Walden University

College of Health Sciences

This is to certify that the doctoral dissertation by

Adam Musah

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Ronald Hudak, Committee Chairperson, Health Services Faculty
Dr. Lawrence Fulton, Committee Member, Health Services Faculty
Dr. Angela Prehn, University Reviewer, Health Services Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2014

Abstract

Barriers to Healthcare Access for Members of the

Bronx Ghanaian Immigrant Muslim Community in New York City

by

Adam A. Musah

MS, City College of New York (CUNY), 2003

MPA, New York University (NYU), 2001

BS, Lehman College (CUNY), 1998

AS, Bronx Community College (CUNY), 1996

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services Administration

Walden University

August 2014

Abstract

Cultural beliefs on healthcare in the 21st century by the African immigrants in the United States have contributed to the severity of illnesses in their communities. The results of this research identified the healthcare barriers experienced by members of the Bronx Ghanaian Immigrant Muslim Community (BGIMC) in New York City. The purpose of this research was to investigate the influence of education, immigration status, health insurance status, and cultural beliefs on the BGIMC members' perceived access and willingness to use healthcare services for various ailments. A sample of 156 male and female members of the BGIMC completed the survey questionnaire. The study was grounded in the conceptual frameworks of critical theory and complexity theory. The results of logistic and linear multiple regressions indicated that those with insurance were 9 times more likely to report that they had access to healthcare than those who did not have insurance. Additionally, those with health insurance were almost 7 times more likely to report using healthcare services in the past 12 months. Results of the multiple linear regressions indicated that immigration status, health insurance status, and education levels did not predict willingness to use healthcare when an arm was broken, nor did they predict willingness to use healthcare for a severe fever. However, immigration status, health insurance status, and education levels did predict willingness to use healthcare when experiencing dizziness. Understanding the social and cultural factors related to use of health care services will lead to tailored health insurance and access initiatives for the BGIMC; this increased understanding will also promote positive social change in their community and serve as a model for other African communities in the United States.

Barriers to Healthcare Access for Members of the Bronx Ghanaian Immigrant Muslim Community in New York City

by

Adam A. Musah

MS, City College of New York (CUNY), 2003

MPA, New York University (NYU), 2001

BS, Lehman College (CUNY), 1998

AS, Bronx Community College (CUNY), 1996

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services Administration

Walden University

June 2014

ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 - 1346

Dedication

To my wife, Bilkis Musah, for her unprecedented love and support, and our dedicated son, Abdul-Hakeem, for being my study partner and putting up with my limited attention to his needs due to the demands of this project.

Acknowledgements

First and foremost, I am thankful to Almighty God for giving me the strength and wisdom for completing my doctoral program. Secondly, the guidance of my committee members and the support of my family and friends have played an important role in achieving this goal, and I am grateful for that. My deepest gratitude goes to my humble advisor Dr. Ronald Hudak for his excellent guidance, patience, and the provision of an excellent atmosphere for accomplishing this task. I have been incredibly fortunate to have him as an advisor in this challenging program. Further, my sincere gratitude goes to Dr. William Barkley for his insightful comments and constructive criticisms at different stages of my dissertation that helped me focus my ideas. I appreciate Dr. Larry Fulton's decision to step in for Dr. William Barkley. His precise comments were indeed helpful and appreciated. I am also grateful to Dr. Angela Prehn for her expertise and professional guidance on this project. It is my pleasure to acknowledge some colleagues and friends who have contributed immensely in accomplishing this goal.

I am indeed grateful to Alhaji Baba Allaino for his invariable support and beautiful words of encouragement during our coffee breaks at our favorite place, the Bronx Coffee Shop. Our community organizations such as the Bronx Ghanaian Immigrant Muslim Community, the African People Alliance, and the Galagala Restaurant also deserve appreciation for their wonderful support. Finally, this dissertation and my educational accomplishments in general would not have been possible without the love and patience of my family. My lovely family, to whom this dissertation is dedicated, has been a constant source of love, moral and material support during the long years of my education. Thank you all!

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

Background

Some people from Ghana, a small country along the West African coast, have immigrated to the United States for better living conditions. Many of these immigrants settled in the Bronx, one of the five New York City boroughs (Thompson, 2009). These immigrants formed a community identity group called the Bronx Ghanaian Immigrant Muslim Community (BGIMC), an organization established to provide Arabic/Islamic education and officiants to conduct traditional ceremonies for marriages and bereavement in conformity with Islamic doctrine (The BGIMC Constitution 1990, Article 3-1).

In 2009, the board of directors of the BGIMC discussed health issues in the membership population. As a result, I was hired to conduct interviews to understand the prevailing health concerns of the community. The findings of these face-to-face interviews indicated that the BGIMC members were not satisfied with their healthcare services, yet reasons for their dissatisfaction were unclear. A significant number of BGIMC members had been diagnosed with high blood pressure, kidney disease, and other illnesses, but access to healthcare was inadequate (Musah, 2009). These interviews helped identify the need for further research and led to the current study.

Immigrants were often found to be uninsured, and their cash expenditures for healthcare were often higher than individuals with insurance, resulting in a further reduced ability to pay for the care they needed (Selden & Sing, 2008). Other factors such as language barriers also affect immigrants' healthcare access. The outcome is that immigrants use fewer primary and preventive medical services than they are supposed to,

including emergency medical services and dental care, compared to U.S. citizens, even when the effects of race, income, and insurance status are controlled (Howie, 2009). Because employees at some public healthcare facilities inquired about immigration status, immigrants feared that accessing these services could jeopardize their status in the United States (Sreenivasan, 2007). As a result, some immigrants turned to unlicensed healthcare providers and purchased black market prescription or traditional drugs (Sreenivasan, 2007).

These disparities in health coverage impact the ability of uninsured immigrant parents to obtain medical care for their children to the detriment of their health (Leighton, & Broaddus, 2008). Leighton and Broaddus (2008) argued that it is the duty of Congress to permit states to approve Medicaid coverage to immigrant children and pregnant women from the day they arrive in the country.

The Robert Wood Johnson Foundation (RWJF) (2011) noted that, despite improvement in healthcare services, some minorities still experience more difficulties than White patients in receiving quality care, even when access to care is equal for both groups. In addition, there is a disparity in the treatment of cardiovascular diseases between Black patients and White patients, and Black patients suffer more heart attacks than Whites (RWJF, 2011).

The U.S. Department of Health and Human Services (HHS; 2011) found that healthcare disparities between White U.S. citizens and minorities included inferior care in the treatment of HIV/AIDS, diabetes, and hypertension. Further, the HHS Action Plan to Reduce Racial and Ethnic Health Disparities (2011) reported the following findings:

> Individuals, families and communities that have systematically experienced social and economic disadvantage face greater obstacles to optimal health. Characteristics such as race or ethnicity, religion, SES, gender, age, mental health, disability and sexual orientation or gender identity, geographical location or other characteristics historically linked to exclusion or discriminations are known to influence health status. (p. 2).

According to Derose, Gresenz, and Ringel (2011), despite several health disparity studies on immigrants' health services, little progress has been made on immigrant healthcare access. A large number of racial and ethnic health disparity incidences continue to penetrate the healthcare system, and that calls for immediate solutions (Derose et al, 2011).

Poor, undocumented immigrants with rudimentary English skills—particularly those lacking medical coverage—faced daunting obstacles to accessing medical care (Gusmano, 2012). Although a substantial amount of existing literature has addressed how and to what extent level of education, immigration status, health insurance status, cultural beliefs, perceived access, and willingness affected access to healthcare services, research specific to BGIMC members was needed. This research study was conducted to determine the relationship between these factors as related to healthcare access and utilization for members of the BGIMC.

Problem Statement

Nandi et al. (2008) found that the United States has accepted more immigrants than any country in the world for the past four decades. As a result, foreign-born

residents in the Unites States have increased more than 50% (Nandi et al. 2008). These trends hold true for people arriving in New York City where 36% of the population was born outside the country (Nandi et al., 2008). Nandi et al. (2008) further indicated that if immigrants continue to arrive in the United States in their large numbers, healthcare access issues may increase as a result of increase in demand for healthcare services. Therefore, necessary structures need to be put in place to alleviate future health related issues pertaining to immigrants (Nandi et al., 2008).

The BGIMC is located in the Bronx-New York, and 100% of its members are immigrants from Ghana (BGIMC Constitution). Access to healthcare is challenging to these community members as indicated in the initial findings from face-to-face interviews with BGIMC members (Musah, 2009). Further, although BGIMC members have indicated a lack of satisfaction with their healthcare services, the cause of their dissatisfaction was unclear and requires additional investigation (Musah, 2009).

Thompson (2009) stated that immigrants have contributed immensely to the U.S. economy in terms of labor force and diversity. Despite their contributions, immigrants cannot attain the health services they needed as compared U.S born citizens. Although several research efforts (Capps & Fortuny 2006, 2010) have examined why ethnic groups lacked access to healthcare services, these researchers did not explore cultural influences impacting the issue (Nandi et al., 2008). This study explored the cultural influence on BGIMC members' perceived access and willingness to use healthcare services.

Attention to healthcare disparities has been largely focused on race and ethnicity and data regarding these dimensions of disparities was relatively widely available

(Snowden & Fawley, 2008). In contrast, data on the West African Immigrants health disparities were less common (Snowden & Fawley, 2008). Consequently, more targeted research focused on factors related to healthcare access and use within African immigrant communities is needed. Immigration status, lack of appropriate education, and lack of healthcare programs are some of the possible factors inhibiting BGIMC members' healthcare opportunities (Musah, 2009). Yet a complete picture of the community members' challenges in accessing and using healthcare services in the United States is needed. This study is expected to contribute to the understanding of healthcare access, not only for BGIMC members, but also for everyone in the United States, and serve as a conceptual model for future studies.

Research Questions and Hypotheses

The following research questions were addressed in this research:

1. To what extent do BGIMC members' education, immigration status, and health insurance status predict their perceived access to healthcare services and their willingness to use healthcare services?

   Hypothesis: Education, immigration status, and health insurance status will significantly predict BGIMC members' perceived access to and willingness to use healthcare services. The outcome of this research question will help identify possible covariates for Research Question 2.

2. To what extent do cultural beliefs predict the willingness of BGIMC members to use healthcare after education, immigration status, and health insurance status variables are controlled?

Hypothesis: Cultural beliefs will significantly predict BGMIC members' willingness to use healthcare services after controlling for education, immigration status, and health insurance status.

Definitions of Terms and Variables

Terms

Culture: The collective behaviors, beliefs, values, and symbols accepted by a group of people and communicated from one generation to the next, distinguishing members of the group from other groups (Karakowsky, 2001).

Ghanaians: The people from Ghana, a county in West Africa, bordered by Atlantic Ocean in the south, Burkina Faso in the north, Togo in the east, and Ivory Coast in the west.

Bronx Ghanaian Immigrant Muslim Community (BGIMC): A New York City Bronx organization dedicated to the support of Ghanaian immigrant Muslims.

Healthcare access: The ease with which an individual can obtain needed medical services.

Healthcare use: The extent to which a given group of individuals take advantage of available healthcare services.

Variables

Perceived access: The extent to which people believe they have the right to use healthcare services. This variable is measured using a perceived access scale that includes questions such as "If you are sick, do you know where to go get help?" These dichotomous questions were coded as 1 for a *yes* and 0 for a *no* response.

Willingness to use health services: This variable measures the extent to which people are willing to seek medical care under appropriate circumstances. Questions such as "How willing would you be to go to an emergency room if you break your arm?" were measured on a 5-point Likert scale where 1 indicates *least willing* and 5 indicates *most willing*.

Level of Education: Level of education was determined by the highest level of education completed or degree obtained.

- Less than high school
- High School
- Some college but no degree
- Associates Degree
- College (e.g., B.A., B.S.)
- Some graduate school but no degree
- Graduate School (e.g., M.S., MD., Ph.D.)

Health insurance: Health insurance provides financial support for an individual to access healthcare; this variable was measured based on the question "Do you have health insurance coverage?" A *no* response was coded as 0, and no further questions were asked. A *yes* response was coded as 1 and followed-up with a further question:

What type of health insurance coverage do you carry?

- Employer provided
- Self-purchased
- Medicaid

- Medicare
- Other

Immigration Status: Immigration status refers to the documentation that permits an individual to reside or settle in a country other than his/her country of birth. Participants were asked to identify their current U.S. immigration status by selecting from two possibilities:

What is your immigration status?

- U.S. citizen or green card holder
- Neither U.S. citizen nor green card holder

The U.S. citizen or *green-card holder* was coded 1, *neither* was coded 2.

