could only happen through divine assistance. Participants explained health imperfections such as illnesses and diseases as the consequences of human inadequacies, from which no one was exempt (38). One study found that Muslim participants believed death by disease was a result of the expiration of a person’s time on earth. According to the participants, if it was God’s will that one would die from cancer for example, then there was nothing anyone could do about it. Conversely, if it was not destined for one to die yet, then despite such a disease, one would still live (34,41,42).

This connection between spirituality and health also influenced how the participants viewed preventive healthcare. Some participants refused to answer hypothetical questions about what they would do, were they to be diagnosed with diseases such as cancer. Their rationale was that words and thoughts could affect one’s life outcomes, such as health experiences. Therefore, speaking about adverse events hypothetically was equivalent to invoking them into one’s life (40). The Christian participants in the study expressly rejected the question, stating that it was not their lot to suffer from such diseases (33).

Furthermore, Adekeye et al. found a connection between African immigrants’ religiosity and dealing with mental health. Both the Christian and Muslim participants described their
church and mosque attendance respectively, as necessary for coping with life’s challenges. In their views, religiosity was instrumental in shaping healthy spiritual lives, which was crucial for overall health and well-being (31). However, this reliance on the protective function of religion was an obstacle to healthcare utilization. Findings from a study of key-informant focus groups indicated the African immigrant women participants were reluctant to go for cancer screening, due to their belief that their health was determined by God, who would shield them from diseases not meant for them (33). Other participants felt Western medical care was mainly dependent on human abilities to rectify health problems, and almost negligent of the roles of spirituality and God in shaping human health (39).

**Stigma in the African community**

The significance of culturally-situated stigma in the healthcare experiences of African immigrants in the United States, was demonstrated in seven studies (32,33,36,41–44). Blanas et al. found that one of the reasons why the African immigrant participants in their study did not make use of certain healthcare services in the United States, was the resultant negative reactions within their communities. They explained that even when the services were preventive and did not involve subjects commonly regarded as taboo, such as sexual health, they still attracted stigma from their communities (43). This experience was applicable to participants in another study which focused on utilization of human immunodeficiency virus (HIV) prevention services. The participants emphatically preferred not knowing their status to the potential stigma and social consequences from utilizing such services, especially with HIV-positive results. According to these participants, merely going to get tested was sufficient to elicit stigma in their communities; many would deem that a positive confirmation (41). Healthcare-related stigma within African immigrant communities is not restricted to sexually transmitted diseases or infections. Participants
in the study by Ndukwe et al. explained that cancer was perceived as a curse in their communities. Consequently, the notion that the person with a cancer diagnosis has been cursed spiritually, translated to avoidance of, or cautious interaction with, the affected person (33). Another group of participants interviewed by Raymond et al., equated cancer with HIV, in terms of perception. According to them, because both diseases were viewed by community members as death sentences and shameful, family and friends tended to be distant from the sufferer (42).

Although not linked with death as are HIV and cancer, depression is also stigmatized within African immigrant communities. Results from Sellers et al. revealed that even when participants were aware of depression its existence within their communities, the fear of the stigma attached to being identified as depressed often overrode the desire to seek treatment. According to the participants, depression was viewed as a conception and condition of white people in their communities (36). Also, because depression was not a recognized mental health condition in many African cultures, some participants could not differentiate between health issues referred to in the United States as mental health problems, such as bipolar disorder, from those commonly known as “madness” in their home countries, which described mentally ill individuals roaming the streets (36).

Furthermore, the impact of health-related culturally-situated stigma within African immigrant communities, also extended beyond the affected individuals. With a cultural emphasis on a good reputation, many participants expressed fear of what would happen to their families’ standings, were it to be known that they suffered from dreaded health problems, such as cancer and mental illness. Thus, they would rather not find out their health status (41). Even when they decided to utilize healthcare services, participants’ perceptions of privacy was an obstacle. For instance, results from Foley’s study indicated participants saw confidentiality, as managed by US providers as inadequate, due to
concerns about insufficient anonymity (44). In addition, some participants suspected certain healthcare facilities were particularly more interested in testing them unnecessarily during office visits. They feared it was only a matter of time before their private data were compromised and their livelihoods jeopardized, especially in cases of positive results for stigmatized diseases (32).

