African Immigrant and Refugee Families' Perceptions on Informational Support and Health Status: A Comparison of African Immigrants Living in South Africa and the United States

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Abstract

The relationship between migration and health is complex, and its impact varies considerably among individuals, across migrant groups, and from country to country. Although African immigration to the United States (U.S.) and South Africa has increased rapidly over the past two decades, little is known about the health experiences of this growing population even though conditions surrounding the migration process have been found to increase vulnerability to ill health. The aim of this study is to examine and compare the perceptions of African refugees and immigrants to South Africa and the U.S. on informational support and its impact on health status. Data was collected from purposively selected 62 African immigrants to the United States and 66 African immigrants to South Africa using the PROMIS Global Health v1.2 and the PROMIS Item Bank v2.0 (informational support) instruments which assess an individual's general physical, mental and social health. Participants were selected based on their country of origin and immigration status in the country of residence. We developed a Health Perception Index (HPI) and Information Support Index (ISI) as a composite of the measures of the response to health questions and how information support contributes to migrants' overall health status. In addition, we conducted Chi Square test to assess if there was any difference between the

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indicators in terms of association of the two cities. African immigrants to South Africa reported that they were very satisfied with the South African Health Services offered to migrants, contrary to those in the U.S. healthcare. The evidence indicates that migrants in South Africa seem to have a better HPI index compared to those in the U.S. In general, there was no difference in the challenges faced by these immigrants in accessing relevant information to enable them to improve their socio-economic conditions in destination countries. Access to healthcare services remains a major challenge for most migrants. Given that countries rely on formal documentation for access to information and healthcare services, governments could institute special medical and information support structures that cater specifically for refugees and asylum seekers, as well as undocumented immigrants, in the course of waiting for formal recognition in the state. In order to improve African immigrant and refugee families' access and utilization of healthcare services, policies and programs that seek to address social determinants of health and tap into culturally relevant networking, collaborative approaches are needed.

Keywords Migration, health, refugee, immigrant, social Services, South Africa, United States.

Introduction

Migration has been on the increase across the world and remains the defining issue of this century. The decision to emigrate depends on a combination of various factors, such as lack of social security and justice, the low level of confidence in the state, poverty, urbanization, climate change, youth unemployment, as well as better opportunities for work abroad (Dinbabo and Nyasulu, 2015). These flows have generated opportunities and challenges that affect the social, political, economic and health conditions of people and raised complex questions for both policy-makers and researchers. At the global level, but in Africa in particular, there is a paucity of data and scientific research on the issues, challenges, opportunities, benefits and costs of the experiences of international migrants. To address these concerns, scholars are compelled to move out of traditional paradigms and disciplinary boundaries to analyze the multi-faceted and interlinked nature of migratory processes. In this paper we present findings from a comparative study done in the U.S. and in South Africa

exploring the health experiences of African immigrants in their countries of destination.

Background

Although migration places individuals in situations that impact their health and well-being, there has been a surge in human migration in recent years. According to the World Health Organization (WHO) (2019), there are an estimated 1 billion migrants in the world today, of whom 258 million are international migrants and 763 million are internal migrants. In the U.S., as in many other countries, immigrant and refugee families form a considerable and growing proportion of the population, with African immigrants representing one of the fastest growing groups of immigrants. Africans now make up 39% of the overall foreign-born black population, up from 24% in 2000 (Anderson and Lopez, 2018). Much of this growth has been fueled by African migration mainly from Nigeria, Ghana, Kenya, Ethiopia, and Somalia (Capps et al., 2012). South Africa, like the U.S. has also witnessed a surge in the number of people migrating from other African countries. According to the International Organization for Migration (IOM), between 2010 and 2017, the number of immigrants living in South Africa increased from 2.2 million to 4 million (IOM, 2019). The surges in African migration, whether to the U.S. or to South Africa, happen as a result of economic, social, political and environmental factors such as fleeing political persecution, war or terror, enhanced education and employment opportunities, reunification with family members, and better quality of life (Vaughn and Holloway, 2010).