Cultural beliefs: Cultural beliefs refer to traditional Ghanaian beliefs that might prevent participants from seeking medical help in the United States as measured by a set of response options to the following question: Do the following traditional beliefs prevent you from using U.S. healthcare services? Indicate "True or False."

- Male healthcare provider seeing or touching my private parts prevents me from using healthcare services – (True) (False)
- Female healthcare provider seeing or touching my private parts prevents me from using healthcare services – (True) (False)
- Receiving healthcare services from providers not from my culture prevents me from using healthcare services – (True) (False)
- Receiving healthcare services from a provider whose religion is different from mine prevents me from using healthcare services – (True) (False)

- I believe in traditional medicine only, so this prevents me from using healthcare services – (True) (false)

The outcome of the focus group study by Kaplan (2011) among 63 Ghanaian immigrants living in New York City was used to create a set of items for the cultural belief's survey. Prior to the survey, a panel of healthcare providers from the community reviewed the survey contents to establish content validity. Further, a test-retest reliability study on the resulting instrument was conducted.

Nature of the Study

I have leveraged the focus group results and developed a cultural instrument that assessed the willingness of BGIMC members to use healthcare services in the United States. The instrument measured the relationship among demographic variables, insurance status variable, variables related to cultural beliefs, perceived access to healthcare, and willingness to use healthcare. A test of reliability (test-retest) and an internal consistency instrument were conducted to evaluate the new instrument.

Purpose of the Study

The purpose of this research was to investigate the influence of cultural beliefs on BGIMC members' perceived access and willingness to use healthcare services. A cultural survey instrument was developed and I collected data for analysis and recommended appropriate intervention methodologies.

Theoretical Foundation

This research was grounded in the conceptual frameworks of critical theory as developed by Anderson (1998) and complexity theory relative to healthcare disparities as

presented by Eppel (2009).

Critical Theory

Critical theory is valuable as a rational framework to reflect that individuals have different but equally valid explanations of their experiences. It is the critical theorists' understanding that instead of our society becoming a unified body to address problems, it has become rather fragmented as a result of resources and power struggle (Anderson, 1998). The proponents of critical theory also believe that people are judged based on what they are or what they deserve based on their current life style or environment instead of investigating the actual cause of their current situations (Anderson, 1998). Further, coming up with new health policies and or updating the old ones will prevent many health issues in our society (Anderson, 1998).

Shaw and Stahl (2011) affirmed that healthcare systems require a long-term investment before a socioeconomic return and other benefits can be evident. Thorough research is required to understand the healthcare system and to implement new ideas appropriately (Shaw & Stahl, 2011).

Critical theory recommends a thorough investigation about immigrants' health issues and health issues in general for a better understanding and application of accurate solutions (Shaw & Stahl, 2011). Therefore, when the guidelines of critical theory are adhered to by the healthcare industry, that is effective investigation and implementation of health policies suitable for every patient, a lot of health disparity issues would be eradicated (Shaw & Stahl, 2011).

Complexity Theory

According to Ryan (2009), in integrated theory of health behavior change, models from complexity theory include the idea that organizations are dynamic, living, and social systems. Based on this view, the healthcare industry should be creative in putting in place effective healthcare services. Healthcare programs or forums to understand the perception of Ghanaian immigrants on healthcare are especially needed (Musah, 2009). The two theories helped determine a simple correlation study because they address communities' social issues and societal norms. In that, accommodating new challenges is very important. Some of these challenges are America's adjustment to and addressing the healthcare needs and cultural issues of African and other immigrants (Ryan, 2009). According to Moir (2009), healthcare is a complex and dynamic environment that contains many social forces and perspectives that shape the organizational culture and nature of leadership, and that requires creativity and adaptation to changes. Thus, when one considers the broad organization of healthcare services, the introduction of a large population of immigrants is likely to demand necessary and effective changes (Moir, 2009). If the immigrants from Ghana have not perceived acceptance and ease within the health services sector, perhaps the self-organization to adapt to this new group has not yet been developed.

Egede & Bosworth (2008) indicated that people express concern that our healthcare system is complicated for the ordinary person to understand and utilize effectively. The healthcare industry should consider coming up with a less complicated system through series of research; a health system that will provide a breakdown for

understanding and appealing to the society holistically (Driebe & Wheatley, 2008). The healthcare industry should adopt a better approach of educating the public with the healthcare research findings, one that can enhance the understanding of everyone instead of a portion of the society (Driebe & Wheatley, 2008). Therefore, a better understanding of the relationship between the BGIMC members and the healthcare system is needed. This will bring changes and new ways of organizational management. A detailed examination of critical and complexity theories is provided in Chapter 2.

Assumptions

Based on previous research (Musah, 2009), members of the BGIMC have sought healthcare access and experienced differing levels of success. It was assumed that a more formal study examining members' reports of their experiences, especially based on an instrument designed specifically for that purpose, will reveal additional layers of relationships regarding culture and language between Ghanaians and the U.S. healthcare system. It was also assumed that participants responded truthfully to all items on the survey instrument.

Limitations

This study was limited to members of the BGIMC who were 18 years or older and who have lived in the United States for more than a year. Participants were not more than 240 and were selected using a systematic sampling only as they were leaving the BGIMC premises. I was the only one responsible for data collection, analysis, and interpretation. The study was not applicable to the entire Ghanaian population since it concentrated on the Bronx Ghanaian Muslims only and not on Ghanaians of other religious faith. In

addition, it was not applicable to other African immigrant populations; however, a similar design could be replicated in other Ghanaian and African immigrant communities to help assess the similarity of results.

Scope of the Study

The participants in this study were 160 systematically selected members of BGIMC who were 18 years of age or older. Data collected from this population were analyzed and evaluated for issues regarding perceived healthcare access and recommended appropriate intervention methodologies. The study focused on determining the extent to which cultural beliefs and other factors influenced the perceived access and willingness to use healthcare services.

Significance of the Study

Findings form this study revealed specific difficulties within the healthcare system for this immigrant group, which was used to generate solutions and recommendations for promoting better healthcare access and use by this population. It was indicated that other immigrant groups and healthcare providers could replicate the findings for future research.

In addition, this research contributed to a positive social change in BGIMC by developing appropriate recommendations for intervention services. Although the study findings could not be generalized to all immigrants in the United States, the results could be applied to other immigrant communities from countries like Nigeria, Senegal, and other West African countries whose citizens have similar ethnic backgrounds, religions, and cultural similarities. Recommendations were based on creating adult education

programs and programs on attaining legal residence status in the United States. These programs will improve the health insurance benefits for the BGIMC members, thereby improving their healthcare access.

Summary

The issue of healthcare access in the United States not only pertains to European Americans, African Americans, and Hispanics, but to other ethnic minorities such as immigrants from Africa and Asia. Previous interviews I conducted revealed that members of the BGIMC experienced barriers to healthcare access; however, little was revealed about the actual causes of these healthcare disparities. The findings from this study were used to recommend appropriate interventions for the BGIMC members to improve their healthcare access and use. Generalizing the findings of this study to other African communities in the United States may be possible if they practice Islam, and replicating this research design in other immigrant communities is appropriate and recommended.

In Chapter 2, a review of the literature on healthcare access and use pertaining to immigrants in the United States is provided which includes a discussion of various sectors of healthcare such as preventive services for a better understanding of immigrant healthcare issues. In Chapter 3, the theoretical method of inquiry that grounded the research is discussed along with how the research questions were answered. The justification for choosing a quantitative method approach and the process that was used for the systematic random sampling (Nth) and the data analysis are also discussed. In Chapter 4, I discussed the instrumentation used for this study, pilot study, and data

analysis. The method, results, and answers to the research questions were also discussed. Further, I discussed the study limitations, interpretation findings, implications for social change, recommendations for further study, and conclusions from the study in Chapter 5.

Chapter 2: Literature Review

Introduction

This review examined, analyzed, and synthesized the academic literature on healthcare disparities, especially regarding the social, economic, and political impacts of healthcare disparities on immigrant populations in the United States. In addition, current research on the barriers to healthcare confronted by health reformers are reviewed, and gaps in the literature are discussed.

The following aspects of immigrant healthcare disparities are addressed in Chapter 2: definitions and conceptualizations of healthcare disparities, research designs and current research on healthcare disparities, and a review of the theoretical frameworks and methodologies used in past studies. Finally, overall evaluations and conclusions based on the literature are provided.

To develop the conceptual framework for this study, I reviewed literature relative to immigrant healthcare access and utilization and health disparity in general. The New York Library and local university libraries in the Bronx were used to gather research articles. Online search engines for databases such as Google Scholar, ProQuest Nursing and Allied Health Source, ProQuest Dissertation and Theses-Full-Text databases of Walden University, EBSCO databases, Academic Search Premier for social science and medicine, MEDLINE medical literature index, CINAHL nursing, and allied health literature cumulative index were also used to search relevant literature. Search terms included *gaps in minority health, patients' satisfaction with healthcare providers, undocumented immigrant healthcare access, immigrant challenges with the healthcare*

system, health disparities in the United States, immigrants and healthcare access, ethnicity and health, immigration and healthcare reform, eliminating minority healthcare disparities, cultural competence among immigrants, perceive access to healthcare, and *barriers to healthcare access*. The publication dates of research articles searched ranged from 2007 to 2013 and were restricted to English-only-articles.

Health Disparities

Disparities in healthcare existing among ethnic groups results from several factors including limited or no access to care and lack of insurance coverage (Flores, 2010). There are other disparity factors that have no direct relationship on the healthcare system. Some of these factors are socioeconomic status, literacy, language, lack of regular source of care, and community related health issues (Flores, 2010).

Definition of Health Disparities

Healthcare disparity is also referred to healthcare gaps in the quality of healthcare among immigrants or socioeconomic groups (Herbert, Sisk & Howell, 2008). Flores (2010) indicated that although several definitions were created for disparity, the Health Resources and Services Administration view health disparities as disease outcome variations and access to health services among populations. The American Academy of Pediatrics (2010) research committee concluded that children's racial and ethnic disparities have been taking place in all aspects of healthcare services for decades. The report further indicated that disparity incidents were not properly documented.

Stratton, Hynes, and Neupal (2007) indicated that lack of necessary health services contributed to the mortality rate among minority population. Further, Derose et

al. (2011) defined disparity as the following: "A population is a health disparity population if there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality or survival rates in the population as compared to the health status of the general population" (p. 3).

Defining health disparities effectively was important to the continued research. This effort by the agencies who accurately defined health disparities has helped narrow the focus of research; however, eliminating health disparities has remained an ongoing challenge in minority communities, and many who have experienced health disparities have unusual means of healthcare (Egede & Bosworth, 2008).

Outcome of Health Disparities

Jones (2010) indicated that health disparities are morally wrong because they exemplify a long period of injustices to some group of people and that health disparities are present in clinical outcomes and in quality of health services. Jones (2010) further stated that minorities receive poorer health services than Whites. The evidence of this disparity is found in both patient inconveniences and quality of services (Jones, 2010). In addition, lack of insurance affects minorities in getting the necessary health services they need, such as professional health advice and preventive services (Jones, 2010).

A report by the Health and Human Services (HHS; 2011) indicated that immigrants use emergency rooms less than the native-born citizens. Healthcare providers at the border areas of the United States with higher concentrations of immigrants encountered huge healthcare costs because so many immigrants were uninsured, and these costs are not replaced (Scherzer, Rejeske, & Gurvitch, 2010). In addition, Derose

(2009) mentioned that although reimbursement for hospitals' emergency care costs incurred by immigrants has begun, a lot of other healthcare costs are under the responsibility of state and local governments and health facilities of charitable and religious organizations. Those with private insurance were also indirectly charged when their premiums increased due to uncompensated care for uninsured people (Derose, 2009). Despite such strategies, a large number of immigrants still do not have access and often turn to their communities to help pay for healthcare costs (Derose, 2009).

Disease Rates and Clusters

In this section, differences in disease rates, mortality rates, and exposure to preventive health services between ethnic minority and majority groups in the United States is discussed.

As indicated earlier, Flores (2010) said that literature has shown that children's health disparities are noted in all aspects of healthcare delivery, especially in the mortality rate of minority children. Minority children are more vulnerable in all causes of mortality than White children (Flores, 2010). Flores concluded that all optimal health and healthcare for all children should recognize health disparities as persistent problems that require intensive studies and rigorous evaluation. In another report by the Center for Disease Control and Prevention (2010), the results revealed that African and Latino Americans stand the chance of developing diabetes faster than European Americans and that minorities have a higher heart disease rates, HIV/AIDS, and infant mortality than European Americans. In addition, minorities are mostly diagnosed at the later stages of cancer than European Americans and have lower survival rates--an indication that

minorities are not receiving care that would foster the early detection and better prognoses of illnesses (Flores, 2010).