**Linguistic Discordance**

Three studies discussed how the impact of language on the healthcare experiences of African immigrants in the United States (32,42,44). Some participants experienced difficulties with translating their health needs to terms and concepts understood by US providers, especially in dire circumstances. Other participants believed the language barriers they encountered were exacerbated by negative provider attitudes towards them (44). This challenge was also pointed out by participants in the study by Kaplan et al., who felt their communication with US providers would be greatly improved if the providers were more patience and less dismissive. To the participants, the poor attitudes resulted from those providers’ prejudiced expectations of language barriers from their interactions with their African immigrant patients (32).

According to some participants, productive interactions with US providers entailed more than linguistic competency or availability of translators. Cultural know-how, in their views, was an inseparable aspect of effective healthcare communication. These participants’ interactions with providers were compounded by different cultural names and descriptions which were difficult to fully translate into the English language (42). This was true even for Somali immigrants, who, despite having the highest number of translators in the public service sphere, continue to find their interactions with US challenging. Also, participants regarded this wearisome communication with providers as a deterrent to their healthcare access, due to their fears their health needs would be unmet, or they would receive wrong
Adverse experiences with the US healthcare system

Lack of culturally-competent providers

The absence of healthcare sensitive to the backgrounds of African immigrant patients, was a pervasive theme in six articles (31,32,36–38,42). Participants in one study were disinclined towards office visits, because they feared they would result in complications, due to providers' lack of understanding of their health needs. Not only did the participants regard those unproductive office visits as a waste of scarce resources, they considered them justifications of their lack of trust in the health system (31). Also, participants explained that their unique cultural and healthcare backgrounds received little to no attention from the providers. In their views, those encounters constituted missed opportunities for the providers to gain broader, deeper understanding of their patients, which would have resulted in more informed interactions, and effective treatment decisions. According to the participants, even when they initiated efforts to bridge the providers' knowledge-gap, the outcomes were still the same, due to the providers' unaccommodating outlooks (31).

In another study, participants expressed their dissatisfaction about not being asked about their cultural or religious beliefs, which could interfere with their care. They described those omitted data points as crucial, with the power to improve effectiveness of care, though they might have seemed trivial to those providers (32). According to other participants, the Christian or Muslim faith came with certain considerations in healthcare, including gender-roles in patient-provider interactions, and treatment options, none of which was addressed in their interactions with providers (42). Some participants described this experience as a double-edged barrier, because their backgrounds and preferences were often excluded from their healthcare, leaving them with the providers' approaches,
which they had difficulties comprehending and adhering to (38). For instance, some participants described how providers would often recommend difficult modifications to their diets, such as substituting one of their culturally staple foods, but without any guidance to help them achieve those goals (37). Results from the study by Sellers et al. showed participants preferred physicians from comparable ethnicities, or, who were relatable. They described interactions with these types of providers as more emotionally soothing, effective, and less resource-consuming, due to quicker resolution of their health challenges (36).

**Complex U.S. healthcare system**

Difficulty navigating the US healthcare system was discussed by four studies (31,36,38,44). However, this barrier did not unfold similarly in every setting described by the participants. Results from the study by Adekeye et al., indicated participants ascribed their challenges with navigating the complicated US healthcare system, mainly to linguistic discordance. To them, this barrier was not only in reference to low English language proficiency, but also lack of understanding of the culturally divergent aspects of the US healthcare system, including terms and policies. Some participants highlighted inundation with excessive information and paperwork, with little or no guidance towards grasping their import, as a key challenge (31). Other participants, although they had health insurance coverage, described as difficult, utilizing healthcare services, due to the challenges with deciphering which services they were eligible for and which providers were suitable (44). Results from the study by Sellers et al showed participants viewed the US healthcare system as the most challenging aspect of their immigrant experiences. They described their healthcare experiences as replete with emotional and mental anguish, emanating from caring for the sick individual while navigating the myriad barriers to care, knowing the problems might not be adequately addressed (36).
**Cost of healthcare**

Five articles contained the relationship between the cost of healthcare in the United States and the healthcare experiences of African immigrants (31-33,43,44). In the study by Adekeye et al., participants identified high cost of care and the lack of western treatment alternatives, as the key barrier to their access to healthcare. Also in their views, the western assessment of African treatments as quack, inadvertently contributed to high cost of care, since it left them without cheaper alternatives (31). Due to the exorbitant healthcare costs, some participants regarded preventive care or cases not perceptibly serious, as resource-wasting. Their rationale was that spending a lot of time and money to determine the presence of a health problem would be fiscally irresponsible, if it turned out nothing was wrong (32).

