



COMMON HEALTH CONCERNS IN AFRICAN IMMIGRANTS IN THE US- IMPLICATION FOR THE FAMILY PHYSICIAN

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ABSTRACT

African immigrants in the US encounter many issues on arrival to the US over time. The healthy immigrant effect (HIE) is a phenomenon that should be explored as many African immigrants lose their HIE on adoption of the 'American lifestyle'. Family medicine practices in the US encounter a significant African immigrant population from different African countries, which is an underserved population. Highlighting their health issues will enable the family physician to become aware of their unique needs and manage these patients in their clinical practices. African immigrants tend to be viewed as 'all from Africa' when indeed Africa is a continent with 54 countries. Some of these unique health problems, though suffered by Americans may be differently manifested and therefore may require special management. Africans continue to migrate to the US and family medicine practitioners that are the first point of contact need to be educated to holistically manage them. Barriers to seeking health care and issues of physician patient relationship are important areas that also need to be explored in this special population.

Keywords: Healthy immigrant effect, African, Immigrant, Hypertension, Diabetes, Mental health, HIV/AIDS.

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Contribution/ Originality

This paper's primary contribution is making family physicians aware of the individual needs of African immigrants from different countries. It emphasizes that unique medical conditions may present in different ways in this special population. It also emphasizes how respective African cultures may impact access to healthcare in the US.

1. INTRODUCTION

Several states in America experience an influx of immigrants from different parts of Africa with unique experiences and needs [1]. About 70% of African immigrants in the US are from eastern or western Africa. Methods of admittance include family connections, refugee, diversity visa program and employment [2]. Specific practices, beliefs and cultures should not be broadly categorized for all African regions as each African country or region is unique [1]. There is likelihood to know immigrants for their menial labor and economic contributions instead of what they represent. Africans have been wrongly categorized as black or Caribbean without identifying their unique identities and this has affected major research in this population except for those related to infectious disease [3]. Africa is a continent composed of 54 countries and over a billion population; including hundreds of ethnic groups and languages, and it is difficult to generalize about migrants from the continent. The biggest set of

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immigrant Somali is located in the state of Minnesota making them a special population [4]. Also, a unique feature of Sudanese immigrants is their young vibrant population in the US when compared to other immigrants from other parts of Africa [5]. African immigrants are the least studied minority group and researchers do not focus on their unique requirements or needs, especially in the consideration of the reasons for migration: economics vs. war [6]. Barriers such as language, stigmatization and lack of structured services specific to immigrant African populations prevent acclimatization [7]. These put them at risk for severe health and economic consequences [8]. Francophone African immigrants experience more acculturation issues and adaptability into the US compared to their Anglophone immigrant counterparts thus affecting their various accesses [9]. African immigrants however are proficient in English and are qualified to participate in the American labor force [2]. Africans are one of the most highly educated subpopulations in the US [10]. While inadequate literature exists about the socio-economic power and performance indices of African immigrants, the US' immigration policies has aided the American economy when a certain category of highly educated and skilled African immigrants are allowed to immigrate into the US [11]. There is a tendency for African immigrants to be exploited from an economic standpoint [12]. Many Somalis have migrated to the US because of war while Tanzanians migrate to areas like Kansas because of low cost of living, educational pursuits and better prospects in life [13].

1.1. Commonalities and Differences in Diseases in African Immigrants and US Counterparts

African immigrants are healthier than their American counterparts because of the healthy immigrant effect (HIE) [14, 15]. The HIE wanes after the African immigrants acclimatize into the US system upon adoption of unhealthy lifestyles and behaviors [6, 16]. Many African immigrants do not experience diabetes prior to arrival in the US because they are used to eating healthily before arrival [14, 17]. Physicians should continually improve their knowledge of peculiarities pertaining to African migrant populations and provide care acknowledged as culturally useful to them because of already existing stereotypes [18]. African immigrants are at risk of lack of knowledge or negligence on the part of healthcare professionals who don't identify their uniqueness [19, 20]. An immigrant paradox exists which may be like the healthy immigrant effect where immigrants in general show a lower likelihood and risk for disorders of mood and anxiety [21].

Communication nuances, subtleties and cues; demystifying medical treatment, gender sensitivity and interpreter services are important [20]. Migrant Nigerian women prefer to return home for healthcare because of cost, spiritual beliefs, lack of health insurance and stigma in spite of the availability of healthcare in the United States [22]. African immigrants challenge the ethical reasons or considerations for genetic studies because of perceptions of race or perceived colonialism and this impacts participation in research to improve their disease outcomes [23].

1.2. Chronic Disease

Health screenings in Liberian immigrants show that diabetes; hypertension and stress are the most known chronic conditions. Hypertension in East African countries was never a concerning condition until arrival into the US in Minnesota and Kansas states [14]. However, in Kansas, diabetes was rated highest when compared to other conditions [17]. It is not clear whether diabetes in some of these countries like Somalia existed prior to departing their native countries [6]. African immigrants may suffer from hypertension and diabetes on arrival to the US because of the consumption of inorganic foods compared to native foods in their countries [17, 24]. Overall, African immigrants have better health outcomes in diabetes, hypertension and stroke compared to their African American counterparts and suffer less end organ damage from hypertension when compared to their African American counterparts [15, 25]. Pregnant Somali women however have higher reports of gestational diabetes than other groups in the US, which might be attributed to the loss of the HIE [15].

