



# Report of Findings of Focus Groups with African Immigrants

The Rhode Island Department of Health in partnership with The African Alliance of Rhode Island • September 2011

## Background

The African Alliance of Rhode Island (AARI) partnered with The Rhode Island Department of Health (HEALTH) to conduct a series of focus groups with African immigrants and refugees in Rhode Island. HEALTH contracted with Margaret E. Thomas Strategic Marketing (Strategic Marketing) to coordinate, facilitate, and analyze the groups. AARI and Strategic Marketing cooperatively developed two distinct sets of research objectives, screening questions, baseline questionnaires, and moderator’s guides to conduct a total of five focus groups over a two-year period. Tool Set A was used to conduct three focus groups between June 2009 and March 2010, and Tool Set B was used to conduct two more groups in April 2011 as outlined in **Table 1**. All tools were developed to frame questions in a culturally sensitive manner at an appropriate literacy level for African immigrants. The objectives of the two sets of groups are described in **Table 2**. The first three groups were coordinated as single-gender groups to encourage participants to discuss their personal experiences more openly. The last two groups were mixed groups of adults and children to facilitate and explore intergenerational interactions.

**Table 1: Focus Group Overview**

	Description	Date	Location	Observers*	Tool Set
<b>FG1</b>	Women 1	06/27/09	AARI 570 Broad Street Providence	Yassin Goree Komasa Traub	A
<b>FG2</b>	Women 2	03/14/10	All Nations Church 50 Exchange Street Pawtucket	Yassin Goree	A
<b>FG3</b>	Men	12/06/09	Calvary Baptist Church Broad Street Providence	Julius Kolawole Maxwell Freeman Jerry Amoak Bisola Awoyemi	A
<b>FG4</b>	Refugees 1 (male and female)	04/03/11	Mount Hope Community Baptist Church 734 Hope Street Providence	Susan Resendez Sandra Richardson	B
<b>FG5</b>	Refugees 2 (male and female)	04/10/11	St. Paul’s Lutheran Church Elmwood Avenue Providence	Sandra Richardson Brown University students	B

\* To put people at ease and help them feel safe in sharing their feedback, AARI requested respected community observers who were African to attend all focus groups and provide testimony about their health experiences. See page 2 for more information about observers.

## Table 2: Objectives

### Focus Groups 1-3 (Tool Set A)

- Determine priorities in the African culture.
  - Examine attitudes about health and accessing healthcare.
  - Determine level of knowledge regarding preventing common diseases.
  - Assess the best way to provide preventive health information.
  - Determine the likelihood and best venue for participation in the planned community health assessment.
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### Focus Groups 4-5 (Tool Set B)

- Learn more about certain health behaviors in African households, especially eating and physical activity.
- Examine attitudes about their neighborhoods and how they relate to physical activity.
- Examine intergenerational differences in eating habits and physical activity.
- Learn more about recreational activities of interest to the African community.

## Methodology

AARI formed a committee to coordinate this project and engaged all available resources to conduct outreach. Participants were recruited through AARI, which has strong links to the African community in Rhode Island. AARI board members, staff, and committee members verbally conducted recruitment with individual community members. They screened participants for characteristics such as age, city of residence, and length of time living in the United States. Screening targeted geographic areas with a large concentration of Africans, including Providence, South Providence, Pawtucket, and Woonsocket. Four of the five focus groups were conducted at churches that had a large population of Africans congregants, and the sessions were scheduled immediately after church services to maximize attendance. The target number of attendees for each focus group was eight or more. A translator was only needed and used for FG5 and was able to effectively interpret the languages of all participants.

Upon arrival at a focus group, each participant completed a baseline questionnaire collecting demographic data. These demographics are summarized in **Table 3** and **Table 4**. Strategic Marketing facilitated each focus group using a moderator's guide. AARI project committee members were present as observers at each session to better comprehend participant responses and to use this information to further accommodate the needs of their population. Observers were the same gender as participants in the single gender focus groups (FG1-FG3) to encourage candid discussion. Observers did not speak beyond providing testimony (see below).

In the first three focus groups (FG1-FG3), the moderator introduced an individual at the beginning of each session to tell a story about the importance of talking about health. This personal testimony for all three groups was coordinated prior to each session with the purpose of encouraging participant discussion of health topics. Observers provided this testimony in the two female focus groups while a participant shared his story of surviving cancer with the male group. Cancer was selected as a testimonial topic because it is a taboo subject in the African community.

At the end of each focus group, there was a wrap-up discussion or "open forum" to address specific, difficult topics and to provide participants with an opportunity to extend discussion into areas that might not otherwise be addressed. For example, rather than directly asking participants about their experiences with mental health, another taboo subject in the African community, the moderator elicited discussion by framing the question as, "I have been told that in the African culture mental health is not something that is

discussed openly. Please tell me about that.” The moderator steered the conversation to better explore these difficult topics.

Strategic Marketing then compiled initial summaries of all five focus groups. This report consolidates these five summaries, identifies several overarching themes, and offers specific strategies to help AARI respond to the focus group Objectives<sup>†</sup>.

## Limitations

Focus groups are an appropriate method for understanding the experiences and opinions of individuals. By definition, however, focus groups are qualitative. They involve relatively small numbers of participants, and the results may not be representative of the entire population. The results should provide AARI with an overview of participants’ perceptions, beliefs, and attitudes toward the “health” of their community. The information, however, should be interpreted in general terms only and not in terms of percentages.