According to findings by Foley, when participants did go to the doctor, they felt hard done-by to find out the services they received were not well-covered by their health insurance. This did not only disincline the participants towards subsequent visits, it also deteriorated their distrustful views of providers, who they felt were not looking out for them as patients (44). The problem of high healthcare cost was compounded for participants without health insurance. They could not afford the payments because they held jobs that neither provided health insurance nor paid high enough salary to allow the participants to afford healthcare services (43). Also, participants cited the lack of transportation as one of the contributors to the high cost of care. Due to family members and friends always working, unfamiliarity with, or absence of wide-spread, transit system, the participants could not take advantage of some healthcare services, including free screenings (33).

**Biased/hostile provider attitudes**

Five articles discussed the barricading roles of discrimination in the healthcare
experiences of African immigrants in the United States (31,32,34,38,44). In one study, the participants believed their accents or dressing styles often triggered unsavory provider attitudes. They described their poor experiences including hostile, condescending staff approach, and provider dismissiveness and reliance on African cultural stereotypes (31). In another study, participants described the perfunctory manners providers interacted with them, both in-person and on the telephone. The participants described being made to feel like they and their health needs were undesirable encumbrances by providers, as disrespectful and humiliating, which made the prospect of interacting with providers, dreadful (38).

Additionally, adverse provider behaviors towards African immigrants were not restricted to one race or ethnicity. According to Foley’s study results, participants’ accents, looks, names, amongst other background information, elicited some type of hostile attitudes from providers, whether Black or White (44). Other participants described their experiences with providers whose approaches were mainly derived from uninformed or stereotypical information about African immigrants, which were manifested in the providers’ questions or comments about their health issues. Still, some participants felt they were unreasonably subjected to certain tests as a result of the providers’ suspicions, founded on related stereotypes. For this reason, the participants felt targeted and avoided those locations as well as grew more distrustful of other providers (32). Findings from Opoku-Dapaah’s study revealed a similar pattern. Participants avoided certain healthcare services, including cancer screenings, due to their suspicions that the services provided to African immigrants were more harmful than those received by their White counterparts (34).

_Lack of trust of the U.S. health system_

Three articles discussed African immigrants’ distrust of the US health system and its
healthcare implications (34,36,42). According to the study by Sellers et al., participants’ lack of trust in the US healthcare system, was inspired by the unwelcome ways they felt African immigrants and Blacks in general were targeted in their personal and public domains (36). Other participants did not believe US providers had the best interests of African patients at heart, and even if they did, they felt those providers were not suitable. Also, some of the participants were convinced the health of some of their community members deteriorated medical treatment, as a result. They expressed their unwillingness to fully acquiesce to the views of providers, because they may not be aware of, or care about, the adverse effects of their approaches on their African immigrant patients (36).

Furthermore, some participants’ distrust of the US health system emanated from their negative views of the pharmaceutical industry’s roles. They believed the operational philosophy of the pharmaceutical industry targeted the general public’s susceptibilities. For instance, it was their views that the expensive medical interventions were inventions of the pharmaceutical industry, primarily aimed at profiteering, while cancer screenings were smokescreens used to target unwitting Africans as participants in pernicious Western health research (34). Some participants in a study by Sellers et al believed certain medications would result in previously absent health complications, or the exacerbation of existing ones. They were convinced they would be left to bear the brunt should that happen, while the drug manufacturers’ agenda of profiting from people’s health challenges would remain uninterrupted (36).