1.3. Mental Health Issues

These include stress, depression, mood disorders, anxiety, domestic abuse and posttraumatic stress disorder [14, 26]. Refugees suffer post-traumatic stress disorder, depression and ostracism [15, 27]. War, discrimination, stressful fleeing process from war torn countries, asylum status, refugee health issues and the inability to assimilate into a culture foreign contribute to mental illnesses [27]. These are under reported because of stigma, acclimatization issues, change in environment and lifestyle and the likelihood of causing social issues. In Nigerian immigrant women, depression is an unacceptable diagnosis for the same reasons [6, 28]. Older African immigrants may not readily assimilate the host environment compared to younger immigrants for example, they may have had healthier eating practices in their countries before relocation [24]. In spite of African immigrant men and women working for a living, women don't report domestic violence because of cultural differences and financial dependence on spouses as well the need to have an intact marriage [26]. Among African immigrants who came into the US at the age of 13 or older, the risk of mood and anxiety disorders is lower than their US counterparts (OR= 0.43-Mood disorders, 0.47= anxiety disorders). However, for immigrants who arrived earlier than 13 years of age, there is no difference in the lifetime risk [21]. While this age group may have the same risk for mood and anxiety disorders with their US counterparts, they are less likely to be substance abusers [21].

1.4. Cancer

Delays in seeking healthcare and complementary medicine are experienced by female Nigerian immigrants diagnosed with breast cancer, yet African immigrant women are more likely to practice breast-feeding, which is protective against breast cancer [3, 22]. The second most suffered cancer among East African women, especially Somali women is cervical cancer. This is related to low screening rates, cultural assimilation into a new system, fatalistic beliefs and stigma. African immigrants do not complete screening schedules for vaccinations and cancer unless interpreters are involved in the process [29]. 65% of women who are eligible for screening for breast and cervical cancer actually screen therefore, preventive services tailored specifically to this group is imperative [16]. West African men have been shown to have lower prostate cancer rates than their African American counterparts. When other immigrant groups are compared for the same disease, there seems to be a relationship between environmental changes as compared to genetics [30]. For brain and lung cancer mortalities, African immigrants have lower rates than their American counterparts [15].

1.5. Infectious Disease: Tuberculosis and HIV/AIDS

This group is the most significant in African immigrants in the US [31]. The most common infectious disease in immigrants is tuberculosis. African immigrants have been shown to have active TB; data from prisons have shown that African born prisoners have a higher test rate than US born prisoners [32]. In particular, studies have shown that nearly 65% of Somalis were diagnosed with tuberculosis within twelve months of migrating to the US and had tested positive for purified protein derivative. These immigrants had extra pulmonary involvement even without a diagnosis of AIDS [33].

African immigrants had lower HIV/AIDS rates initially than African Americans but the trend is changing especially in favor of African immigrant women [6]. The rates of diagnosed HIV are now quite high in African immigrants compared to other groups [34]. In Somalia, because of female circumcision, there is an increased likelihood that upon migration, these women would develop AIDS [31]. African immigrants tend to be diagnosed with HIV/AIDS at the final stages of the disease, even though mortality rates are lower in this population. Immigrants were not granted entry into the US on the premise of being infected with HIV/AIDS; because of the medical, political and ethical considerations of this practice, it has since been stopped [34]. Infection routes in African immigrants and Americans are different; for African immigrants, there is less practice of injection drug use as compared to more of heterosexual transmission. Stigma prevents African immigrants from seeking treatment;

however, gaps exist in the literature that examines the relationship between seeking treatment after diagnosis [6] and HIV/AIDS in Nigeria is a typical example [34, 35].

1.6. Osteoporosis

Bone mineral density (BMD) levels are significant in African immigrant women's groups such as Sudanese, Somali and Gambian immigrants. BMD is higher in African-American women than African immigrants from Somalia [31] While Somali women had higher BMD than Caucasian women, Gambian women had lower lumbar spinal BMD than Caucasian women [31]. For Sudanese women, their spinal BMD is lower than either African American or

Caucasian women. The differences in BMDs across these groups of African women are because of lifestyle and sun exposure prior to arrival to the US or nutritional factors but it is largely unclear.

1.7. Obesity

African immigrants have the second highest rate of obesity among all immigrant groups in the US [14]. The sedentary lifestyle in America is far from the active lifestyle many Africans enjoy in their respective countries. Barriers to physical activity in immigrant African men and women include convenience, poor weather and imbalanced prioritization where physical activity is not ranked as highly as survival and diet. Ethiopians and Somali have sugar common to cultural foods from both countries [14, 15]. Changing diet from high fiber diets to sugar based diets is usual [24]. However, Nigerian immigrant men had greater intake of organic foods, more physical activity and healthier smoking habits than their counterparts who did not migrate and these are in line with the availability of these foods and the appropriate environment [30].

2. CONCLUSION

It is important that healthcare professionals are knowledgeable about the background of African immigrants (war, economics or family), and their unique country-specific needs. Life expectancies, healthy immigrant effect, acculturation, healthcare barriers and health coverage/insurance should be carefully studied. While there are conditions similar to both US citizens and African born immigrants, underlying factors are different for both groups. Physician competencies in this regard are very important. American physicians should know specific needs such as female circumcision and maternal morbidity and mortality in this practice and refugee health, vitamin D deficiency, cervical cancer, nutritional concerns and infectious disease so that they can be addressed in detail by physicians.

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