Recruitment barriers posed another limitation to this research. In FG3, rather than eliciting the target audience of immigrants who have been in this country from 2 to 10 years, participants had been in the United States for an average of 24 years. Because most focus groups were scheduled immediately after church services to maximize attendance, focus group participants were more likely to be members of the congregation where each focus group took place. In FG4, this may have skewed results because that church reportedly emphasized health. Only a limited number of participants took part in some focus groups, e.g., FG1 only had three participants and FG4 only had one child participant.

Although the moderator reported that the interpreter for FG5 was excellent, interpreting participant responses may have skewed the accuracy of that information.

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## Results: Focus Groups 1-3

**Table 3: Participant Demographics & Media Use**

<b>Demographics</b>	<b>FG1</b>	<b>FG2</b>	<b>FG3</b>
<b>Number of Participants</b>	3	16	12
<b>Gender</b>	Female	Female	Male
<b>Age</b>	Not reported	36 (average)	51 (average)
<b>Countries</b>	Gambia; Tanzania	Ghana (6), Togo (3); Nigeria (3); Liberia (2); Kenya (1); Dem. Rep. of Congo (1)	Democratic Republic of Congo; Jamaica; Liberia; Nigeria
<b>Years in United States</b>	6-10	10.5 (average)	24 (average*)
<b>Level of Education</b>	College degree (1)**; secondary school (2)	College degree (11); some college (3); high school graduate (2)	Masters (3); Bachelors (2); Associates (5); High School (2)
<b>Medical Care</b>	Health center; hospital	MD practice (6); clinic (2); hospital / no primary care MD) (6)	Primary care MD (6); hospital (5)
<b>Had Health Insurance</b>	0/3	9/16	11/12
<b>Interpreting Needs</b>	No interpreter needed	1 request for French interpreter, interpreter not used	5 spoke other languages***, all comfortable speaking English
<b>Media Use</b>	<b>FG1</b>	<b>FG2</b>	<b>FG3</b>
<b>Television</b>	All news, other shows	All news, other shows (primarily in evening)	All TV, mostly news plus sports, other shows
<b>Radio</b>	All (Lite 105, Hot 106)	12/16 (various stations plus Christian Shine 1220 a.m.)	WPRO (2); Hot 106 (3); NPR (2); Lite 105 (2); B101 (2); other stations
<b>Newspaper</b>	2/3 ProJo	10/16 most ProJo	10/12 daily ProJo

\* One participant immigrated only three years ago.

\*\* Participant recently completed her Bachelor's degree in Nursing at Rhode Island College.

\*\*\*Po, French, Gio, Swahili, Kirundi, Mano, Basu, and Isio.

### Personal Priorities

Only one of the three focus groups (FG1) was asked about their priorities (What is most important to you? What do you worry about the most?). Responses focused on “paying the bills”. Further discussion touched on how illness causes stress, especially when you can't pay the bills, and uncovered a central theme of a lack of health insurance that persisted throughout discussion.

## Healthcare Attitudes & Utilization

**Discussing Healthcare:** Participants in all three focus groups were very talkative and forthcoming, interested in the topic of healthcare, and willing to discuss their health. Male participants said that in Africa, health is not openly discussed. Men and women reported that when someone dies in Africa and the cause of death is unknown, Africans often say the death was caused by “witchcraft” or the person was “bewitched”. However, all participants agreed that African views of health and their comfort discussing health have changed. Female participants commented that discussing health, such as illnesses or the cause of death of family members, is now much more “open” for Africans living in both the United States and in Africa. They reported discussing health issues openly in their families, but acknowledged that this varies widely as some families are more open than others. The men added that younger people, who are born in the United States, are more comfortable talking about health than older people and are more likely to go to a doctor.

The women were excited and eager to share health information with each other and exchanged details regarding which clinics are best, which doctors are good, and where to go for care. They told stories they had never shared with anyone before. One woman told a story of her first baby dying in Africa because of an herbal remedy that was given to the baby. Later in that group, another woman shared a story of a mental health issue in her family. After an Observer first shared his story of prostate cancer, the men also shared their personal health stories and encouraged each other to be tested for prostate cancer and colon cancer.

**Healthcare Access:** Female participants indicated that they are very willing to seek healthcare when they need it, but went into great detail about the barriers, cost, and discrimination they face because they don’t have health insurance. They explained that they often ignore health concerns and go without care until they are very ill and unable to function because they either can’t afford care or don’t have health insurance.

Female participants further reported difficulty in accessing care. They said that they know about applying for free care, but don’t want to fill out the paperwork, provide proof of income, or deal with the government for a variety of reasons. One woman finally filled out all of the paperwork necessary to receive free care, but said the process is extremely arduous and invasive. When participants received care, they faced large bills. One was denied surgery and several were taken to court for outstanding bills they are still struggling to pay.

In addition, female participants cited feeling discriminated against and “talked down to” by nurses and especially front desk staff in hospitals and doctor’s offices. They reported being discriminated against by Latino clinic receptionists who appear to take Latino patients ahead of other patients while ignoring others in the waiting room. One woman explained that she waited for hours to be seen while others, who seemed to be “friends” with the front desk receptionist, were called first. Female participants reported feeling underrepresented in the healthcare field and pointed out a need to have Africans working in these facilities. They suggested that more African nurses and doctors would “open the door”. They also commented that they felt rushed in doctor’s offices and that doctors have to rush people because they schedule too many appointments.