Egede and Brosworth (2008) also indicated that despite the vast improvement of diagnosis and treatment of most chronic diseases, minority patients experience a higher morbidity and mortality rate of long-term diseases than European Americans. Clear geographic disparities were found to exist in premature mortality from leading causes of death both at the national and regional levels; patterns of association between measures of socioeconomic conditions and premature mortality were also found to be fairly consistent (Egede & Brosworth, 2008). Income was a significant factor in determining the geographical differences of heart disease, and heart diseases were found to disappear with an increase in income (Flores, 2010).

This study was reliable because heart disease was identified by studies as one of the top three leading causes of death and has been associated with high blood pressure, cholesterol, and type-two-diabetes (Collins, Kaplan, & Marks, 2009). However, risk factors such as age, gender, and race explained just a few differences in heart disease rates (Collins et al., 2009). Recently, income and education have surfaced as heart and other chronic diseases' risk factors (Collins et al., 2009).

Adler, Bush, and Pantell (2012) reported that the distribution of good health and longevity were not properly distributed among populations, and individual susceptibilities to diseases are linked to their socially disadvantaged groups. Adler et al. (2012) further stated that several health disparity researchers have proven a link between several components of socioeconomic status (SES) and many health indicators like income and

education. Adler et al. (2012) has also identified a correlation in negative behavior among people with less than a high school education and who are unemployed or unskilled employees among immigrants. Mortality from income inequality and stroke were related, proving that inequality in income-affected factors trigger stroke (Larson & Halfon, 2010). Theorists that commented on this relationship contended that social status and income influenced a suitable twist that ultimately impaired one's health (Larson & Halfon, 2010). Both the social status and income level affected immigrants in the United States, as a result of inability to obtain residence and or work permit. As such, acquiring a decent job to boost their social status becomes a challenge. Access to healthcare services was also affected because they were unable to afford private health insurance.

Health Insurance and Healthcare Access

In Immigrant Healthcare Report by Footracer (2009), the concerns about whether everyone is entitled to appropriate healthcare in the United States stood out in addition to paying for the health services Footracer (2009) further indicated that about 46 million people in the United States have no health insurance, and moreover, the number of both documented and undocumented immigrants without insurance is increasing.

According to Gusmano (2012), about 73% of undocumented immigrant children were born in the United States and the majority of these children have no health insurance. The United States born children, of whom 25% lack health insurance even though they were likely to qualify for Medicaid or the State Child Health Insurance Program (SCHIP), were included in the 73%. The inconsistency between foreign born and American-born citizens continued among those with incomes far below the poverty

line, where more than 50% of immigrants who were without documents lacked health insurance compared to 23% of nonimmigrant Americans (Gusmano, 2012). The main reason for the inequality in health coverage was that immigrants with low income could not secure coverage from their employers and other private coverage, although the gaps were getting smaller (Gusmano, 2012).

According to Ryan and Ng'andu (2012), lack of insurance among immigrants varies by citizenship status. Naturalized citizens are more likely than noncitizens to be insured and naturalized citizens have higher rates of un-insurance than their U.S.-born peers (Ryan and Ng'andu, 2012). According to the HHS (2010), it was understood that the aim of healthcare was to take care of health and general well being of all Americans; unfortunately, Americans including undocumented immigrants too often did not receive the care that they needed. In most cases, the healthcare system unfairly distributes services among communities; some citizens receive more care than others (HHS, 2010). In addition, analysts at the National Academy of Sciences (2009) mentioned that the proportion of undocumented immigrants had increased quite recently, and that caused the number of legally admitted to decrease. Undocumented immigrants could not qualify for major public assistant benefits except Medicaid coverage for emergency situations only, and had a hard time and sometimes impossible to obtain private health insurance (NAS, 2009). Working in companies that did not provide health insurance coverage were some of the reason immigrants had no health insurance, and examples of such industry were agriculture, construction, and service industry jobs like restaurants and hotels (NAS, 2009).

The Henry Kaiser Family Foundation (2008) noted that some of the most important challenges in healthcare for all Americans were cost of providing care and the duration of health insurance coverage. These problems were particularly evident for immigrants who could not afford health insurance coverage and had limited or no access to healthcare services (The Henry Kaiser Family Foundation, 2008). Due to higher uninsured rate, non-citizens are much less likely than citizens to have a usual source of care, and that translates into several times higher than the American-born citizens (The Henry Kaiser Family Foundation, 2008). Many immigrants experienced barriers to healthcare due to lack of health coverage, as a result, out of pocket medical expense was extremely high (Braveman & Woolf, 2011). In addition, besides the health and humanitarian concerns, other economic and social factors also caused concern (Braveman & Woolf, 2011). For example, chronic health problems prevented immigrants from maintaining productive employment because many of them worked in physically exhausting jobs with an enormous occurrence of injuries (Braveman, 2008). Further, because a large number of immigrants lacked health insurance coverage, even the outpatient cost of illnesses contributed to enormous debt and financial instability (Larson & Halfon, 2010).

Private Health Insurance

For quite a while, insurance sponsored by employers has been the main source of health coverage for the majority of Americans, but undocumented immigrants were excluded (Footracer, 2009). Census data analysis indicated that this lack of coverage stemmed from the reality that American citizens receive health insurance coverage by

employers than immigrant (Footracer, 2009).

According to Siman (2009), many immigrants traditionally work for smaller employers who do not provide health insurance, and some companies rather relied on paid contractors for labor than hiring workers directly. The expenses involved in this type of labor sources such as farm workers, janitorial and many more were lesser than direct hiring of workers, with the knowledge that contractors do not provide a benefit in order to save cost (Siman, 2009). Scherzer, Rejeske and Gurvitch (2010) reported that a majority of immigrants work in smaller firms as compared to citizens who work in larger firms. Scherzer et al. (2010) further mentioned that 55% of noncitizens is employed in firms with less than 100 employees. As a result, immigrants could not afford to purchase private insurance because of cost and that increases un-insurance rate among immigrants. Federal law specified that employers should offer health insurance on equivalent basis to all workers, but unauthorized immigrant workers did not enjoy that privilege (Siman, 2009).

Public Health Insurance

Shanafelt (2013) mentioned that the Affordable Care Act's reform was intended for everyone to have insurance with a few exceptions. That is an undocumented immigrant and immigrants who are legally present and are not more than five years in the Unites States will not benefit from the healthcare reform. Moreover, they cannot obtain private insurance and will not qualify for Medicaid either. The National Immigration Law for Healthcare Policy viewed the decision as purely political (Shanafelt, 2013). Undocumented and lawfully present immigrants are more likely to dwell without

insurance than citizens, and most of them work in jobs that the employers hardly provide healthcare coverage; their Medicaid and the Children's Health Insurance Program (CHIP) access is not reliable (Shanafelt, 2013).

According to Scherzer et al. (2010), Medicaid has been the main source of health insurance in the United States. However, many immigrants were ineligible for Medicaid and the children's health insurance (SCHIP). Scherzer et al. (2010) further stated that illegal immigrants could not secure coverage in health insurance programs as Medicaid, Family Health Plus, and Medicare so long as they remain undocumented in the United States. Among many health programs, the Child Health Plus (CHP) of New York is opened to all children regardless of immigration status because New York subsidies for health coverage where federal government fails to cover. Despite this assurance, even documented immigrants were wrongfully excluded from this unique local program (Scherzer et al., 2010).

Most permanent residents admitted to the United States after the 1996 welfare reform law were prohibited from Medicaid coverage until after they have lived at least five years in the U.S. (Scherzer et al., 2010). In addition, illegal immigrants and temporary visa holders were not qualified for medical coverage, except Medicaid for emergency room services (Scherzer et al., 2010). Although immigrants 65 years or older were often not qualified for Medicare and Social Security benefits because they did not work in the United States for the required number of years, they were still offered Medicaid because of affordability or lack of income, and/or have met other qualifying criteria (Scherzer et al., 2010).

The Kaiser Family Foundation (2011) noted that since the 1996 welfare reform law, the number immigrants with low or no income and without Medicaid coverage have increased, and it is more unlikely to be insured within a short time. Additional requirements that were added to the 2006 healthcare reform bill indicated that a U.S. citizen who applies for Medicaid coverage program must submit proofs of citizenship (Kaiser Family Foundation, 2011). The Kaiser Family Foundation also mentioned that immigrants were already required to submit documentation of their legal status when applying for Medicaid. Although the 2006 healthcare reform legislation was aimed at citizens, it had repercussions for immigrants as well. It led many to believe they were required to show proof of citizenship to obtain coverage, and that discouraged them from applying for the public health insurance coverage (Kaiser Family Foundation, 2011).

Figure 1 below represents uninsurance estimates for adults and children by citizenship status proving how likely citizens can live without health insurance.

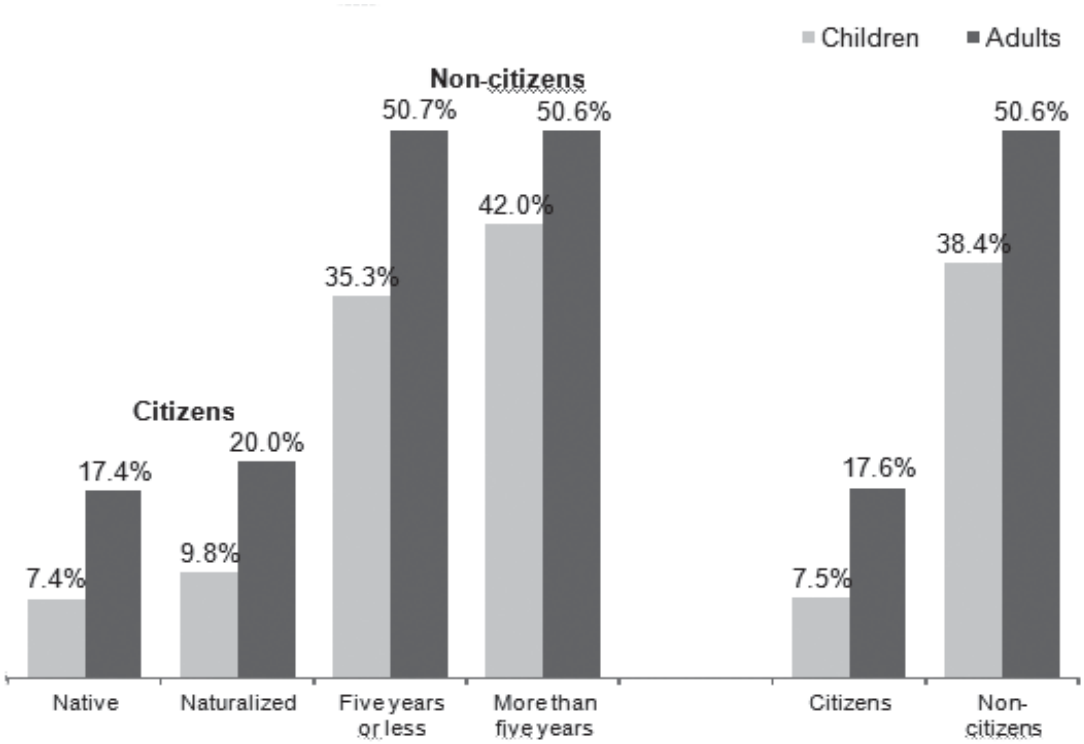


Figure 1. Bar graph showing uninsurance estimates for adults and children by citizenship status. From "A profile of the uninsured" by Ormond B., Palma A., & Phadera L. (2009). Urban Institute survey report. Used by permission of the Urban Institute.

The graph shows a beak-down of noninsurance estimates among immigrants and native Americans. It indicates that noncitizen adults are more likely to live without health insurance, and that is detrimental to their lives (Ormond et. al. 2009). According to Ormond et. al. over 50% of the noncitizen adults are not insured for more than 5 years compared to only 17% for citizen adults. Further, uninsured noncitizen children was 38%

compared to only 7% uninsured citizen. This finding is an indication of disparity that needs to be addressed. Please refer to Appendix G for a copyright permission note from the Urban Institute.

The Committee on Pediatric Research (2010) explained that disparities were found many areas of healthcare that includes mortality rates and healthcare access because immigrants' children could not participate in several healthcare programs. The number of immigrant children without insurance coverage went up more than 5% in 2004 (Gusmano, 2012). Even though, United States-born children were born to eligible parents, Medicaid benefits diminished due to the outcome of welfare reform (Gusmano, 2012). Gusmano (2012) further indicated that 8 % of U.S.-born children with U.S. parents lack health insurance, and undocumented immigrants might have difficulty enrolling their U.S. born children in Medicaid or SCHIP. This problem has eased due to substantial outreach and educational endeavor by concerned group of people from the state, local governments and community-based organizations (Yu, Huang & Kogan, 2008). Consequently, children's healthcare coverage in mixed-status families had improved, even though the chances of losing their coverage were more than children of U.S.-born parents (Yu et al., 2008).