Despite the increase in number and diversity of Africans in the U.S. and South Africa, and the diverse reasons for immigration, no comparative studies have examined African immigrants' and refugees' experiences in African and U.S. settings. There are four global migration flows. The largest flow, South-South, involves people moving from one developing country to another (e.g. from Indonesia to Costa Rica, from Zimbabwe or Congo to South Africa). In 2013, over 82 million were part of this flow (Duncan, and Popp 2017). For Africa, 79% of sub-Saharan African migrants move within the same region and fewer than 22% of migrants from Africa emigrate outside of Africa (Zong and Batalova, 2017). The second largest flow, South-North, constitutes people moving from low- and middle-income countries to high-income countries (e.g. from Congo to France, from Mexico to the U.S., from South Africa or Zimbabwe

to the U.S). In 2013, close to 82 million people migrated under this classification (Martin, 2019). According to Zong and Batalova (2017), of the African immigrants living in the U.S. in 2015, 44.6% were from West Africa, 35.7% from Eastern Africa, 5.8% from Southern Africa and 7.5% from Middle Africa. The third flow, North-North, consists of people migrating from one high-income country to another, as from the U.K. to the U.S. Human migration from high-income countries to low and middle-income countries constitutes the fourth flow (North-South). Our study is founded in the first two largest flows: South-South and South-North. Each of these flows presents unique features and experiences that warrant examination. We argue for a global understanding of migration. Our argument for this examination lies in the inevitability, volume, and heterogeneity of migration (Dinbabo and Nyasulu, 2015).

Although evidence suggests that African immigrants in general have a health advantage over other immigrant groups, this work is limited to comparisons between black immigrants (from all regions) and native-born African Americans or between black African immigrants and native-born African Americans (Mason et al., 2010; Read et al., 2005; Singh and Hiatt, 2006; Singh and Miller, 2004; Hummer et al., 2007; Jasso et al., 2004; Palloni and Arias, 2004). For example, in their analysis of National Health Interview Surveys (NHIS) data, Read et al. (2005) found that African immigrants report their own health to be better than African Americans report. In their study, African immigrants reported the best status, as compared to West-Indian and European-born blacks and African Americans (Read et al., 2005). However, other researchers have questioned the 'healthy immigrant' phenomenon (Fennelly, 2007). Researchers have also noted the gradual deterioration in health among many immigrants (John et al., 2005; Kandula et al., 2004). Length of residence in the receiving country has been found to impact negatively on health (Dinbabo and Carciotto, 2015; McDonald and Kennedy, 2004). In U.S. census data, Africans are generally lumped together as Black or African American thereby overlooking the effect of cultural background and length of stay in the country of destination on their health. Relocation from one country to another can result in family and social disruption that impact health (Lum and Vanderaa, 2009). Factors such as being poor, acculturation stress, and

lifestyle changes, have been associated with declining health for some immigrants (Fennelly, 2007).

It appears there is an information gap because of the understudying of some immigrant groups (Cunningham et al., 2008). With the surge in African immigration around the world, there is a need to fill this information gap. Health and migration is a multi-dimensional matter. When specific ethnic groups are under-studied or under-represented, culturally competent care is compromised thereby exacerbating health disparities among populations (Betancourt and Green, 2007; Cooper et al., 2002; Dinbabo et al., 2017; Sithole and Dinbabo, 2016; Smedley et al., 2003, Pavlish et al., 2010). According to the Institute of Human Development and Social Change, low-income immigrant families disproportionately face barriers in accessing health and human services programs and are at greater risk of living in poverty (Perreira et al., 2012; Yoshikawa et al., 2019). Thus, rapid changes in population movement have important public health implications, including limited access to healthcare services, disrupted family and social networks, and financial barriers.