Both male and female participants explained that in Africa, healthcare is not readily available in the countryside and hospitals are often miles away. As a result, people do not go to a doctor or a hospital until they are very sick. Male participants said that young people in Africa do not go to the doctor at all, while those born in the United States are more likely to go to a doctor. Many of the men mentioned that they had been in this country for 15 to 20 years before they saw a doctor and often only go to the doctor when they have a symptom of an illness.

Male participants attributed the characteristic of not seeking healthcare until they are sick both to “old” African culture and a general cultural norm among men. One man said that even though he has insurance, he still does not go to the hospital or doctor.

*“In my country, not many people go to the doctor, so when I came to the US it wasn’t on my radar.”*

*“When I go to the hospital, I don’t feel comfortable. I don’t like people touching my body. My prevention is eating right and going to the gym. This is the African way.”*

The remaining men were more “Americanized”. They had yearly physicals, showed no reluctance to seek medical care, and encouraged each other to get screened for high blood pressure, prostate cancer, and colon cancer. These participants were firm believers in annual check-ups and screenings. Most had experienced the effects of not having any symptoms of a problem only to find out that they had a serious issue like prostate cancer, colon polyps, or high blood pressure. Most of these men had been in the United States for an average of 24 years, excluding one participant who had only been in the United States for three years. This recent immigrant explained that he was examined in a refugee camp before being allowed to enter the United States and that he is now required to have yearly examinations and a good health record to maintain his green card. This experience has familiarized him with the American healthcare system.

Several men mentioned the importance of family history and reported trying to talk to relatives in Africa to find out more about their family medical history. One encouraged his brother to have screenings, but was not successful in convincing him of the importance of going to a doctor.

Male participants reported generally good encounters with healthcare. They did not experience discrimination or other barriers to care. Only one man had no insurance, so the healthcare of these men was not limited by a lack of insurance, but they recognized this as a barrier to others.

*“Many people don’t go get medical attention because they don’t have insurance. Some people prefer to die in their house because of this. Other people are illegal, so they don’t want to expose themselves and then have to leave the country. People are afraid to go.”*

After this statement, another participant explained that hospitals do not report illegal people seeking healthcare.

**Medication:** Male participants reported that because they were not used to seeking treatment, they used herbal remedies in Africa. Several mentioned that their grandmothers had used leaves and juices to make remedies. They said that they felt better after taking them, but had lost the recipes after being in the United States for so long and cannot find the same ingredients in this country. They reported that they knew exactly what was in the home remedies, but dislike taking pills because they are unfamiliar with the

ingredients. The recent immigrant said that it is “very African” to stop taking prescribed medication once you feel better. He described that some people in the refugee camp stopped taking medicine once they started feeling better, even when they were told to finish the medicine, while others might not take it at all.

Some female participants favor and use herbal remedies, while several said they would not touch them. Some women use ginger weed tea (for a cough and to “flush out the system”) and other remedies available at Chinese markets, but reported using them less in the United States than in Africa. They said that just because Africans in Africa might use herbal remedies, that does not necessarily influence Africans living in other places. In Africa, people are more likely to use herbal remedies because of the difficulty in accessing healthcare. In the United States, on the other hand, even those who do believe in the efficacy of homeopathic remedies use them less often because healthcare is more available. Female participants acknowledged that when they are sick and don’t have the money or time to get to a doctor or clinic, they use herbal remedies and “do it the African way – quick”. They were not aware of needing to tell a doctor if they use herbal medicine and that herbals could interact with prescription medicines.

In general, the women were opposed to taking medications. A couple of women cited a fear of becoming addicted. One woman who described being on blood pressure medication for several years reported that it is not helping. Another said she doesn’t like taking medications because she doesn’t know what’s in them. All of the women talked about the side effects of medication, as well as the side effects of herbal remedies.

**Role of Religion:** The role of religion and prayer in healing was not a strong theme in the female focus groups. None of the women sought healing through prayer over seeking medical care, and they did not report pressure in this area from religious authorities in their community. One woman described receiving three different diagnoses from three different doctors so decided to simply go home, pray, and turn herself over to God for healing and was healed in that way. This discussion of religion and prayer in healing was skipped in the male focus group. All but one man sought regular medical care, seemingly regardless of religious beliefs or concerns.

**Mental Health:** Only the male focus group was directly asked about mental health issues in the African community, while women in FG2 discussed mental health only during the wrap-up conversation. FG1 participants did not discuss this topic. While participants were very forthcoming about other health issues, they agreed that Africans would not talk to someone outside of the family about mental health issues and do not seek counseling because it is considered a disgrace to the family. They said that in Africa, mental means “crazy”. They equated mental health with dignity and explained that to Africans, the family “name” or reputation is very important. Participants acknowledged that things in Africa are changing and people do seek care for mental health issues. They suggested that Africans who have been in America for some time might discuss mental health because they have adapted to this country, but felt that Africans generally need more education in this area. They understand that in the United States, mental health is related to stress and taking care of yourself and does not mean that you are crazy. Male participants suggested that there is more stress in this country than in Africa, and that this contributes to illnesses here that they do not have back in Africa.