The health insurance issues discussed in this section were also experienced among members of the BGMIC. Medicaid programs were not renewed and unauthorized immigrants used emergency rooms for healthcare services because the majority of employers did not offer health insurance coverage (Gusmano, 2012).

Immigrant Sponsors

Rhee, Belmonte, and Weiner (2009) found that some immigrants had misconceptions about government sponsored insurance plans. The fear of arrest contributed to their lack of familiarity with the health system and access to healthcare (Rhee et al., 2009). Some lawmakers indicating that immigrant sponsors should cater for immigrants' health coverage influenced modification on Medicaid coverage 10 years ago (Nam, 2008). As of 1997, immigrant sponsors were asked to assume the responsibility for Medicaid or SCHIP cost for the immigrants they sponsor (Nam, 2008). Expecting the recent immigrants to obtain adequate insurance coverage from employers or their sponsors has proven to be impossible (Nam, 2008). Although sponsors were provided with financial support in some areas, the cost of providing health insurance was prohibitive (Rhee et al., 2009). For example, the average family cost employer-sponsored health insurance coverage was estimated to be more than $10,000 in 2008 and more than $4,000 for an individual (Rhee et al., 2009). Rhee et al. affirmed that the health insurance policies were more expensive when purchased on a non-group basis just as the case of immigrants who were not members of any sponsorship (Rhee et al., 2009).

Immigrant Challenges Regarding Healthcare Services

According to Crzywacz & Donadio (2012), foreign-born workers in the United States have increased tremendously since 1980 and the portion of workers who are foreign-born has also doubled, and immigrants made up 50% of the growth in the workforce. They work in low paying jobs without benefits, and more likely to work in dangerous industries or occupations (Crzywacz & Donadio, 2012). A high level of

occupational injuries was noted among predominantly unauthorized immigrant day laborers, and close to one half of the laborers had sustained injury at the workplace but a few of them were given medical help for their injuries (Crzywacz & Donadio, 2012). Immigrant workers were afraid of deportation, and they could not seek treatment at public healthcare centers (Crzywacz & Donadio, 2012). Although some analysts expressed concern that immigrants medical care cost such as emergency care created enormous business insolvency on the United States healthcare system, immigrants' per capita medical expenses were reported as lower than the U.S.-born (Crzywacz & Donadio, 2012).

As indicated by Crzywacz & Donadio (2012), there is a rapid increase of foreign-born citizens in the U.S. that ultimately increases the foreign-born workers in the United States. Despite this dramatic increase, individuals born in foreign countries had less access to formal healthcare than the U.S.-born counterparts (Crzywacz & Donadio, 2012).

Perceived Access and Access to Healthcare

Bibbs (2012) indicated that the female African Americans' high incidence of breast cancer is related to social values, and that affects their perceived access to breast-related health services. Cultural beliefs affect immigrants' health services; therefore, to increase immigrants' use of health services, their perceptions of health services should first be acknowledged (Bibbs, 2012). In addition, Thorpe, Thorpe, Kennelty, & Pandhi (2011) said that a long waiting time at health centers, difficulties in making appointments to see physicians, language and cultural barriers to communication with healthcare

providers, and a lack of available transportation to health centers were some of the factors that determined the perceived difficulties in obtaining access to healthcare services. A long waiting time for health services was found to be the most serious concern among older adults (Thorpe et al., 2011).

Further, Rodriguez, Bustamante, & Ang (2009) found that Latino immigrant patients perceived healthcare access to be associated with blood pressure, cholesterol level checks, quality of care, and healthcare information from doctors, and that patients are likely to live for a long time without these services. The authors also found that Latino immigrants perceived lower levels of relational continuity with their primary care physician, thus highlighting the need to develop professionals' skills in order to improve care for immigrant patients.

In addition, because immigrants were mostly not insured, self-paid healthcare amounts were higher compared to the insured, and immigrants could not afford the care they needed (Selden & Sing, 2008). Other factors, such as inability to communicate in English language also inhibited immigrants from seeking healthcare services (Selden & Sing, 2008). Therefore, immigrants' use of primary and preventive healthcare services and other hospital services such as emergency medical services was less than citizens, even when the influence of income on health insurance status was controlled (Selden & Sing, 2008). Further, low income immigrant adults were two times more than the adults born in the United States to report that they had no means of healthcare services (Selden & Sing, 2008). In addition, immigrants' children from low-income family were more unlikely to receive healthcare services compared to children from low income U.S. born

parents (Seldon & Sing, 2008). Seldon and Sing (2008) further said that although health disparities gaps among racial and ethnic groups were shrinking gradually between African Americans and European Americans, they were broadening between European Americans and African immigrants. The poor healthcare access of African and Latino immigrants was a major cause for this broadening gap in healthcare services (Selden & Sing, 2008).

In a study of California farm workers, just 17% had employer-sponsored health coverage and 33% of them could not afford the insurance coverage offered to them (Siman, 2009). More than 50% of the males and 33% the females had no access to a physician and had not seen for 1 or 2 years prior to the study, even though many of them had work-related and other illnesses like high blood pressure and diabetes (Siman, 2009). Scherzer et al. (2010) also reported that a national study of high level of work related injuries mostly on immigrant day laborers found that a large number of these workers had a history of work-related illness, but those who received medical services among them were less than 50%.

Healthcare Utilization/Willingness to Use Healthcare

A study by Song et al. (2010), found that despite the United States uniform healthcare utilization policy on terminal illnesses, the use of health services among minority groups has not been explored effectively. They indicated that an effective implementation of community health resources would tremendously improve access to healthcare. Moreover, Cunningham & Felland (2008) indicated that poor adults who had less access to and utilization of health resources were more prone to illnesses; lack of

insurance coverage, and more likely to die at a younger age than nonpoor adults. Small (2011) also pointed out that the reasons patients did not utilize health services were, inability to take off from work, lack of transportation, fear of personal safety, and inability to adjust immigrant status.

Small (2011) further noted that the following conditions affect immigrants' willingness to use healthcare: economic conditions that disproportionately affect the lives of poor, lack of health insurance, ineffective community support, trouble with transportation due to location of care, cultural beliefs and attitude toward the healthcare system, and mistrust of healthcare providers. Culturally sensitive care and immigrant integration process were interlinked, according to Bustamante Var & Van Wees (2012). Therefore, situations can easily arise in which immigrants' cultural health belief and practices clash with the standard of care; some health related beliefs and practices could lead to unhealthy, even fatal outcomes (Bustamante et al., 2012). Geyen (2012) reported that although social scientists are interested in patient/provider interactions such as physician perceptions of patients' race and socioeconomic status, they give more attention to the process of utilizing healthcare rather than the actual interactions of patients who have entered the healthcare system. Furthermore, many healthcare models fail to address preventive healthcare utilization that affects the majority of immigrant patients due to poverty (Geyen, 2012). Geyen further mentioned that future research should address both access and willingness to use preventive healthcare services among the poor as well.

Nadeen et al. (2007) noted that stigma-related issues affect the use of health services among immigrants at the mental health facility. They further said that even though the insurance related barriers to mental health patients have been reduced, minorities still receive less service than Whites. Stigma about mental health can keep minority women from utilizing treatment at the initial stages of mental disorders, and since research has proven that cultural beliefs and stigmatization from illness influence immigrants' willingness to seek healthcare services, that should be addressed (Nadeem et al., 2007)

Vaughn et al. (2009) indicated that immigrant families might encounter problems using healthcare services for many reasons. Among them are the lack of cultural competent healthcare providers who understand and address their healthcare issues effectively. Affordability of treatment costs, perceptions of lack of respect by healthcare providers, and the complexity of our healthcare system can contribute to reduced access and a willingness to use healthcare services (Vaughn et al., 2009). Further, immigrants born outside of the United States were significantly more likely to lack health insurance than immigrant born in the United States (Vaughn et al., 2009). In addition, recent immigrants sometimes arrive with infectious diseases that require immediate treatment but because of unfamiliarity with the healthcare system and lack of health coverage, getting immediate treatment turns to delay and that poses serious health problems in the future (Vaughn et al., 2009).

According to Cruz (2010), the use of dental services and dental coverage were the two most important indicators of immigrants' level of oral healthcare services use among

immigrants living in New York. Cruz (2010) further indicated that researchers concluded that it is important to establish an affordable, culturally related, and community-oriented oral healthcare services for the affected populations. Bustamante et al. (2012) reported that Mexican immigrants who did not have residence permit found it difficult to access a doctor compared to documented Mexican immigrants and only 35% had access to health services. In addition, Bustamente et al. (2012) stated that if the purpose of the Patient Protection and Affordable Care Act was to reduce health disparities then every undocumented immigrant legal status should be upgrade to gain access to health services.

Contributions to Gaps

Limited or lack of English communication skills, immigration status and unfamiliarity with healthcare system were among other factors that have contributed to the recently arrived African immigrants' healthcare barriers (Gusmano, 2012). These vital needs that serve the African and other immigrant communities were rarely tackled by the healthcare systems (Gusmano, 2012). Flores (2010) noted that a comprehensive approach is needed to address the healthcare gaps faced by immigrants. He stated the exclusion of 48 studies from scholar databases due to the researchers' approach to the study; that was combining all minority children into one nonwhite category, and a comparison group of white children was not provided. Therefore, Flores (2010) emphasized that in order to understand the real effect of health disparities, findings from appropriate healthcare research should be used to recommend changes in our healthcare system.

As indicated earlier, Flores (2010) asserted that appropriate research methodology

is required in order to document and analyze health disparity issues among immigrants. Children's health and social problems should be recognized to help assess the enormity of disparities in order to guide healthcare providers to attain rigorous interventions for the pediatric community (Flores, 2010).

The HHS (2011) reported that findings on disparity research should be made easy to access and should be free from complicated jargons and methodologies for better understanding. Gathered data mostly contained inadequate or incomplete notation regarding the severity of illnesses and the types of treatments available (HHS, 2011).

Footracer (2009) argued that the significant limitations of current and past research were the failure to examine medical care differences beyond comparing African-American and European-American patients. A few major studies were conducted in ethnically diverse locations of the United States, but only a few studies have assessed whether disparities in care existed for Asian Americans and African immigrants, and researchers that examined differences in subgroup within these populations were not many (Footracer, 2009). These concerns were particularly significant for African immigrant subgroups whose healthcare have been affected by language barrier, cultural differences, documentation for residence, and other issues affecting healthcare access; the reasons for not studying these subgroups were unknown (Footracer, 2009). No comprehensive health study had been conducted with members of the BGIMC, but leaders of the community needed to understand the health issues of the community to find solutions. Therefore, the gap in the literature was specifically problematic to BGIMC leaders.

Language Barriers

Language barriers were found to have a significant effect on education, economics, housing, employment, and many other social functions including perceived inequity in employment opportunities and housing (Kao, 2009). Limited language skills directly affected the economic consistency of immigrant families (Kao, 2009). Parents of African immigrants who had a problem communicating in English language found it challenging to assist their children with education (Kao, 2009). These issues combined with several social beliefs; the new American culture against the former indigenous African culture presented danger to the traditional African family values (Kao, 2009)

Obviously, individuals who cannot communicate in English often go through challenges in their daily activities, such as asking for direction, however, the result of poor English skills between patients and healthcare providers was more dangerous than that (Kao, 2009). Kao (2009) also mentioned that immigrants were not able to receive essential public assistance due to ineffective communication and that barriers threaten their health, safety, and civil rights (Kao, 2009).

In addition, Braveman and Woolf (2011) approached health literacy as initiative that every individual should have the right and the capability to access and comprehend basic health information necessary to help make appropriate health decisions. The English medical terminologies were not familiar even to the English-speaking patients, how much more to the immigrant patients who struggle with basic information (Braveman & Woolf, 2011). Immigrant patients have difficulties understanding information from their doctor's office due to barriers in communication, and that affects

their compliance with medication and treatment procedures (Braveman & Woolf, 2011).

Cultural and Communication Barriers

There were a few numbers of culturally knowledgeable healthcare providers serving the African community due to lack of opportunities for African immigrants with relevant healthcare experience from their countries of origin to obtain training and credentialing in the United States (Braveman &Woolf, 2011). Furthermore, immigrant patients may continue to experience communication problems with healthcare providers even after they have become naturalized citizens or reside in the United States for many years (Braveman & Woolf, 2011). The difficulty in communication was caused by both the lack of familiarity of immigrants' culture by healthcare providers, and patients' lack of familiarity with the skills involved in negotiating the U.S. healthcare system (Braveman & Woolf, 2011).