The vast differences between the way of living in Africa and in the U.S. make African refugees and immigrants in the U.S. an especially vulnerable group. Immigrants have to adjust to nearly all aspects of living – the weather, food, and laws (Boise et al., 2013). During this adjustment phase, immigrants may feel sad, lonely, and disappointed about moving from their home country. They may also feel separated from networks of support left behind in Africa (Boise et al., 2013). Immigrants are also likely to experience acculturation stress due to adaptation to the U.S. including such factors as enhancing language skills, fear of deportation, finding employment, housing, schools, and navigating the bureaucracy of immigration and documentation (Artiga and Ubri, 2017; Boise et al., 2013; Warheit et al., 1985; Aroian et al., 1998). Further, depending on the acculturation process, African immigrants tend to have less access to and utilization of healthcare services. Factors increasing immigrants' vulnerability regarding access to healthcare include, knowing where to go for healthcare, a lack of perceived need, the cost of care, language and cultural barriers, a lack of transportation, perceptions of lack of respect, discrimination or racism, and not understanding how the U.S. healthcare system works healthcare (Boise et al., 2013; Perreira et al., 2012; Siegel et al., 2001). These barriers may result in

many people turning to hospital emergency departments as their main source of care (Boise et al., 2013). Along the same vein, Derose et al. (2007) found that immigrants have lower rates of health insurance, use less healthcare, and receive lower quality of care than the U.S.-born population.

To understand African immigrant health, which is changing as migration transforms the health profile of Africa, it is important to explore the health experiences of African immigrants in their countries of destination. The primary objective of this research was to investigate the experiences of health of African immigrants to South Africa and the U.S. It was hypothesized that immigrants in advanced economies have better access to healthcare services and greater information support compared to immigrants living in developing economies.

This study aims to contribute to the current small body of research on African immigrant health by comparing perceptions on health of African immigrants to South Africa and the U.S. In our review of the literature, we have not found any studies that compare perceptions on health between South-South and South-North African immigrants. This type of analysis will shed more light on the inter-connectedness between health and migration from a global perspective. This understanding can nurture opportunities to brainstorm on collective responses to the unmet health needs of immigrants at the global rather than national level.

Methods

Instrument: Quality of social support refers to interpersonal relationships that serve particular functions. This includes the interactive process by which emotional, instrumental or informational support is obtained from one's social network. It also includes companionship, feeling cared for and valued as a person, communication with others, and feelings of belonging and trust. Measures of social support generally seek information about a person's perception of the availability or adequacy of resources provided by others. For our study, we used the PROMIS Instrumental Support to collect data. The instrument assesses self-reported perceived availability of assistance with material, cognitive or task performance. The instrumental support short-forms are universal rather than disease-specific. It assesses emotional support (quality of life, physical health, mental health, social satisfaction, social

activity, physical activity, emotional problems, fatigue levels, and level of pain), and informational support (companionship, feeling cared for and valued as a person, communication with others, and feelings of belonging and trust).

Data collection: Ethical approval was obtained from the University of the Western Cape and the University of Missouri prior to data collection. Data for this study was drawn from migrants living in Cape Town, South Africa and Columbia, Missouri in the U.S. In the U.S. researchers partnered with an immigrant who volunteers at the Refugee and Immigrants Office in order to reach the population of interest. The community partner was trained on how to complete surveys. The training included sessions in which the community partner observed researchers interviewing participants. The community partner then recruited and interviewed immigrants who come for services at the Refugee and Immigration Services. The community partner also identified other participants based on his knowledge of immigrants in Columbia, Missouri. In South Africa, migrants were randomly selected from different neighborhoods for the project. For example, migrants were selected from Bellville, Parow, Maitland, Wynberg and the Cape Town central business district (CBD). This process helped to ensure that migrants from all income classes and status levels had a fair chance of being selected for the survey. In total, 128 respondents were successfully interviewed using a structured survey questionnaire. Of the 128, 62 were in Columbia and 66 in Cape Town. All participants were selected based on their migrant status in the country of residence and their country of birth or country of origin. Though the data may not be representative of the migrant population in both cities, it at least provides a synoptic overview of the migrants' perception of their health and health services. For both sites, the requirement was for participants to have lived in their host country for at least one year.