One of the men said he is aware that lead paint affects children mentally. The men commented:

*“What we consider mental problems at home are different than in the US. At home you have to be crazy to have a mental problem. When kids act up in school, they treat them differently. It is considered bad behavior and not ADD.”*

*“At home we don’t have the ability to discover what is mental retardation or other mental health issues. We never heard of how to classify someone who needs special education.”*

*“We only understand mental health in Africa in terms of “crazy”. In reality, here mental health is if they are acting up at home, rebellious, or depression. It is hard to compare mental health in Africa and in the US.”*

One woman told the story of her brother who was in business school and just “snapped”. She said he needed a break and sought treatment in the Congo. Participants said that in Africa, they were unaware of diseases or conditions such as dementia or Alzheimer’s. They just took care of their elders and everyone realized that they were failing, but this was considered a normal part of aging.

Although participants reported that some Africans still avoid talking about mental health or seeking help, they felt that this was not a “cultural” or “African” phenomenon but rather an individual preference or bias. One woman reported that she would not talk to anyone or seek help if she was having marital problems, and others indicated that they would talk to other family members or a pastor.

## **Prevention Knowledge**

All three focus groups were asked several questions to determine their level of knowledge regarding disease prevention, immunization, and the uses of various tests. Female participants were generally very knowledgeable, while the medical knowledge of male participants varied widely.

**Prevention:** When asked what prevention means to them, female participants said “stopping harm” or taking precautions so you don’t get a disease. The male participants had a more limited understanding of the concept of prevention. When asked if they knew what prevention was, specifically health prevention, one participant started the discussion with the question, “What’s the difference between cure and prevention?” The moderator explained that she would not respond to the question because it would influence the discussion, but that she would respond after the discussion. Male participant responses to what prevention means included:

- Avoiding something from happening.
- You go to the doctor to know where your blood pressure is at so you can keep tabs on it so you can prevent a heart attack from happening.

Another participant said he did not think that any illness is curable, but only manageable, especially since all medications have side effects that can cause something else.

There was confusion among the men between the concept of prevention and seeking medical care as a means of prevention. The moderator prompted them to think in terms of what you can do *before* you go to the doctor. After this portion of the discussion, the moderator clarified that prevention is what you do before you get sick, while a cure is what you seek once you are already sick. To illustrate the difference, she cited the example of a more active lifestyle in Africa versus a more sedentary lifestyle in the United States.

All participants acknowledged that their lifestyle, which is more sedentary in the United States, contributes to illness. They agreed that Africans in Africa do a lot more walking and are thinner than Africans in the United States. The women said that when they visit Africa, they are the largest people in the villages. The men mentioned that in Africa, all the food they ate was natural and fresh, while all the food you buy in the supermarket in the United States is processed.

*“At home everyone is skinny. Here not so much.”*

*“When Africans come here there are no issues with cholesterol and other things that are prevalent in the US. How can we eat healthy when we come here?”*

Most men said that their diet consists of too much red meat, “carbs”, and protein. They said this is a mixture of African and American diets, including too much processed food.

**Disease Contributors:** When asked what contributes to heart disease, women mentioned obesity, diet, lack of exercise, genetics, lifestyle, and stress, while men mentioned high blood pressure, not eating right, and not exercising. When asked what contributes to diabetes, women said obesity, diet (including sugar or too many “carbs”), and genetics, while men cited lifestyle, stress, diet (including too much sugar), and family history. One man said that family history is very important. The men discussed that many Africans don’t know anything about their family medical history yet need to know. The described that now that they are here in the United States, they discuss health issues within their families.

The women reported knowing that smoking causes lung and other cancers, and that diet, genetics, pollution, and radiation can contribute to certain cancers. They know that sexually-transmitted diseases and HIV/AIDS are transmitted through sex and bodily fluids and that you can get them from your partner. They know that HIV/AIDS can also be transmitted through blood transfusions and sharing needles. Answers for these questions were not reported for the men’s group.

**Screenings:** Male and female participants were able to list many tests received in a doctor’s office, lab, or hospital and the purposes of these tests. Women were familiar with mammograms to check breasts, pap smears for cancer, tuberculosis tests, blood tests for diabetes, CAT scans, X-rays, and urine tests for infections. Men mentioned a scratch test to detect tuberculosis, pulmonary function test, stress test for cardiac function, colonoscopy to detect colon cancer, PSA to detect prostate cancer, urinalysis, and cardiac “cath” for artery blockage.

**Immunization:** Female participants were familiar with a number of immunizations, including hepatitis, MMR (also mentioned separately as measles, mumps, and rubella), human papillomavirus (HPV), chickenpox, combined tetanus, diphtheria, and pertussis (TDAP), and flu. Male participants listed tetanus, cholera, malaria, hepatitis, and H1N1 flu vaccines. They did not mention seasonal flu. At least half of the women and men received flu shots. One woman dispelled the myth expressed by others in her group that

you can get sick from a flu shot. Another woman explained that she would not get the H1N1 flu shot because “she doesn’t know what’s in it.” One woman with a young son said that the school tells her what immunizations he needs.

### **Best Way to Provide Prevention Information**

Female participants were very interested in health information and receiving health information. They wanted to learn more about health, staying healthy, and making nutritious meals. They acknowledged that the “African” way of cooking (i.e., using lots of palm oil) is not healthy. They also mentioned that a lot of growth hormones are used in the United States, and that this is also not healthy.