Immigration Status

Kenny and Huntress (2012) found the following in their snapshot of Foreign-Born Population in 2009:

> In 2009, 30.3 million non-elderly adults and 3.1 million children were born outside of the United States. Of these, collectively, 39.7 percent were naturalized citizens. Access to public health insurance is limited for certain categories of the foreign born by law. The Person Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 generally restricted immigrant from Medicaid access. (p. 3)

Therefore, this bill also restricted immigrants residing in the United States prior to

its passage and who should have been considered as “qualified immigrants” from the Medicaid program.

KCMU (2008) reported that access to healthcare is strongly affected by citizenship documentation and English language fluency, and illegal immigrant must reside in the United States for at least 5 years to qualify for naturalization. Immigrants who did meet this category were not qualified for Medicaid or SCHIP programs. Bustamante et al. (2012) noted that even if immigrants are covered with public or private health plans, coverage does not automatically translate into access. Moreover, recently arrived immigrants are often used to health systems that are differently organized and administered than the US healthcare system. The differences in care quality, prices, and methods of payment, patient expectations, or patient-physician relationships are some of the aspects that immigrants have to become familiar with (Bustamante et al., 2012). Lack of familiarity with the healthcare system may contribute to low healthcare use (Bustamante et al., 2012). In addition, Braveman & Woolf (2011) asserted that it is reasonable to expect immigrants’ experiences in the U.S. healthcare system to be different due to short time stay in the Unites States, English language fluency, and knowledge of the American healthcare system. However, the primary reason for this health issues was that immigrants could not obtain employment that provided health insurance coverage because of immigration status (Braveman & Woolf, 2011).

Leighton and Broaddus (2008) also indicated that lack of health insurance was mostly related to the lack of English communication skills and U.S. residence status. Refugees and other immigrants endure a high level of stress and this experience stays

with them for more than two years, and in most cases leads to depression (Leighton & Broaddus, 2008). Leighton and Broaddus (2008) further stated that research has repeatedly found stress to be a key health concern for immigrants in the Unites States and that immigrant documentation status is a strong baseline in determining African immigrants' health status.

According to Bustamante et al. (2012), immigrants comprised almost about one-third of the uninsured in the U.S. according to the 2009 data from Migration Policy Institute. Less than half of foreign-born had private health coverage, one-fifth had public health coverage (i.e., Medicaid, Medicare, Children's Health Insurance Program), and 33% were uninsured. By contrast, only 12.5% of the native-born population was uninsured in the same year.

Bustamante et al. (2012) also found that the Patient Protection and Affordable Care Act (ACA) will give the U.S.-born and documented immigrants similar entitlements, and these policies, however, will benefit those who have been here longer. Their waiting period to receive some benefits will be five years (Bustamante et al., 2012). In addition, documented immigrants with less than 5 years in the United States will be subjected to the health insurance mandate but will not qualify for Medicaid. Undocumented immigrants, however, are excluded from all provisions, and the overall effect of ACA on newly arrived documented and undocumented immigrants are currently uncertain Bustamante et al. (2012).

Further, Bustamante et al. (2012) indicated that low healthcare among immigrants could also be attributed to legal status. One of the main factors that delays seeking care

among undocumented immigrants was the fear that their legal status will be uncovered if they access the health system (Bustamante et al., 2012). Bustamante et al. also reported that a recent study that compared healthcare access and utilization among Mexican immigrants found that a majority of undocumented Mexican immigrants did not have a general check-up the previous year due to lack of insurance coverage.

Based on these findings, immigrant communities such as the BGIMC need more programs to address health access and utilization, immigration status, familiarity with the healthcare system, and other health-related issues for their members.

General Issues Facing African Immigrants

The Office of Minority Health (OMH; 2007) reported that recently arrived African immigrants encountered enormous barriers because of their limited English language skills, inability to obtain health coverage, and lacked familiarity with the healthcare system. These immigrants concerns were hardly addressed by the U.S. healthcare industry or by the healthcare providers who attended to health needs of African immigrants (OMH, 2007). The following recommendations were identified at the National African HIV/AIDS Initiative of 2007:

1. Identify health disparities within the African immigrant community, which may not match disparities in other communities.
2. Organize collective action to address health disparities within the African immigrant community.
3. Increase research efforts regarding healthcare needs in the African immigrant community.

4. Make information about medical job opportunities available to members of African immigrant communities.
5. Assist U.S. healthcare providers in understanding the cultural beliefs of African immigrant people.
6. Identify community/opinion leaders to become potential stakeholders to reach out to African immigrants.
7. Convene a dialogue with African immigrants as a whole instead of maintaining tribal and country level associations.
8. Build trust between immigrants, healthcare providers, and community activists regarding health and immigration issues.
9. Promote regional and national networking, communications, and dialogue among African based community organizations, healthcare providers, and government officials.
10. Design culturally appropriate health prevention and care interventions for the community.

Solutions to Healthcare Barriers

The U.S. healthcare industries, as well as healthcare providers face challenges as a result of changes in the demographics of arriving immigrants; therefore, the healthcare industry should provide effective healthcare services sensitive to health requirements for the diverse immigrant groups (Dogra et al., 2009). In order to avoid service gaps for major segments among U.S. population, healthcare policies should respond to diversity in terms of cultural beliefs (Dogra et al., 2009).

Dogra et al. (2009) further indicated that children and other family members of immigrant patients who could not communicate in English were used as interpreters between immigrant patients and their healthcare providers, and that has created many specific cultural issues among cultural beliefs (Dogra et al., 2009). For example, a physician once asked the help of a woman to assist her mother-in-law during a health evaluation but the woman refused because it was culturally unacceptable; doing so would have dishonored a long-established tradition in their society (Dogra et al., 2009). Although Language alone cannot be considered as culture, however the dissimilarity between language and culture was hardly explained (Scherzer et al., 2010). Immigrants and or minorities continued to have significant health issues because healthcare providers or the healthcare industry failed to investigate, understand and manage their social and cultural differences (Scherzer et al., 2010).

Kao (2009) also mentioned that many efforts were taken to improve healthcare access for the LEP patients and among them was social marketing campaign for a period of 2 years. The goal of this campaign was to enlighten immigrants about their rights to language interpreters at their healthcare centers. The ethnic media coverage mainly targeted the urban immigrant duelers, healthcare providers and those responsible for public health (Kao, 2009). Although it is challenging for the health centers in the communities to develop culturally and linguistically knowledgeable health professionals, achieving that objective will translate into quality and greater healthcare access for the immigrant communities (Dogra et al., 2009).

Another program designed to alleviate health disparity is to encourage practicing

physicians to visit schools and serve as role models and encourage children from underrepresented groups to consider a career in medicine and healthcare (Siman, 2009). Despite these efforts to improve healthcare access and utilization for immigrants, small ethnic groups such as the BGIMC were not the targets of these programs. Therefore, additional effort should be made to include immigrant communities across the nation.

Potential for Change

HHS Action Plan to Reduce Racial and Ethnic Health Disparities (2011) reported that new and effective research effort was required to address the new trend health disparities. Racial and Ethnic Approaches to Community Health (REACH) program has created awareness for immigrants to strive for better health without fear of being deported to their country of origin (HHS, 2011). This has positively impacted on local healthcare practices, and immigrant communities were educated for effective utilization of healthcare services in order health disparities (HHS, 2011). In addition, the American Recovery and Reinvestment Act (ARRA) in conjunction with the Affordable Care Act implemented community programs to address health and environmental issues related to improper nutrition, lack of exercise, tobacco, and alcohol consumption on people's health (HHS, 2011).

Further, the U.S. congress has debated on the issues of reforming immigration rules to improve healthcare access to immigrants; by potentially proving residence permit to a large number of immigrants and by providing the impetus for stakeholders to recommend changes to policy makers regarding the status of immigrants in the U.S. (HHS, 2011). The direction of immigration reform is not yet clear; many researchers

(Brody 2010; Weinstein & Skinner, 2010) were not optimistic about the new policies in providing healthcare access to many immigrants; it will rather restrict access for health and social service programs. On the other hand, providing options for immigrants' legalized status, immigrant workers' employment prospects could improve and thus increase opportunities to secure private, employer-sponsored health insurance coverage (HHS, 2011).

Cultural Competency

According to Dogra et al. (2009), cultural competency has changed healthcare researchers' understanding on immigrants' healthcare access and utilization, and that has resulted in a goal to set national standards for healthcare providers. American Institute for Research defined cultural competence as a set of congruent behaviors, attitudes, and policies which come together in a system, agency, or among professionals that enable effective work in a cross-cultural situation (Dogra et al., 2009, p. 7). However, to attain a culturally knowledgeable healthcare system the number of qualified practitioners from diverse communities needs to be increased (Dogra et al., 2009). Further, research by Dogra et al. found that it would be beneficial for National organizations to help in translating cultural competence broad statements into simple forms for health providers to apply. Cultural competency can be achieved by understanding the experiences of the patient population by increasing number of healthcare providers who are familiar with immigrants' culture (Shanafelt, 2013). Leighton and Broaddus (2008) also said that healthcare information and experiences of the African immigrant community has been disregarded in the medical research and clinical practices.

According to Vaughn et al. (2009), significant cultural differences between healthcare providers and patients made it difficult to develop better understanding for adequate healthcare services. Healthcare providers must acknowledge cultural differences, as a result of race, ethnicity, country of origin, and other cultural factors in making healthcare decisions (Vaughn et al., 2009). Vaughn et al. also noted that with the increased in diversity of the U.S. population, physicians and other healthcare professionals were encouraged to develop competence in providing culturally sensitive care to people with backgrounds other than their own. They further indicated that cultural competence goes beyond cultural awareness or sensitivity and requires the effective use of skills in cross-cultural situations and community-based health management. Cultural and linguistic appropriate services (CLAS) should be employed to reach out to immigrants and facilitate their integration into the U.S. healthcare system (Vaughn et al., 2009). In addition, Vaughn et al. asserted that physicians and healthcare personnel should participate actively and regularly in training-programs designed to increase cultural awareness, knowledge and skills; this training should begin in medical school and continue throughout their careers. Medical education must acknowledge cultural differences and how those differences affect treatment and decision-making in providing care to patients (Vaughn et al., 2009).

BGIMC

Initial interviews with 40 members of the BGIMC revealed that many were unable to get the kind of treatment they needed at hospitals and other health centers because they could not afford health insurance coverage. A small number of BGIMC

members had attained U.S. citizenship status, yet access to healthcare remained a problem (Musah, 2009). Members' knowledge of healthcare rights and responsibilities and the ability to communicate effectively with their healthcare providers were cited as additional issues within the community. However, the main issues had to do with traditional beliefs regarding the access and utilization of healthcare services (Musah, 2009). Interviews revealed that BGIMC members were concerned about the lack of health coverage, and believed that family members were dying due to premature discharge from hospitals due to a lack of health insurance coverage (Musah, 2009).

Health concerns of minority groups from Asia and North America were shown to have similarities to those expressed by members of the BGIMC, including barriers related to language, culture, immigration status, and communication (Adler et al., 2012). According to the Collins, Kaplan, and Marks (2009), health disparities affect minority groups mostly due to cultural background and socioeconomic status, although other factors also play a role. Further, Collins et al. (2009) mentioned that the nation should establish an effective system for the assessment of preventive services and support for interventions to improve health at reasonable cost. Such system will not only help the American citizens but will have a positive impact on immigrant healthcare access due its cost-effective focus.

Collins, Kaplan, & Marks (2009) asserted that the National Association of Chronic Disease Prevention and Control were in the process of developing programs that call for nutrition and physical activity knowledge. That effort helped address heart diseases and stroke ailment in various communities (Collins et al., 2009).

Theoretical Frameworks

This study was broadly grounded in the frameworks of complexity and critical theories. According to Shaw and Sahl (2011), several points from critical theory were used to clarify the concepts of adequate care provision in health services. They further indicated that the theories continue to shed light on current issues affecting the healthcare system by calling for a long-term investment to help every patient. Scrambler (2001) also mentioned that in an asymmetrical relationship between doctors and patients where the doctor characteristically "active" and patient characteristically "passive", patients tend not to benefit. He insisted that the patient should also be characteristically active to allow a potential balance in communication. To improve this scenario, the cultural aspects of patients need to be understood by healthcare providers, and that calls for cultural competence training (Scrambler, 2001). Scrambler (2001) further indicated that communication ethics and healthcare decision making in a shared understanding can lead to fair and just in decision making. As such, communication between healthcare providers and patients should be meaningful to both parties in order to effectively improve healthcare access and utilization (Scrambler, 2001).