Data analysis: To achieve the main objective of the study, we first provide a descriptive and comparative overview of the demographic characteristics of the migrant population. We then develop a Health Perception Index (HPI) and Information Support Index (ISI) which were used to determine the extent to which immigrants perceive their health status and whether such perception correlates with access to healthcare services as well as their relevant information support within their social space in the destination country. According to Babbie (2007), when studying a phenomenon with multiple

indicators, it becomes paramount for the researcher to develop a data reduction instrument so that a composite indicator is developed with a single numerical score to measure the extent of the problem. Several studies have applied the same principle such as the Consumer Price Index (CPI), developed by Bryan and Cecchetti (1993), the Human Development Index (Noorbakhsh, 1998) and the Economic Security Index designed by Hacker et al. (2014).

The HPI and ISI are composites of the measures of the response to health questions and how information support contributes to migrants' overall health status. According to Babbie (2007), developing an index is an ideal way of data reduction that allows for reducing multiple Likert scale variables or multiple response variables into a single numerical score.

We computed the indexes by first assigning values from 1 to 5 where 1 represents a low score and 5 represents a high score, thus indicative of excellent health or higher propensity to access of information. This 5-point Likert scale procedure was used to allow respondents to easily evaluate their health perception and their information support.

Results

We analyzed some of the demographic characteristics of migrants who participated in the study. Migrants from 19 countries were successfully interviewed with the majority coming from sub-Saharan African countries. The result shows that men continue to dominate in the flow of migrants. Males were at 75% compared to females at 25%. However, the sample showed that male migrants in the U.S. constituted 34% compared to 41% in South Africa. The majority of these migrants (76%) were aged 26 to 45 years. In addition, migrants classified as refugees were by far the dominant category of participants interviewed.

Table 1: Demographic Structure

Demographic structure of migrants in SA and US				
	US	SA	Total	
	N=62(48%)	N=66(52%)	N=128	%
Gender				
Male	43(34%)	53(41%)	96(75%)	
Female	19(15%)	13(10%)	32(25%)	
Total	62(48%)	66(52%)	128(100%)	
Years in host country				
1-5	52(42%)	23(18%)	75(60%)	
6-10	5(4%)	21(17%)	26(21%)	
11-15	2(2%)	16(13%)	18(14%)	
16-20	1(1%)	4(3%)	5(4%)	
21+	1(1%)	0(0%)	1(1%)	
Total	61(49%)	64(51%)	125(100%)	
Legal status				
Refugee	49(38%)	18(14%)	67(52%)	
Asylum seeker	1(1%)	11(9%)	12(9%)	
Work/business visa	0(0%)	9(7%)	9(7%)	
Undocumented	12(9%)	1(1%)	13(10%)	
Other	0(0%)	27(21%)	27(21%)	
Total	62(48%)	66(52%)	128(100%)	

Analysis of Empirical Data

Refugee status was 41% for the U.S. and 38% for South Africa. However, on the whole, people with refugee status constituted about 52% of the sample. The proportion of immigrants who classified themselves under 'other documentation' in South Africa was very high (21%) compared to none for U.S. Besides the issues of documentation, the results showed that 60% of the sample have lived in the destination country for between one and five years. In the U.S., the majority of immigrants have lived there for between one and five years. The situation in South Africa was rather spread out between one and fifteen years.

Global Health Perception and Information Calibration of Immigrants

Immigrant health has been broadly studied and evidence in the literature suggests that given the current wave in international migration, disproportionality exists in the assessment of migrants' health. Abubakar et al. (2018) acknowledge that it is not possible to cover all the broad topics of migrants' health. In this analysis, the HPI and ISI indexes are used to draw inferences based on the total weight values and the index deviations from the mean. Items above the mean are seen to have higher response rates from the population.