The women expressed enthusiasm about the prospect of future health forums at their churches or other community venues. They said that an event, like an outdoor barbecue, would bring out the community. They suggested promoting events using flyers at churches, mosques, libraries, and health center sites, such as the Fatima Health Clinic. They also recommended holding an event in different community locations, as there are communities of Africans in different cities throughout the state. The women said they would like to participate in screenings and health education seminars. They were less enthusiastic about brochures or printed materials and preferred the hands-on approach of group meetings.

Male participants were also very interested in health information and receiving health information. They wanted more information about what causes different diseases and what can be done to prevent them. One suggested that more outreach is needed in the community. While most men indicated interest in health education programs, one participant likened it to a struggle between “opportunity and desire”: while they may desire more health information, they may not be able to take advantage of an available opportunity if they are working or busy. They said that they would be unable to skip work to attend a health education presentation, so finding convenient times might require some trial and error.

Only the male focus group was asked if they know what the Health Department does. Responses included: makes policies, analyzes statistics, issues licenses, makes rules and regulations, environment control, and works on health issues like health insurance.

### **Likelihood of Participation in Community Health Assessment**

Female participants were unenthusiastic about the idea of answering a door-to-door survey. Africans like gathering together, so the women suggested that the community would be more receptive to a survey if surveyors attended community events, elicited survey responses at these events, and used the events to spread the word that they would be going door-to-door. Some women said they would be afraid to open the door to a stranger, and others were concerned about the amount of time it would take to answer the survey at home.

Men reported that they were very receptive to participating in a health assessment survey and would be willing to answer the door for a community worker. One participant said, “Anything for health.” Men suggested that they would participate even if the survey took 20 to 30 minutes to complete, but acknowledged that time might be a factor at home. They also cited the need for strict confidentiality.

*“It’s a 50/50 chance of getting the person at home. If you can get them in a meeting setting, and still keep it confidential, it would be easier to respond to the questions.”*

## **Other Discussion Topics**

During the open forum discussion among women in FG1, several additional topics were discussed.

In a discussion on marital relations in Africa, participants explained that if a wife cannot have a child, it is assumed that the problem is with the woman and the husband can take another wife. Up to four wives are allowed in one of the represented cultures. Although this practice is being frowned upon, it is still done and is legal.

When asked if they would go back to live in Africa, all women in FG1 said that they would return if they could. They reported liking the communal aspect of living in Africa and believe that people there lead a healthier, more active lifestyle. They pointed out that there is little obesity and all of the food, produce, meat, and fish are fresh and do not include growth hormones.

## Results: Focus Groups 4-5

**Table 4: Participant Demographics**

	<b>FG4</b>	<b>FG5</b>
<b>Number of Participants</b>	8 (5 women, 2 men, 1 girl)	7 (4 women, 1 boy, 2 girls)*
<b>Countries</b>	Ghana; Kenya; Cape Verde	Burundi; Tanzania
<b>Years in United States</b>	All more than 11 years except for the young girl who had been here one year	All less than three years**
<b>Level of Education</b>	Minimum of high school and three with graduate degrees	The children were in elementary school, the adults all had a middle school education
<b>Health Messages</b>	Most said they would like to receive health messages via email and/or a brochure in the mail	They would like to receive health messages via email and/or a brochure in the mail

\* One child had a strong command of English and fully participated. The other two children were younger than 15 years old and were unable to fully participate in discussion.

\*\*Most participants had lived in the United States for an average of only two years and had limited English language skills. An excellent interpreter provided translation services for these participants.

### Health Behaviors

**Typical Day:** The five adult women in FG4 know what they need to do to take care of themselves. Their typical day is active and includes work and working out. They take the lead in deciding what foods to purchase and cook in their households. The female adults in FG5 typically get up early (6:00 a.m.) and get their children ready for school then either go to work or attend English classes at the International Institute. After work or school, they go home to do housework, do laundry, and cook dinner. One of the women walks about 30 minutes a day to work. Housework is their primary source of physical activity. The two young men in FG4 are in their twenties, have active jobs, and work long hours. They do not actively work out because their jobs require them to move and be active throughout the day. They tend to grab food when they can rather than eating regular meals.

Most of the adult participants in this focus group do not work on weekends, but those who do, work no more than 50 hours per week. Most participants reported that their weekday routines are different than weekends, when they prefer to relax and may not exercise. One woman said, “I become a couch potato on weekends.”

The typical day of the twelve year-old girl in FG4 includes school, soccer practice, homework, and computer. She spends at least an hour a day on the computer and watches two to three hours of television each day. She has very little physical activity beyond soccer practice. Of the children in FG5, one of them walks to school and the others take a bus. One attends an after school program while the other two go home after school. They get some physical activity with pick-up games of soccer and kickball, but do not participate in organized sports.

**Eating Habits:** All participants primarily eat home-cooked meals, including a lot of rice and beans, staples of an African diet. They frequently boil and steam their food rather than frying it, and their

descriptions suggest that their meals are well balanced. The group of recent immigrants (FG5) said that the food they cook here is very similar to the food they cooked in Africa and that they have not gained weight in America. “The way I came is the way I stayed.” Participants reported eating at restaurants only on special occasions. Some mentioned IHOP as a place they like to eat, and the young boy mentioned that he likes it when his mom sometimes brings pizza home for dinner. One mom said she buys frozen breakfast food for her children because it is quick and easy in the morning.