Discussion

The “black-boxing” of African immigrants is problematic because it obscures the distinctiveness of African immigrants’ health needs and experiences. The ramifications of this misidentification are plenty, including flawed data collection and analysis, over-generalization of results, and inefficacious treatment of African immigrant patients by US
providers (15,19,45,46). Also, the perception of blacks in the United States as a monolithic group, would misguide the approaches of policymakers. For instance, foreign-born blacks have been found to have lower rates of cardiovascular diseases including heart disease and obesity, than US-born blacks (47). To understand the role of the immigrant health paradox in health disparities among black US immigrants, focus on the differences in health outcomes by nativity is required (48). Also, there exists a strong distrust of the US health system among blacks. However, contrary to the well-documented mistreatment of African Americans by the US health system including the Tuskegee Syphilis experiment (49), the underpinnings of this cynicism within the US African immigrant community has been poorly understood (39). Another step towards understanding the health needs and experiences of African immigrants in the United States, is examining the impact of intersectionality on their healthcare experiences. Being identified either as African immigrants or African Americans attracts distinct barriers, including provider biases and discrimination. Beyond that, some participants were discouraged by the negative attitudes and biases from both white and black providers, which contributed to their conclusions that most office visits were a waste of resources. This study’s results have revealed the limitation of the reductionist view that pairing a patient with a provider from the same ethnicity or relatable background, would eliminate bias and discrimination. Also, the interpretation of barriers to African immigrants’ healthcare access in the United States has been oversimplified, with language often being indicted (50,51). However, language barrier should not be circumscribed to deficiency in English language proficiency. The availability of translators for African immigrants does not guarantee the absence of communication barriers in their healthcare experiences (51). Accents, the complex US healthcare system, and culture-derived healthcare expectations, can still constitute barriers to African immigrants (19). This was demonstrated by some
participants’ accounts of their healthcare challenges. Even when providers communicated the required dietary changes, the participants were at a loss regarding their implementation, because they were not provided any guidelines. Not only did those health goals go unmet, the opportunities for some critical patient education were lost (37,42). African immigrants encounter barriers to good nutrition in the United States as regards availability, affordability, and accessibility (31), so provider-recommended nutrition changes are insufficient. Furthermore, for immigrants, studies have shown a positive association between education level and socio-economic status, which in turn is positively linked with health insurance and equally, healthcare access (52,53). However, despite being the most educated immigrant group in the United States, African immigrants have very limited healthcare access (45,54). While the trajectories of these experiences over time have been studied in other immigrant populations, nothing is known about how they unfold within the African immigrant community.

The impact of religion on the healthcare experiences of African immigrants is unique. Besides Christianity and Islam standing as the two major religions in Africa, there are also traditional African spiritual or cultural practices which are often combined with, or at odds with those two religions. According to the African value system, a person’s well-being is determined by both physical and spiritual experiences, with the latter bearing superior influence on the final outcome. Consequently, African immigrants’ health perspectives are multifaceted (55,56). Among African immigrants, religion and culture affect gender roles, which play key roles in their healthcare experiences. Understanding roles of gender in the healthcare experiences of African immigrants, is critical in the efforts adequately meet their healthcare needs. Moreover, US immigrants face more healthcare access barriers, which results in their reliance on emergency departments (57,58). It is important to assess the utilization of emergency departments among African immigrants. Some
participants in the reviewed studies preferred the emergency department to office visits, because they believed it eliminated the barriers they would normally encounter in seeking primary care (38). In addition, it is necessary to understand the views and attitudes of US providers on African immigrant health issues. Most of the results showed participants felt US providers were not adequately equipped to address their health concerns. Finding the roots of this deep-lying distrust using input from US providers, is key to improving the African immigrant patient-US provider relationship.

**Conclusion**

Very little is known about African immigrant health in the United States. Even as the number of African immigrants in the US continues to climb exponentially, healthcare providers and policymakers have no information to guide their decision-making. Generally, the immigrant healthcare experience is characterized by higher morbidity and mortality rates due to lack of health insurance, residence in poor neighborhoods, and lower-paying jobs, which often result in lack of access to early or adequate healthcare. However, these findings still need to be verified among African immigrants because an approach that is effective for one immigrant population cannot be assumed to be applicable in other immigrant settings. The small number of articles on African immigrant health emphasizes the need for funding and research. To that effect, this study is a good foundation for future lines of inquiry.

**List Of Abbreviations**

US - United States

**Declarations**

**Ethics approval and consent to participate**

Not applicable.
Consent for publication

Not applicable.

Availability of data and materials

Data sharing is not applicable to this article as no datasets were generated or analyzed during the current study.

Competing Interests

The authors declare that they have no competing interests.

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Author Contributions

OIO carried out all the stages of the scoping review and developed the manuscript. DPW and HCH critically reviewed the methods and results sections. All authors reviewed and approved the manuscript.

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OIO is an Assistant Professor and the Diversity Initiatives Facilitator, at the Butler University College of Pharmacy and Health Sciences. He earned his doctorate in Public Health, with a Health Policy and Management concentration, from the Richard M. Fairbanks School of Public Health at Indiana University. His primary research interest is in immigrant health disparities, and his current research focuses on African immigrant health because researchers, healthcare professionals, and policymakers lack the necessary information for their decision-making regarding the unique healthcare experiences and
needs of African immigrants. As a Nigerian immigrant to the US alone at a young age, OIO understands the difficulties with being “invisible” in the healthcare system. This scoping review was the first phase of a qualitative study of the African immigrant healthcare experience, using Nigerian immigrant participants in Indianapolis.

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Figures
Figure 1

Flowchart of Data Search and Results
Figure 2

Included Articles by Year (1980 - 2016)