Table 2: Overall Satisfaction of Health Status

	Poor 1	Fair 2	Good 3	V. Good 4	Excellent 5	Kruskal-Wallis				
						Total	TWV[5]	HPI	*HPI-HPIμ*	P-Value
Global health	18	21	42	14	30	125	392	**3,14**	0,24	0.0001
Quality of life	17	20	61	16	11	125	359	**2,87**	-0,02	0.0813
Physical health	14	21	52	11	26	124	386	**3,11**	0,22	0.0001
Mental health	20	19	49	15	22	125	375	**3,00**	0,11	0.0001
Social satisfaction	16	21	70	10	7	124	343	2,77	-0,13	0.0001
Social activity	18	15	66	15	10	124	356	**2,87**	-0,02	0.0001
Physical activity	23	14	56	13	19	125	366	**2,93**	0,03	0.0001
Emotional problems	36	24	45	12	8	125	307	2,46	-0,44	0.0019
Fatigue levels	11	30	51	20	10	122	354	**2,90**	0,01	0.7385
Level of pain	43	18	29	16	19	325	125	2,60	-0,29	0.0017
							360	**2.86**		

Analysis of Empirical Data

We identified factors that affect immigrants' health perceptions as well as their ability to access support generally which fall under the information calibration items for the study. The results shown in Table 2 above present the responses from the immigrants in relation to their health perceptions using 10 health perception indicators. The average score for the HPI was 2.86. Seven of the health perception indicators in the scale had a mean score above the overall mean score of 2.86. A score of 3 rated as good or greater in the scale of 5 indicates a respondent is perceived to be generally healthy. Three indicators were =>3 that is, global health, physical health and mental health.

A score of less than 3 indicates that a respondent might be experiencing poor health conditions. Given that the overall mean score of HPI for both the U.S. and South Africa was 2.86, which is less than 3 on the scale, the authors conclude that, immigrants perceive their health status as below average. The mean HPI for the U.S. was 2.71 while the mean HPI for South Africa was 3.59.

A *t test* was executed to test significance of the mean difference. The result showed that *t = -7.4396* and *P-value-<0.001 at 95%.* In addition, a Kruskal-Wallis test was carried out to show the overall difference in means for each of the indicators for the study areas. There was no evidence of a significant difference in the fatigue levels and quality of life of the immigrants. However, 8 of the indicators showed significant results as shown in Table 2. These differences are between the U.S. and S.A. As already stated, the overall mean difference shows that S.A. immigrants have a higher health perception index compared to U.S. immigrants and this was significant at P-value<0.05.

A similar procedure was carried out for ISI scores. In Table 3 below, we show the responses of immigrants' access to information support especially in crisis times. We developed the ISI index to measure immigrants' information access using the design information calibrated items measured on a 5-point Likert scale.

Table 3: Overall access to information support

ISI Indicators	1	2	3	4	5	Kruskal-Wallis				
						Total	TWV	ISI	ISI-ISIμ	P-Value
I have someone who gives advice in times of crisis.	27	12	49	12	21	121	351	2,90	-0,16	0.1667
I have someone to turn to for suggestions about how to deal with a problem.	20	5	58	15	23	121	379	3,13	0,07	0.3473
I can get helpful advice from others when dealing with a problem.	14	5	65	17	20	121	387	3,20	0,14	0.3203
I have people I can turn to for help with a problem.	17	5	64	18	17	121	376	3,11	0,05	0.1462
I have someone to give me information if I need it.	20	7	54	22	18	121	374	3,09	0,03	0.6025
I get useful advice about important things in life.	18	6	50	26	21	121	389	3,21	0,15	0.8024
My family has useful information to help me with my problems.	16	7	40	22	36	121	418	3,45	0,39	0.7773
Other people help me get information when I have a problem.	21	6	53	27	14	121	370	3,06	0,00	0.3488
My friends have useful information to help me with my problems.	23	6	56	18	18	121	365	3,02	-0,04	0.1241
I have someone to talk with about my money matters.	49	9	37	11	15	121	297	2,45	-0,61	**0.0041**
Never=1, Rarely=2, Sometimes=3, Usually=4, Always=5								3.06		