Most adult participants pack and bring daily lunches to work. The two men do not eat as well as the women because they grab food when they can rather than eating regular, balanced meals. One admitted to eating fast food quite a bit. The children all eat lunches provided at school. Most of the kids like the staples of the American childhood diet, such as hot dogs, chicken fingers, pizza, and hamburgers. The twelve-year-old girl, however, hates food in the United States. She finds it tasteless and especially dislikes chicken nuggets and pizza.

Participants primarily buy their groceries at supermarkets (Stop & Shop, Price Rite, BJ’s, Walmart). One or two participants reported shopping for specialty items, such as Indian food and spices, in smaller, local stores. When prompted, others mentioned shopping at a couple of African markets. Participants said they are able to get most everything they previously bought in Africa except green bananas. Overall, they are happy with the food they buy here.

Because of time constraints, participants shop only once a week in the United States rather than shopping daily as they did in Africa. Another difference between living in the United States and Africa is that they do not grow their own food in the United States. In Africa, their families grew their own vegetables. Two of the more recent immigrants said that the food here does not taste the same as it did in Africa because it is not as fresh, is not organic, and contains chemicals that they don’t use in Africa.

Participants reported that they no longer grow their own food as they did in Africa because “I’ve made it” (i.e., they now make enough money to buy their food). This concept was closely tied to their living arrangements. They explained that in Africa, extended families live together, which helps with child care and the division of household tasks. Participants said that in the United States, they avoid living with many extended family members in the same household because they would be judged poorly. Yet by adapting to American standards, they acknowledged losing the family support they depended on in Africa. This puts a greater burden on the woman of the household, forcing her to work, take care of the children, and take care of the household while having less time to take care of herself.

**Physical Activity:** The five adult women in FG4 lead active lives and typically work out on weekdays. They also find time to engage in leisure activities such as bowling, roller skating, watching movies, playing Wii, and dancing. In contrast, the adult women in FG5 were not physically active. These women said housework was their primary source of physical activity except for one woman who walks 30 minutes to work. The leisure and weekend activities of FG5 participants revolve around visiting friends, socializing, parties, and barbecues. The young men in FG4 are so physically active in their jobs that they do very little physical activity at other times. The children in FG4 and FG5 only engage in limited physical activity. The adults explained that their neighborhood is bad so they don’t let their children play outside alone. They sometimes go to Roger Williams Park.

Participants reported that in Africa, they walked everywhere. They explained that in the United States, however, if you walk everywhere or take public transportation it means that you can’t afford a car. “If you have a car, why would you walk?” Another cultural norm in Africa is social support. Only one person in the focus groups currently lives with her mother and has a constant source of support. Her mom cooks the family dinner every day and she never has to get a babysitter, yet she feels judged by Americans. “In the US, everyone wants their own space,” she explained. The twelve-year-old girl, for example, wants her

own bedroom. Participants said that “part of being American changes them and they lose their culture in the process.”

## Recreational Interests

*Community Activities: Focus group participants were unfamiliar with the concept of community gardens but were very interested in the idea. Other suggested community activities included:*

- *Dance classes*
- *Walking groups by neighborhood*
- *Community gatherings with games*
- *Health fairs with screenings*
- *Health awareness groups at churches*
- *Exercise groups*
- *Soccer league*
- *Biking groups*

When the recent immigrants (FG5) were asked what they thought they could do to lead a healthier life, they said that finding work would reduce their stress and help with everything. They also said they would be interested in and would attend health education programs.

## Healthcare Attitudes

**Discussing Healthcare:** Participants in FG4 and FG5 were very talkative and open about their health behaviors, eating habits, and physical activity. Participants in FG4 said that they freely discuss health at home with their families, but some suggested that it depends on the type of health problem. They explained that in Africa, they don't talk about wellness and are very private about health, and they particularly avoid discussing mental health issues and cancer. Participants in FG5 indicated that they would tell their children if they were not feeling well, but would not share specifics of the illness. They said that they would tell older children but not younger ones, but it was unclear as to whether this related to sharing details about specific illnesses or about feeling sick. FG4 participants said that health is emphasized everywhere, that most people want to be healthier, and that the emphasis of health through their church was helpful.

**Mental Health:** One woman in FG4 opened up to the group about her stress-related problems. In Africa, she had been very active in sports but she gave it up when she came to the United States. In the United States, she learned to talk to someone about her stress and now she exercises and walks to control it. Although Africans avoid discussing mental health issues, she felt that she should share her story to help other people in the group because it happened to her and she had no way to deal with it.

*Some of the ways participants in FG4 suggested coping with stress included:*

- *Talking to somebody*
- *Being physically active—sports*
- *Laughter*
- *Perspective (keeping things in perspective)*
- *Writing*

Adults in the group of recent immigrants (FG5) reported that their stress comes primarily from not being able to find jobs and affordable child care. They felt that having a job would reduce their stress. One woman lost her job because she couldn't find child care. When asked what AARI can do for them, these participants prioritized having help finding work followed by assistance finding affordable day care for their children so they are able to work.

Participants said that they deal with the stress they feel by praying and singing. Most of the recent immigrant adults reported going to the doctor both when they are sick and for annual check-ups. Only one woman visits the doctor only when she is sick.

## COMMENTARY

African immigrants participating in these focus groups came from many countries, were many different ages, had different levels of education, and had been in the United States for varying amounts of time. In some instances, focus groups had demographic clusters that might have influenced participant responses. In FG4, most adult participants had a high school or graduate education while in FG5, no adult participants had higher than a middle school education. In FG4 all participants had been in America for more than 11 years while in FG5, participants had been in this country for an average of only two years.