In the theory of human need on healthcare issues, Doyal and Gough (1991) argued that there needs to be a clearly informed agreement of appropriate means of addressing social issues in healthcare in order to satisfy human interest. Technical knowledge for fairly addressing issues in our healthcare system is critically required (Doyal & Gough, 1991). They further indicated that a shared decision making process

between healthcare providers and patients could enhance the effectiveness of treatment to patients (Doyal & Gough, 1991).

Waitzkin (1989) also noted that immigrant patients often visit their healthcare providers with problems that often have roots in social issues beyond medicine. He further mentioned that medical training generally overlooks the significant effect of patients' social issues beyond medicine. Immigrant/minority health issues are almost always connected to social issues beyond medicine, although, the links may not be obvious (Waitzkin, 1989). Patients present their doctors with a variety of personal troubles beyond medicine; yet social issues in healthcare tend not to receive critical attention from policy makers (Waitzkin, 1989).

In summary, critical theory calls for a transparent communication between healthcare providers and patients; everyone's opinion should be respected because doing so will positively impact on healthcare services. In addition, cultural competence training for healthcare providers should incorporate social issues beyond medicine, as that will educate healthcare professionals to provide appropriate care beyond medicine.

Several points from critical theory can be used to clarify the concepts of adequate care provision in health services. Complexity theory, however, has been considered a distinctive design for case studies, and has a strong impact on scientific methods for understanding health organizations (Ryan 2009). Eppel (2009) reported that Prigogine (1984) explained that the most beneficial analytic technique was to consider each element in a system separately for the purpose of understanding each one, and then reassembling the elements to draw conclusions about the whole. Most traditional organizational

theorists viewed organizations as similar to a machine system whose parts are replaceable, and that the organization will run smoothly if each part performs its duty appropriately (Mennin, 2013). Organizational theorists believed that the natural state of organization was stability and that people who can be replaced are the ones who carry out the functions and roles of an organization with little damage to operations, and in which results were anticipated and replicable (Mennin, 2013). These ideologies have created an impression that if policy makers and healthcare administrators were coherent in maintaining a "well lubricated machine," then organizations would be successful (Morgan, 1989). Further, Morgan (1989) said that when the "well lubricated machine" concept such as introducing financial incentives to the devoted healthcare providers, regulating policies to address every patient's health concern, and creating other means of promoting best practice initiatives is applied effectively to healthcare, health access will be enhanced.

Policy makers and healthcare administrators sometimes explained the ineffectiveness of traditional organizational approaches through the observation that results never happened as anticipated (Ryan, 2009). The organizational approaches did not work because of certain practices by health providers' political situations, and events that randomly happen that interfered with implementation (Ryan 2009).

Greenhalgh, Plsek, Wilson, Frazer, and Holt (2010) explained that complexity theory model indicates that the concept of organizations is as dynamic as social systems. Greenhalgh et al. (2010) further argued that healthcare organizations and social systems are similar in that they were created to organize resources efficiently and provide care

effectively. Similar to living beings, social systems were maintained by constantly involved in the changing process that produced new regulation of self-organization.

Many scholars believed that healthcare organizations were complex adaptive systems and studying their properties could provide helpful insights to understand complexly adaptive systems as an integrated whole (Ryan 2009). Ryan (2009) explained that because complexity theory is derived from the interaction of a system component, it has attained the level of the system itself. Therefore, to understand holistically, one has to understand the relative patterns among its components (Ryan 2009).

Mennin (2013) emphasized on the quality of health education in healthcare delivery. He said that health professionals' education is about caring for fellow human beings and the environment we co inhabit. Health, as a resource for daily life and well-being, emerges from a constellation of interdependent conditions in social, cultural, political, economic, and geographic events that affect access to food, water, shelter, employment, education, safety, peace and many more (Mennin, 2013). Therefore, it is the duty of healthcare providers and agencies to be certain that these necessities are available to the needy. Mennin added that the complexity theory breaks down the complex application of real life health conditions to medical educators to help foster better understanding for health professionals. Mennin further indicated that education, communication skills to foster understanding between healthcare providers and patients, immigration status, health insurance status, and the immigrant level of cultural belief affect healthcare access and utilization by immigrant patients.

Complex contexts and interactions leading to gaps in healthcare provision must be

understood; to do so, theoretical models and research methods are needed to understand healthcare organizations and delivery systems (Mennin, 2013). Methods that are required to address concerns about healthcare providers who are passionate about preventive services but not successful in delivering them, and certain health circumstances like undernourishment and urinary infection among immigrant patients in the nursing homes were not available (Mennin, 2013). Current methods were not leading to true changes in healthcare practice (Mennin, 2013). Healthcare researchers have emphasized that the best way to implement changes in healthcare is by first dealing with the physician who is considered as the most important aspect in healthcare delivery (Vaughn et al., 2009). Consequently, empirical observations convinced researchers to focus instead on the healthcare organization, because it was within the context of the organization that many issues relevant to understanding and improving healthcare delivery were contained (Vaughn et al., 2009).

Complexity and critical theorists raised the issue that regulatory policies and best practice initiatives would lead to improved outcomes in healthcare organizations if interventions were adequately applied (Ryan, 2009). It was understood that healthcare organizations would be effective if the ideas from both theories were employed with precision; in other words, more successful approaches should be used to understand healthcare organizations.

Research Methods

Several methods of qualitative inquiry were considered, but the hierarchical multiple regressions were determined to be appropriate and chosen for the study.

Ethnography, grounded theory, phenomenology and biography were among the methods considered. According to Creswell (2008), the purpose of a study and the type of data gathered is influenced by appropriate design. Therefore, ethnographic research is about the study of a group or groups' cultural behavior for description and interpretation (Creswell, 2008). This study was not typically about the cultural behavior of any particular group but how a cultural belief may influence the perceived access and utilization of healthcare services. Observation is the major data gathering method applicable for ethnographic study and that was not applicable for this study because survey was used for data collection. Moreover, this study was not for understanding the culture of a particular group of people but to investigate barriers to healthcare access in the Bronx Ghanaian Immigrant Community.

Merriam (2009) explained that the importance of grounded theory is to generate theories from studies and the emergent theory indicates findings. However, the purpose of this study was to investigate the probable cause of health disparities experienced at the Bronx Immigrant Ghanaian Community. Grounded theory lacks the strategy of gathering data through a survey questionnaire (Merriam, 2009) that could be used for this study.

Phenomenology deals with real life situations, experiences or situations to help explain or describe an incident (Merriam, 2009). Further, in a phenomenological study, subjects are supposed to experience the phenomenon being studied in that a few subjects are observed through broad and extensive engagement to develop models and relationship of meanings (Merriam, 2009). Although this study was concentrated on real life activities, participants were not subjected to prolonged engagement to develop

patterns. This study took place at the Bronx Ghanaian Immigrant Community in the Bronx, NY for about 20 days.

A biographical method studies people's lives and it is clearly unsuitable for this study due to boundaries. This study concentrated only on barriers to healthcare access experienced by a group of people instead of on an individual basis. It was a daunting task to study individual's personal life and even doing so cannot present the appropriate data.

I found the quantitative method to be accurate for this study. I learned that a quantitative research is an experimental research that deals with the cause and effect relationships among variables (Creswell, 2008). Its characteristic is the active manipulation of independent variables and only in experimental research is manipulation used, according to Creswell (2008). Further, random assignment of groups is employed, especially in the strongest experimental research designs (Creswell, 2008). The quantitative research design was used in this study.

A Hierarchical Multiple Regression

As indicated earlier, a hierarchical multiple regression was used for this study. It evaluated the relationship between independent and dependent variables by taking into account how different variables impacted on the dependent variables (Freeman, 2005). It was suitable for my study because I evaluated relationships between the dependent variables--perceived healthcare access and a willingness to use health services and the independent variables--gender, age, immigrant status, health insurance status, and educational background of the participants. During the analysis, the hierarchical multiple regressions allowed me to control for some variables while running several multiple

regressions analyses. It allows the contribution above and beyond the first group of independent variables (Fotheringham & Carlton, 2009). This analytic strategy is most appropriate when there is no logical or theoretical basis for considering the impact of one variable over any other (Cohen & Cohen, 1975). As such, a systematic sample of BGIMC members was surveyed to gather data for this study. Additional discussion of the study design is presented in Chapter 3.

Summary

Based on a review of the relevant literature regarding healthcare disparities in immigrant populations, upgrading or modifying current approaches—for example, modifying regulations regarding Medicaid—were found to be needed. Communication and language barriers were shown to affect all social interactions, for example, African immigrants with limited English proficiency found it difficult to navigate the U.S. healthcare system. Obtaining Medicaid or health insurance, especially employer-provided health insurance, were critical issues. A higher level of injuries occurred at workplaces with many unauthorized immigrants who could not afford the cost of treatment, and often feared deportation if they sought healthcare services.

Another important issue in healthcare disparities was the patient–provider relationship. Patients were not treated equally, and interpreters were needed to facilitate better communication and to ensure proper care. Familiarity with immigrants' culture by healthcare providers was lacking. Physicians were involved in a program developed to address cultural-related health issues with immigrant patients. The program's intention was to increase the number of immigrant physicians in hospitals and to introduce

immigrant cultural awareness in medical education. Legal status was shown to play a crucial role in immigrants' healthcare access and utilization. A naturalized immigrant had a better chance of acquiring jobs with health benefits than illegal immigrants.

Theoretical models and research methods that address the complexity of healthcare organizations are needed. The question of why current approaches have not resulted in improvements warrants the attention of policy makers in addressing the health needs of all Americans, including immigrants.

Healthcare access by minorities and immigrants in the U.S. continues to be a high concern, even though measures have been taken to address the complex issues involved. Similarity in healthcare disparities between the literature review and previous health research with the BGIMC members was evident, and that resulted in the research questions for this study. Although a substantial amount of research conducted within ten years on immigrants' healthcare that addressed how and to what extent level of education, immigration status, health insurance status, cultural beliefs, perceived access, and willingness affected access to healthcare services, research specific to BGIMC members was needed. Therefore, this must research study will effect social change for members of the BGIMC.

A detailed discussion about the study design for this study is presented in Chapter 3. It includes discussions of the theoretical tradition of inquiry, population and study sample, data collection methodology and the researcher's role and participants' protection, data management procedures, the data analysis, and ethics in data collection.

Chapter 3: Research Methods

Introduction

In Chapter 3, the research design, theoretical framework, research sample and population, method of data collection and procedures, data management procedures, methods of data analysis, and ethical considerations are discussed. A hierarchical multiple regression was used to assess factors derived from the research questions cited in Chapter 1. Issues such as the most common cultural issues that prevented the BGIMC members from using healthcare, the extent to which education, immigration status, and health insurance status predicted the perceived access and a willingness to use healthcare services, and the extent to which cultural beliefs predicted willingness to use healthcare after controlling for education, immigration status, and health insurance status were addressed.

This research directed efforts toward positive social change, not only among members of the BGIMC, but also in communities with similar healthcare issues. As mentioned earlier, this study has employed the hierarchical regression and effort was made in selecting and utilizing appropriate paradigm. Since a systematic sampling (Nth) method was utilized, I administered the survey questionnaires and gathered data for the study at the community's place of worship. Males and females were grouped separately in the place of worship and were instructed on how to complete the survey. I have satisfied the requirements of the Internal Review Board (IRB) that guided research studies at Walden University. Walden University's approval number for this study is IRB 11-15-0022887.

Study Design

This section describes the research design that was used for the study. It addresses the research sample and population, methods of data collection, data analysis, the structure of the narrative report, issues of ethics and quality, the role of the researcher and dealing with the researcher's bias, as well as participants' protection.

This study investigated barriers to healthcare access among members of a Ghanaian Muslim immigrant community in the Bronx, New York. I have employed a linear and multiple regression model to study the barriers to healthcare access among a systematic sample of BGIMC members. Two hundred forty systematically selected members of BGIMC were invited to complete a survey, but only 160 members participated in the study. Of these 160 participants, 156 completed the entire survey. A survey instrument was the data collection tool used for this research due to its ability to collect a large number of data in a short period.

Research Method

I employed a hierarchical multiple regression in this study. A hierarchical multiple regression was used to evaluate the set of the relationship between a set of independent and dependent variables, controlling or taking into account the impact of different variables on the dependent variable (Anderson, Sweeney, & Williams 2009). I systematically selected the target participants from the Bronx Ghanaian Immigrant Community membership who completed survey questionnaires. Data analysis revealed a relationship between healthcare access and health insurance coverage. Data collected from 160 members of the Bronx Ghanaian Immigrant Community was analyzed for any

relationship among variables for the study.