Analysis of Empirical Data

Overall the ISI index showed that ISIμ =3.06. The ISIμ for Cape Town=3.28 while that of S.A. was ISIμ= 3.24. Nine of the ISI indicators had a positive deviation from the mean. Three of the ISI indicators had a negative deviation from the mean – I have someone who gives me advice in times of crisis; My friends have useful information to help me with my problems; and I have someone to talk with about my money matters. A score of 3 or greater

indicates that immigrants on average are able to access information support satisfactorily. Given that the mean of ISI was greater than 3, we conclude that immigrants from both countries generally have access to information support. Though most of the ISI indicators had scores above the mean score, just one of the indicators yielded a significant result. We applied a ttest to assess the difference in ISI for the U.S. and S.A. and found that t = 0.2381 and p-value> 0.05. This means that there was no overall difference between immigrants in Columbia and Cape Town in their information support. Similar results emerged using the Kruskal-Wallis test for each of the indictors. Despite the negative deviation from the overall ISIμ, I have someone to talk with about my money matters had a score of 4 and this was significant at p-value=0.0041. Thus, Cape Town immigrants show evidence of possible social interactions and social capital that contribute to their information support compared to immigrants in the U.S. city of Columbia.

Discussion

Our study observed that the HPI was significantly different between the cities with migrants in South Africa having a better HPI despite the fact that the average HPI was less than the scale average of 3. On the other hand, the overall ISI was relatively above average which is equivalent to >=3 on the scale. However, we did not find significant evidence to believe that the ISI was different between the study areas. In this context, it is safe to state that immigrants' access to information support is the same for both countries and is higher than the scale average of 3.

A better HPI for immigrants in South Africa is not surprising because refugees and asylum seekers in South Africa, especially pregnant women and children, have access to basic health services. However, this could be even better if the perceptions of xenophobia were eradicated in the body polity. For immigrants to the United States, the current political climate, and debates over issues such as a border wall, become part of the environment that influences access to health and subsequently health outcomes. Over the last two decades, U.S. immigrants have witnessed a changing immigration enforcement landscape. For example, following the passing of the Illegal Immigration Reform and Immigration Responsibility Act in 1996, the number of illegal immigrants detained increased (Hacker et al., 2014; Miller, 2005). Following the creation

of Immigration and Customs Enforcement (ICE), there has been a noticeable increase in detention and deportation activities across American communities (Capps et al. 2015) The current anti-immigrant rhetoric, which emerged more recently, particularly during and after the 2016 presidential election, is exacerbating the vulnerability of immigrants in the U.S. regarding their participation in healthcare. Our research findings, particularly the lower HPI found among African immigrants in the U.S., illustrate that immigrants may experience social inequalities that are a result of the immigration process and related policies that in turn can drive health disparities. Unlike African immigrants in South Africa who share some cultures and languages with their host country, African immigrants in America have to deal with language barriers, cultural assimilation and discrimination and racism – all of which increase their vulnerability regarding access to healthcare.

Our findings support research that highlights 'legal status' and acculturation as major determinant of immigrants' access to social services, jobs, and health services (Dahlan et al., 2019; Parmet, 2018) as immigrant families often forgo needed healthcare and social services because they fear interactions with public agencies. Therefore, the level of social support within the host country plays a crucial role in shaping immigrant health. We observed that few immigrants were able to obtain informational support in terms of advice in times of crisis yet this type information and suggestions that help with problem solving, are critical for the well-being of people. In their study, Dahlan et al. (2019) show that information and social support such as family, friends and community were positively associated with immigrants' oral health outcomes. Informational barriers present a substantial challenge in that, for this population, information on benefits of public programs is often communicated via word of mouth. Thus, immigrants whose networks are mostly bonding (not bridging) in nature often do not receive adequate information about the benefits available to them. This challenge can be more pronounced in small rural communities where there are few immigrant-serving community-based organizations. One of the challenges migrants face worldwide is access to documentation that regularize their status in the destination country. For a variety of reasons including language, literacy, cultural barriers, stigmatization, immigration-related fears, and logistical and information barriers (e.g. transportation), many immigrants live as