In some cases, focus group demographics fell short of or exceeded the target population. One objective of FG4 and FG5 was to elicit intergenerational discussion, but the limited number of participants of various age ranges in each of these two groups minimized opportunities for this type of discussion. Although the primary target population for this project was immigrants living in the United States for between 2 and 10 years, the group of male participants (FG3) had lived in this country for an average of 24 years and the final focus group (FG5) had only been in the United States for an average of 2 years.

African cultural norms and expectations may have further influenced participant input. Unlike their female counterparts in FG1 and FG2, male participants in FG3 did not report difficulties in accessing care, discrimination in health care settings, or a lack of insurance. FG3 participants may have been more familiar with the healthcare system because they had lived in the United States for 24 years on average. It is also possible that both male and female participants in FG4 and FG5 may not have been as open to sharing their true feelings and experiences in the company of participants of another gender.

Despite these limitations, the range of experiences of these groups provides valuable insight into the central theme of acculturation challenges that emerged during these discussions. It also provides an opportunity to educate health professionals and community-based organizations about health-related issues in Rhode Island's African community.

The experiences of most adult participants followed a similar trajectory of negotiating the demands of daily living while simultaneously acclimating to a new and dramatically different culture. At various times, participants grappled with understanding and engaging in an American bureaucracy and social norms that were difficult to access and to reconcile with their African customs. While these experiences were challenging, particularly for newer immigrants, they typically helped participants adapt to new cultural expectations. The adjustments inherent in acclimating to a new culture eventually nudged participants who had been here longer into a comfort zone where they often felt more confident and competent navigating the healthcare system and responding to American traditions. The stories and lessons of these focus group participants offer valuable insights for more recently arrived African immigrants. This cycle of immigration and adaptation also provides opportunities for community agencies, such as the AARI, to support and guide their populations through this challenging process.

*Finding a balance between the lifestyle that they had and the new lifestyle that they are creating was a core theme for focus group participants and was central to their ability to effectively maintain and engage in healthy behaviors.*

A particular challenge for African immigrants is reconciling customs and habits of the homeland that may continue to serve them well in the United States but that may not conform to their perceptions of necessary acculturation. Finding a balance between the lifestyle that they had and the new lifestyle that they are creating was a core theme for focus group participants and was central to their ability to effectively maintain and engage in healthy behaviors. This conflict presents an excellent framing opportunity for AARI to educate their population about preventive health behaviors.

A striking example of this conflict is that in Africa, the tradition of living with extended family helps with the division of household tasks and provides a built-in source of child care. In the United States, participants said that they would be judged poorly if they have many extended family members living together so they avoid this type of arrangement. By adapting to American standards, immigrants lose the family support they depended on in Africa.

A possible framework for discussing similar conflicts follows. Example 1 addresses a preventive health behavior, physical activity, which tended to be more successful for the participant while she was living in Africa. Example 2 explores a health behavior, talking about mental health, which is more easily addressed in the United States. In both examples, understanding what is different in the two cultural settings and how those differences affect health may provide some perspective on prevention. With the guidance of a skilled facilitator, discussing these topics in a group setting could provide a variety of perspectives and solutions, or testimony, to reinforce positive health behaviors and attitudes, debunk negative myths and practices, and provide social support to normalize the African immigrant experience.

#### **Example 1: Physical Activity**

##### *Old Custom*

Prompt: What did you do for exercise in Africa?

Discussion: In Africa, I walked everywhere.

##### *New Custom*

Prompt: What do you do for exercise in the United States?

Discussion: I only get exercise doing housework.

*Why Changed (if relevant)*

Prompt: What changed this behavior for you in the U.S.?

Discussion: If you have a car, why would you walk?

*Compare & Contrast*

Prompt: Which do you think is better for your health?

Discussion: Walking is probably better exercise.

*Reconciliation & Solutions*

Prompt: Is there a way you can regularly walk in the U.S.?

Discussion: I walk 30 minutes to work everyday. I work out on weekdays.

**Example 2: Discussing Mental Health**

*Old Custom*

Prompt: What do people do if they have mental health problems in Africa?

Discussion: In Africa, you don't talk about mental health, you just deal with it.

*New Custom*

Prompt: What do people do to deal with mental health in the United States?

Discussion: They talk to someone about it to make it easier to deal with.

*Compare & Contrast*

Prompt: Which do you think is better for your health? Why?

Discussion: Talking about your problems to help you deal with them.

*Reconciliation & Solutions*

Prompt: If you have a problem you need to talk about, what would you do?

Discussion: I talk to my sister or my mother about it.

Storytelling is an important strategy for conveying wisdom and information in the African community. If a health educator can create a story that frames the experience of African immigrants in their home countries in terms of prevention and guide them in comparing and contrasting those experiences with newer traditions in the United States, community members might better be able to discern between and choose those habits that support a healthy lifestyle regardless of where they live. If “part of being American changes [Africans] and they lose their culture in the process,” then this type of story may also enable immigrants to find value in and retain African customs that support their well-being rather than abandoning those traditions.

Although storytelling can be integrated into a variety of health education strategies and settings, focus group participants overwhelmingly supported the idea of receiving health education in a community setting. In particular, they mentioned receiving information at health fairs, church, and other public events in different communities of Africans living throughout the state. They largely preferred the hands-on approach of group meetings to brochures or printed materials. Several promising approaches to community education emerged during group discussions.