Study Sample

A systematic sampling of 160 members from the BGMIC participated in the study. G*Power (Erdfelder, Faul, & Buchner, 1996) was used to arrive at the minimum sample size for the hierarchical multiple regression. Erdfelder et al. (1996) stated the following:

> The GPOWER is a completely interactive program compatible to many personal computers that performs statistical power analyses for the most common statistical tests in behavioral research, including t tests, F tests, and χ 2 tests. GPOWER computes (1) power values for given sample sizes, effect sizes and α levels (post hoc power analyses); (2) sample sizes for given effect sizes, α levels, and power values (a priori power analyses); and (3) α and β values for given sample sizes, effect sizes, and β /α ratios (compromise power analyses). (p. 176)

Based on the assumption that the hierarchical regression will have 3 predictors (variables), .15 effect size (medium effect), an alpha level of .05, and power of .95, the minimum sample size for this analysis is 119. Therefore, the sampling of 240 respondents was adequate to detect a medium-sized effect. The minimum age for all respondents was 18. The sampling frame consisted of both males and females, and the sample of the study consisted of the Bronx Ghanaian Muslim immigrants who have lived in the United States for at least 1 year.

Data Collection

I was the primary person who carried out this study, including all stages of data

collection, data analysis, and reporting. I facilitated every aspect of data collection. The survey instrument was provided in English and Hausa languages only, and I was in charge of translating the documents to respondents who needed extra help. This direction was chosen because the English language is the only common written and spoken communication medium among Ghanaians (Omoniyi, 2003). The facility maintained by the BGIMC in the Bronx, New York was the primary venue for data collection. Participant recruitment took place during community meetings, special events such as weddings and child naming ceremonies, and at Friday and Sunday prayer sessions. There are 4,000 people in the BGIMC, and they attend the prayer sessions at different times depending on their work schedules and other situations. Therefore, data collection continued until I reached 160 respondents. Recruitment took place as people were leaving the prayer session so as not to interfere with their ability to attend prayers**.** Prior to the commencement of recruitment, I introduced and shared information about the study to BGIMC members during their biweekly meetings. As a past executive member of the BGIMC, and as a well-known member of the Ghanaian community who was assigned this project by the BGIMC board of directors, and given the support of the head committee and the members in general, I did not encounter any major problem with data collection. Recruitment took place on a weekly basis until the target sample size was reached.

Sampling Procedures

A systematic sampling approach was employed. Every third member to exit the BGIMC premises was asked to first complete three qualifying questions. Both men and

women exit the premises at the same point, although their worship area inside the mosque is separated. When they passed the qualifying questions, they were asked to engage in the research. The qualifying questions were as follows:

1. Are you 18 years or older?
2. Have you lived in the United States for at least a year?
3. Do you agree to participate in the study?

Those who answered "Yes" to all the three questions participated in the study and were required to read an informed consent form. Participants were recruited on a voluntary basis, were fully informed about the purpose of the study and its importance to the BGMIC community, and understood that they could end their participation at any time. All of this occurred prior to agreeing with the informed consent form for the study (see Appendix A).

Instrumentation

An existing survey instrument based on previous research was sought for the study, but an appropriate instrument specific to the issues of African immigrants was not found. Therefore, a new questionnaire was developed based on data from six focus groups conducted previously to understand the perceptions of Ghanaian immigrants on the health status and health trajectory of their New York City community. Sue Kaplan, Assistant Professor at the New York University, conducted a focus group interview in 2011 (Unpublished raw data). Permission to adopt the focus group data for my study was obtained (See Appendix F). Participants in these focus groups were asked to provide detailed feedback on topics related to health behaviors, stress, social support,

environmental exposures, and barriers to healthcare. A total of 63 individuals participated, with a minimum of five and a maximum of 13 in each of six focus groups. Data regarding barriers to healthcare from this previous research were analyzed and used to develop the questionnaire for the study. Factors associated with willingness and perceived-access to the U.S. healthcare services by immigrants were incorporated. Participants rated each item on the survey based on a 5-point Likert scale from *strongly agree* to *strongly disagree*. Demographic questions such as gender, age, income, and immigration status were included in the questionnaire (see Appendix B).

Validity and Reliability

Wynd, Schmidt, & Schaefer (2003) explained content validity as the degree to which the test items of a new instrument appropriately represent the content area to be measured. Expert judgment of three experts and a Content Validity Index scale developed by Wynd, Schmidt, & Schaefer (2003) was used. The criteria for being an expert were as follows:

1. An expert in this regard is someone who is currently working in the health field and has been in the field for at least 10 years.
2. He or she has completed a Master's degree from accredited college as a healthcare provider or health educator.
3. He or she lives in the Ghanaian Bronx Immigrant Muslim Community (GBIMC) and shares the same cultural values.
4. He or she has lived in the United States for more than 5 years.

I approached the identified experts at their places of work and a community

gathering. I gave them copies of the scale and explained the purpose and objectives of the study to them privately. The experts then rated each item on the four-point scale based on relevance; 1 was *not relevant*, 2 was *somewhat relevant*, 3 was *quite relevant*, and 4 was *very relevant*. The results were then dichotomized where 1 and 2 were *not relevant* and 3 and 4 were considered *relevant* and analyzed using Kappa's interrater reliability analysis. Kappa values range from +1.00 to –1.00, with a positive kappa indicating interrater agreement occurring more frequently than would be expected by chance; a +1.00 demonstrates complete agreement across raters and a zero kappa indicates that agreements are no more than can be expected by chance (Suen & Ary, 1989) In addition, Suen and Ary (1989, p. 513) stated that a coefficient of –1.00 indicates total disagreement while Gelfand and Hartmann (1975, p. 513) also recommended a minimally acceptable kappa of 0.60 for interrater agreement, and many researchers use it in their measurement. If the kappa value is less than .60, then relevant questionnaire items are removed or edited and retested with the experts. The kappa value for the questionnaire for this study was greater than .60; therefore, no questionnaire item was removed or edited.

Survey

I chose the survey method as a suitable tool for data-collection in this research because it is easy to administer, less expensive, and had the ability to collect large data within a short time (Creswell, 2008). The survey instrument should have been completed within 20 minutes; however, participants were under no time limitation.

I addressed the importance of this study to the community, which convinced members to turn out in large numbers to participate in the research. Questionnaires were

administered at their place of worship and several periods of collection were allocated until the required number of respondents was attained. Questions on the survey focused on the following areas: the most common cultural issues that prevented BGIMC members from using healthcare services, the extent to which education, immigration status, and health insurance status predicted members' perceived access and willingness to use healthcare services, and the extent to which cultural beliefs predicted members' willingness to use healthcare after controlling for education, immigration status, and health insurance status. The outcome of this research was used to formulate an appropriate healthcare model for easing the health concerns of BGIMC members and those of other immigrant communities. This effort significantly enhanced the use of healthcare services by this population, thereby improving their quality of life.

Pilot Study

After the initial survey instrument was developed, a pilot study was conducted with 25 BGIMC members at an arranged location in the community and to determine the clarity of the questions as recommended by Leedy and Ormrod (2013). Participants were not offered any incentive for completing the survey, and the entire survey procedure took approximately 20 minutes. The participants were instructed to refrain from discussion during the introduction of the study and while completing the survey to avoid a diffusion of opinions as advised by Wilde, Larssen, Larsson, and Starrin (1994). Internal consistency reliability of the survey was assessed based on feedback from the 25 participants and no relevant questionnaire items were removed.

Ethics

An informed consent form stipulating how personal information will be kept confidential and participants' rights was developed for participants to read before engaging in the study. Confidentiality of participants' identities was assured throughout the research process, and particularly in reporting outcomes. Each respondent was assigned a unique ID number. The ID number was notated on the survey assigned to each respondent. There was no personally identifiable information on any documents associated with the research except for Respondent ID reference document. This document linked each respondent ID to an actual respondent and it is kept in a safe location. An approval for this research was obtained from the Walden's Institutional Review Board (IRB) prior to data collection. The approval number is 11-15-0022887. A permission to conduct research has also been obtained from the BGIMC's board members. I have submitted the permission letter as Appendix F. The following methods were used to protect the rights of participants: Participants read the consent form prior to completing the survey, their anonymity was carefully protected, and no third party had access to the data during the analysis. I have obtained the Human Research Protection Certificate from the National Institute of Health (NIH) and that guided me in obtaining data appropriately. I have submitted it as Appendix E.

Researcher Bias

My background and being the main instrument for data collection placed me in close contact with the data, which could result in biased results (Goulding, 2002). Several measures were observed in this study that dealt with the possible researcher subjectivity.

Specifically, I was constantly aware of bias, and was impartial throughout the study. I reported any discrepant incidents and applied any adjustments necessary. My academic supervisors reviewed my recommendations and their feedback was incorporated. Finally, I documented the data coding process and made the process of data analysis open for critical analysis by others.

Access to Participants

I have been a member of the BGIMC since 2000. I was asked by members of the board to follow-up previous research I had done with a more complete study regarding health concerns and attitudes of BGIMC members as described earlier in this chapter. The report of that research was presented to the BGIMC board on September 20, 2010. A permission letter to conduct further research was issued by the BGIMC board members as indicated earlier, and for the purposes of building trust with prospective participants, I personally communicated with BGIMC members during several community events and explained the purpose and importance of the study to the community.

Data Management

I organized data categorically, reviewed repeatedly, and continually coded during data analysis. Data was organized into files according to subjects and then placed in folders. I created systematic codes using a combination of letters and numbers for the subjects for easy retrieval and analysis. Further, I prepared a code-sheet using a blank copy of questionnaire and wrote the abbreviated variable names for reference when required. In addition, all skipped questions were left blank and all the dichotomous responses were 1 for *yes* and 2 for *no* and recorded the codes in a codebook for reference

in times of need.

I transferred the raw scores from the survey instrument onto an excel form which was systematically analyzed using the SPSS program. The data collection form was designed based on the questionnaire instrument used. Information on the questionnaire instrument was reorganized to provide space for tallying the responses. The survey questionnaires handouts were used as data collection form by recording it in a manner that made it easily entered into the computer. I placed next to each question a small number that corresponded to the possible value of the variable. For example, the question relating to the respondent's gender was presented as follows, where the appropriate response was checked and the numbers were used for analysis: Gender: Male _____ (1) Female _____ (2).

I coded data gathered using numeric symbols. For example, the number 1 was coded for male and the number 2 was coded for female as I stated earlier on. When using a computer for analysis, the codebook was not specified for each datum; it indicated the name of each datum to be used for the program file. The codebook had four essential items of information; the survey question, which indicated the piece of information to be coded, the column in which the data was placed within the data file (ID NO.) in which the codes ranged from 0001 to 1000. The last item of information that I placed in the codebook was the name of the variable that was used in the computer program file.

Data Analysis

All data were analyzed in terms of how each survey question addressed the research questions that guided the study. The participants' survey item responses were

entered into Excel and were transferred to a Statistical Program for the Social Sciences (SPSS; Zagumny, 2001) for statistical analysis. Descriptive statistics was performed on the demographics of the respondents, including gender, age, immigration status, length stay in the U.S., and health insurance status

A logistic regression was conducted to evaluate the following research questions:

1. To what extent do BGIMC members' education, immigration status, and health insurance status predict their perceived access to healthcare services? Here perceived access to healthcare services was the dependent variable (q14); scored on a 1 to 5 scale, and education, immigration status, and health insurance status were the independent variables.
2. To what extent do BGIMC members' education, immigration status, and health insurance status predict their willingness to use healthcare services? Here willingness to use healthcare services is the dependent variable (q16a); scored on a 1 to 5 scale, and education, immigration status, and health insurance status were the independent variables. Questions 16a through 16c were combined and divided by three to obtain an average score that served as the dependent variable willingness to use healthcare services.

Hypothesis: Education, immigration status, and health insurance status will significantly predict BGIMC members' perceived access to and willingness to use healthcare services. The outcome of this research question will help identify possible covariates for Research Question 2.

3. To what extent do cultural beliefs predict the willingness of BGIMC members to use healthcare after education, immigration status, and health insurance status variables are controlled? Here there will be three regressions performed using three different levels of illness severity as the dependent variables, broken arm, severe fever, and dizziness. Each was scored on a 1 to 5 scale where 1 was *not at all willing* and 5 was *extremely willing*. The independent variable was traditional beliefs that prevent you from using healthcare services. Each of the three traditional beliefs was scored on a 1 (*strongly disagree*) to 5 (*strongly agree*).