'undocumented' or fail to seek information that can help them participate in the social and economic mainstream. In the U.S., access of benefits by unauthorized immigrants is limited due to fear of being detected by immigration enforcement authorities. Community perceptions regarding the effects of immigration on community resources, and increased cooperation between local law enforcement and federal law enforcement can lead to increased fears among immigrants to associate with government officials at any level. In South Africa, the term 'undocumented migrants' refers to anyone residing in the country without legal documentation. It includes people who entered South Africa without inspection and proper permission from the government, and those who entered with a legal visa that is no longer valid (Dinbabo and Nyasulu, 2015). The researchers observed that undocumented migrants feel stigmatized when addressed as 'undocumented migrants', in the context of South Africa. For this reason, the use of 'other document' for such migrants seem to convey some level of self-dignity of the migrants. The proportion of 'other documentation' in South Africa was very high (21%) compared to 'other documentation' for the U.S. In general, migrants in U.S. find it easy to obtain documents.

Implications for Practice

One major implication stemming from our study is that it aligns with the call for greater understanding of how policy processes should address social determinants of health (Carey et al., 2014; Andermann, 2016). Immigrant health determinants can be modified in part through policies that target disadvantaged populations in general (e.g. living wages, access to education, decent housing) and in part through activities and policies targeted specifically at immigrants. We suggest a few promising practices for increasing immigrant access to services and participation in community life.

- There is a need for multi-disciplinary collaboration around theoretical and practical migrant health matters. Researchers, community development practitioners, health professionals, police, and immigrants themselves should collaborate in stimulating further understanding of immigrant health and the strategies needed to engage the immigrant population. As migration between countries, including the United States, continues to increase, there is a need to include migrants in community-level

discussions that shape the design of policies and resource allocation decisions that affect their health and well-being. Studies have shown that building immigrant-friendly communities can result in greater social cohesion and less societal fragmentation (Cheung and Phillimore, 2017; Mulvey, 2018). As such, integration can have positive effects not only for immigrants but also for members of the host society.

- Policy-makers in the socio-political arena should ensure that immigrants have access to accurate and adequate information about what to expect in healthcare settings, on the differences between local law enforcement and ICE (in the U.S.), and on their rights and responsibilities as immigrant community members. Consideration should be given to providing this information through 'spaces' which immigrants consider friendly and accessible, such as churches, schools and social media.

- Cultural respect and competency training, particularly for healthcare providers (including migrant rights) and law enforcement officials in the U.S., are crucial elements in this process. Immigrants serving community organizations can be more proactive in conducting linguistically and culturally sensitive outreach. Use of trusted mentors to disseminate information to low-income parents has been found to have more impact than when a service provider is used (Capps and Fortuny, 2006; Chaudry and Fortuny, 2010; Yoshikawa et al., 2011). Because families develop trusting relationships with community health workers (CHWs), a community-health-worker-approach in which CHWs are trained to hold meetings in immigrants' gathering places and disseminate immigration-related information, holds promise in engaging immigrants.

Limitations and Future Research

Findings should be considered in light of the study's limitations. First, recruiting African immigrants in the U.S. was difficult. Most African immigrants tend to live in clusters, depending on the African country they come from and the language they speak. We used different strategies to address this challenge including recruiting a recruitment coordinator, who was an African immigrant himself; working with service providers to recruit participants when they turn up for services; and snowballing sampling. Our study was limited because most of the participants were recruited by the

recruitment coordinators and were mostly from eastern Africa. Furthermore, some participants were from the same family, which limited the breadth of the findings. Additionally, 49 of the 62 participants (79%) fell under one legal status (refugees) thereby limiting the generalizability of the findings to a broader immigrant population. Future research studies that include a bigger and more diverse sample reflective of the many countries in Africa are needed to better understand health disparities among immigrants in different country settings.

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