**Churches:** In the focus group that took place at the Mt. Hope Community Baptist Church (FG4), participants seemed to have a particularly strong understanding of health issues compared to the other four focus groups. Participants in this group also reported that their church emphasized health. Because focus group participants tended to attend the focus groups scheduled at their own churches, some Mt. Hope participants were likely members of that congregation. This suggests a correlation between the

church emphasizing health issues and the knowledge base of participants (these participants also had a higher education level, which may have further influenced their responses).

**Health Fairs:** One way that the Mt. Hope Community Baptist Church emphasized health was to host a health fair. An African doctor was available to provide health screenings and discuss health without the time constraints of a typical physician visit. The loose structure of this setting, the cultural familiarity of the doctor, and the way he sat down when talking to visitors instead of standing over them made him more accessible to congregants and permitted them to open up to someone outside of the healthcare setting. This model could be applied to other public events in the African immigrant community.

The two preceding examples reinforce the idea of providing health education in the church setting. The various health education opportunities inherent in these two examples include:

- Partnering with churches to provide health education
- Offering health education opportunities in a church setting
- Scheduling opportunities immediately after services
- Providing culturally accessible health education

**Community Groups:** The structure of the focus groups in this project provides an excellent example for offering support around health issues in the African immigrant community. The focus group itself creates an opportunity for individuals in the African community to come together and discuss health with each other in a non-threatening setting. Participants in all five focus groups expressed comfort with discussing most health issues both in general and in a group setting. Many female participants were excited and eager to share health information with each other. The community group also capitalizes on the African cultural norm of social support reported by participants. Some specifically mentioned that talking with someone, laughing, and keeping things in perspective help them deal with stress.

Although focus group discussions were facilitated by an outsider for the purpose of data collection, this group model could be utilized to conduct support or awareness groups with community members on various health-related topics, such as those discussed in this project: physical activity, nutrition, mental health, cultural norms and expectations around health, etc. Discussions could also center on specific populations (e.g., women, men, children, elders, new immigrants) or certain health behaviors and skills (i.e., health care access, chronic diseases, healthy lifestyles, etc.). The custom of storytelling could be similarly utilized to stimulate conversation in this setting by allowing participants to open up with each other and learn from the experience of others in their community. Community members trained to lead discussions and provide support (e.g., health educators, community health workers, social workers, counselors, pastors, or similar professionals within the community) could facilitate the groups, and community members with relevant life experiences could be strategically incorporated into the discussions (like those who provided focus group testimony).

**Community Exercise:** African immigrants open to receiving health information in a group setting may also be receptive to group exercise. Focus group participants shared that they might be interested in the following group activities. Several participants also expressed that being physically active helps reduce stress.

- Dance classes
- Walking groups by neighborhood
- Community gatherings with games
- Exercise groups
- Soccer league
- Biking groups

**Workshops:** Another health education opportunity is to provide skill training or technical support on specific healthcare challenges for African immigrants. These might include applying for free healthcare,

effectively using medications, or eating more healthily in the United States, all areas of concern that emerged in focus group discussion. The trainings could integrate key details about these topics, such as promoting the use of free or low-cost health resources, discouraging high hospital use, or alerting participants to the importance of completing a prescribed medication. Such trainings or workshops could be offered in a community group, at a health fair, or at another public event under the guidance of skilled community members or other healthcare professionals, ideally of African descent or experienced in working with African clients. Facilitators could again utilize African storytelling norms, framing the training as a conversation to promote participant engagement and receptiveness.

These illustrations present several promising community-based strategies that AARI can use to provide preventive health information to African immigrants. Although these models may not be evidence-based approaches to addressing health in this population, AARI can elicit community member and leader feedback on these models and begin testing them across community subgroups, settings, and timeframes to establish best practices. To maximize participant access, AARI can ensure that these opportunities are free and accessible to all community members. AARI can potentially partner with and elicit sponsorship from HEALTH, community churches, community hospitals, healthcare organizations (Lifespan, Care New England), or major Rhode Island health insurers (Blue Cross & Blue Shield of Rhode Island, Neighborhood Health Plan of Rhode Island, UnitedHealthcare). Outreach strategies that are carefully developed, implemented, and integrated into supportive community settings may become self-sustaining. AARI can affordably promote such activities through email and social marketing techniques that tap into its extensive community network.

For the community health assessment that AARI plans to conduct, focus group participants were generally supportive of a door-to-door approach to elicit participation, but they suggested announcing this effort in churches and other venues to let the community know in advance that health workers will be visiting their homes. A proposed alternative to door-to-door solicitation was providing opportunities to complete the health assessment at community events or meetings.

*The African experience and cultural norms may ultimately require an alternate approach to caring for these populations that pushes the boundary of current healthcare practices and standards in the United States.*

These proposed community approaches to health education may help to minimize poor healthcare experiences and outcomes for African immigrants in American healthcare settings. Yet the African experience and cultural norms may ultimately require an alternate approach to caring for these populations that pushes the boundary of current healthcare practices and standards in the United States. This may entail changes such as a modified approach to client visits that reflects the African sense of time and strong oral tradition, training and hiring of more Africans to work in healthcare settings to improve immigrant access to care, and educating healthcare office staff in cultural competency to reduce discrimination.

*To learn more about the African Alliance of Rhode Island and this work, contact Julius Kolawole at 401-333-5535.*