Hypothesis: Cultural beliefs will significantly predict BGMIC members' willingness to use healthcare services after controlling for education, immigration status, and health insurance status.

In these analyses, perceived access to use healthcare and willingness to use healthcare were the dependent variables and education, immigration status, health insurance status, and cultural beliefs were the independent variables. Specifically, the regression indicated which independent variables made a significant contribution to predicting an individual's perceived access and willingness to use healthcare, along with the explanatory power of the significant independent variables.

Summary

In Chapter 3, the study design and method of inquiry for the study were discussed. This study investigated the possible relationships between level of education, health insurance status, immigration status, cultural beliefs and the perceived access and

willingness to use healthcare services among the BGIMC membership using a systematic sampling methodology.

A focus group outcome was incorporated in developing a survey questionnaire and collected data from the BGIMC to understand the factors that influenced the perceived access and willingness healthcare services among its members. Data gathered was coded for convenient use on a computer for analysis. Participants were enlightened about informed consent and their rights to withdraw from the study any time they wish to do so. The researcher assured ethical consideration by completing the Institutional Review Board (IRB) documentation at the Walden University, and by providing consent forms for the subjects at the BGIMC to read prior to engaging in the study. The findings from this study were presented using charts, tables and graphs for a better comprehension.

Chapter 4: Results

Introduction

The purpose of this research was to investigate the influence of cultural beliefs on BGIMC members' perceived access and willingness to use healthcare services; the results are presented this chapter. A cultural survey instrument was developed and used to collect data. The data were analyzed, and the results were used to recommend appropriate interventions that are discussed in Chapter 5 in detail. The following research questions and hypotheses were used for the investigations:

1. To what extent do BGIMC members' education, immigration status, and health insurance status predict their perceived access to healthcare services and their willingness to use healthcare services?

Hypothesis: Education, immigration status, and health insurance status will significantly predict BGIMC members' perceived access to and willingness to use healthcare services. The outcome of this research question will help identify possible covariates for Research Question 2.

2. To what extent do cultural beliefs predict the willingness of BGIMC members to use healthcare after education, immigration status, and health insurance status variables are controlled?

Hypothesis: Cultural beliefs will significantly predict BGMIC members' willingness to use healthcare services after controlling for education, immigration status, and health insurance status.

Analyzing the data collected from the study participants at the BGIMC derived

the solutions to the research questions. In the first section of the data analysis, I discuss the instrument that was used. The second section presents the survey data and includes the demographics of the sample and data analysis of the survey questions. Answers to the research questions based on the data analyses are presented in the last section.

Instrumentation

The survey instrument consisted of three separate sections, and a pilot study involving a small sample of 25 respondents was conducted to verify the content validity of the instrument. Section 1 asked two multiple-choice questions and three closed-ended questions about the respondents' demographics. Section 2 of the survey instrument consisted of 15 Likert-type questions and five closed-ended questions designed to understand participants' health-related concerns that impact their access to healthcare. Furthermore, Section 3 consisted of four Likert-type cultural related questions designed to understand participants' willingness to use healthcare services available to them.

Pilot Study Background

I generated the survey instrument from a thorough review of the literature and by leveraging the focus group data from the interviews conducted by Sue Kaplan, Assistant Professor at the New York University in 2011 (Unpublished Data), and the consultation of four experts from the BGIMC who rated the instrument. Two of the expert reviewers were healthcare providers in the community with more than 10 years of experience. Another expert reviewer was a health education instructor and had lived in the community for 11 years. The final reviewer was a New York City Department of Education tenured teacher in the BGIMC for more than a decade. None of the reviewers

suggested additional items or recommended any items to be deleted. The instrument was written in English and translated into the Ghanaian dialects (Hausa) for those who could not read the English language. The participants were instructed to choose the answer choice that reflected what their experience or feelings are in health access and utilization.

Pilot Testing

The pilot testing of the instrument took place at the BGIMC facility in New York after obtaining approval from the Walden University Institutional Review Board. The instrument was administered to 25 members of the BGIMC using systematic sampling. Nineteen males and (76%) and six females (24%) participated in the pilot study, and 48% had less than a high school education. The participants were at least 18 years old and had lived for more than a year in the United States in the BGIMC community. I used the pilot study to check the clarity of the questions and any logistic issues that needed to be addressed, and no issues were highlighted; therefore, I proceeded with the main data collection.

Data Collection

In the main data collection, the appropriate range of the sample size for this study was between 119 and 240 (Erdfelder, Faul, & Buchner, 1996). Further, the minimum sample size for analysis was 119, which is adequate to detect a .15 medium size effect, an alpha level of .05, and power .95 as presented in Chapter 3 (Erdfelder, Faul, & Buchner, 1996). I made every effort to attain the maximum sample size of 240, but only 160 members participated in this study. Out of the 160 surveys administered, 4 had missing data; therefore, the analysis was done with only 156 participants. This did not impact the

result in a negative manner. Some of the issues that affected the data collection were that many members could not find the time to participate in the study, and some did not meet the criteria guiding the study. Data collection took place because the survey questionnaires did not require any revision as the pilot study indicated. Participants were told it would take from 20 to 30 minutes to complete the survey, and consent forms were explained to them prior to data collection. Further, to protect participants' privacy, they were instructed not to sign a consent form and that agreeing to complete the survey instrument replaced their signatures.

I was the primary person who carried out the study by facilitating every aspect of data collection including analysis and reporting. The survey instrument was provided in English and Hausa languages. The facility maintained by the BGIMC in the Bronx, New York was the primary venue where data were collected. Participant recruitment took place during child-naming ceremonies, wedding, and bereavement events in addition to Friday and Sunday prayer sessions. There are 4,000 members in the BGIMC, and they attend prayer sessions and other events at different times based on their work schedules and their relationship with the events in question. Due to these attendance inconsistencies, data collection continued until I attained data from 160 participants. Data collection occurred on the following dates: December 1, 2013, December 6, 2013, December 07, 2013, December 08, 2013, December 15, 2013, and December 12, 2013. Recruitment took place as the members were leaving the premises, in a way that did not interfere with the event on those days. Prior to recruitment, I met and shared information about the study with the BGIMC members during their biweekly meetings and other

occasions and addressed issues or questions about the study to help alleviate the general uncertainty about this study, including immigration concerns. Data collection went smoothly, although I encountered a few minor issues: I had the impression that because I had a previous meeting with the BGIMC members and addressed concerns about the study, data collection would not meet with any resistance. During data collection, many members rushed to their various places of work and some attended personal issues right after community events, and some even left with the instruments after consenting to participate. Further, because I was a translator and the data collector at the same time, I spent more time on fewer people than it should be on each event, prolonging the time estimated for data collection.

I transferred responses from the survey instrument onto an Excel file for onward transfer onto the SPSS program for analysis. The raw excel data collection was designed based on the questionnaire instrument. Information on the questionnaire instrument was reorganized for tallying the responses. It allowed me to place a number next to each question that corresponded to the values of the variables. For example, I described the questions relating to the respondents' gender as follows, where the appropriate response was checked and the numbers were used for analysis: Gender: Male _____ (1) Female _____ (2).

Data Analysis

All data were analyzed in terms of how each survey question addressed the research questions that guided the study. The participants' survey item responses were entered into Excel and were later transferred to a Statistical Program for the Social

Sciences (SPSS; Zagumny, 2001) for statistical analysis (see Appendix D). The analyses included descriptive statistics represented by frequencies and percentages.

Method

Participants

Data from 156 respondents were used in this study, of which 54.5% were male, and 45.5% were female. The average age of all respondents was 45.99 years (*SD* = 13.27). A third of respondents (33.3%) were high school graduates, while 18.6% had at least a bachelor's degree. Table 1 contains demographic information on the respondents.

Table 1

Frequencies: Demographics (N = 156)

	N	%	*M*	*SD*	Min	Max
Gender						
Male	85	54.5%				
Female	71	45.5%				
Education						
No schooling completed	9	5.8%				
Nursery school to 8th grade	4	2.6%				
9th, 10th, or 11th grade	16	10.3%				
12th grade, no diploma	30	19.2%				
High school graduate - high school diploma or GED	52	33.3%				
Some college credit, but no degree	16	10.3%				
Associate degree (for example: AA, AS)	11	7.1%				
Bachelor's degree (for example: BA, AB, BS)	10	6.4%				
Master's degree (for example: MA, MS, MEng, MEd, MSW, MBA)	7	4.5%				
Professional degree (for example: MD, DDS, DVM, LLB, JD)	1	0.6%				
IMMIGRATION STATUS						
US Citizen or green card	123	78.8%				
Neither	33	21.2%				
AGE			45.99	13.27	18	73

Results

Predictors of Access to Healthcare

Originally, the plan was to run a linear multiple regression, as the dependent variable Access to Healthcare was to be rated on a 5-point Likert scale of 1 (*strongly disagree*) to 5 (*strongly agree*). However, I was advised during a review that the question was best asked using Yes or No as responses. These changes were made prior to the IRB approval and no changes were made to the questionnaire after the IRB approval. I realized after the data collection that the proposed data analysis method in Chapter 3 could not be performed. Therefore, a logistic regression was conducted. Additionally, chronbach's alpha was also not performed, as there were no psychometric tests used in this study. Chronbach's alpha can only be reliably tested if at least 10 questions in a survey have the same scale and are measuring the same construct. Therefore, chronbach's alpha could not be reliably calculated in the pilot study or the main study. However, the pilot study was still used to check for clarity of the questions and to evaluate and correct any logistics issues in administering the survey, as recommended by Leedy and Ormrod (2013). For example, if respondents indicated that they did not understand the question or component of a question, that question would have been altered or clarified. However, I observed the participants during the administration and verbally asked for their reaction after they had finished. They did not indicate any issues with regards to the survey questionnaire clarity or with the administration of the survey.

To examine if education level, immigration status, and health insurance status were predictors of access to healthcare, a logistic regression was conducted. Logistic

regression allows for the testing of models that predict categorical outcomes with two or more categories (Tabachnick & Fidell, 2012). The first independent variable was immigration status, where 1 equaled *U.S. citizen or green card holder* and 0 equaled *neither a citizen nor green card holder*. The second independent variable was health insurance status where 1 equaled *had health insurance* and 0 equaled *did not have health insurance*. The final independent variable was education level. Education level consisted of 10 answer categories, which when cross tabbed with the dependent variable, "if you are sick do you know where to go for help," where 1 was *yes* and 0 was *no*, producing 11 cells (55%) with expected counts of less than five. Since the logistic regression uses the goodness of fit test, it is recommended that answer categories be collapsed to bring the less than five-cell count to below 20% (Tabachnick & Fidell, 2012). Therefore, education level was collapsed from 10 answer categories to two, where 0 was *no college degree* and 1 was *college degree*, with the cutoff being an associate degree. The three independent variables maintained their scoring format across all analyses. Table 2 below contains the cross tab of education level and perceived access to healthcare.

Table 2

Crosstab of Education Level and Perceived Access to Healthcare – 11 Cell of Less Than 5

	If you're sick, do you know where to look for help?		
	yes	no	Total
No schooling completed	9	0	9
Nursery school to 8th grade	4	0	4
9th, 10th, or 11th grade	8	8	16
12th grade, no diploma	23	7	30
High school graduate - high school diploma or GED	46	5	51
Some college credit, but no degree	14	2	16
Associate degree (for example: AA, AS)	10	1	11
Bachelor's degree (for example: BA, AB, BS)	10	0	10
Master's degree (for example: MA, MS, MEng, MEd, MSW, MBA)	7	0	7
Professional degree (for example: MD, DDS, DVM, LLB, JD)	1	0	1

Preliminary results indicated that there was no multicollinearity as the variable inflation factor (VIF) for the independent variables were 1.1 (education), 1.2 (immigration status), and 1.2 (health insurance), which are below the criterion of 10 (Fidell, 2012). These variables were selected for the model apriori based on the research questions. In SPSS, the full model is compared to the intercept only model, which is performed first in the logistic regression analysis to determine if there is an improvement in classification accuracy (Field, 2012). Therefore, no bivariate preliminary analyses were necessary for full model selection. Results of the logistic regression indicated that the full model containing all predictors was statistically significant, χ^2 (3, N = 152) = 18.74, p < .001. This indicated that the model was able to distinguish between respondents who reported access to healthcare and those who did not. The model as a

whole explained 11.6% (Cox & Snell R square) and 20.6% (Nagelkerke R square) of the variance in perceived access to healthcare, and correctly classified 85.5% of the cases. As shown in Table 3, only one of the variables, health insurance status, made a unique statistically significant contribution to the model, having a *p* value of .004 and recording an odds ratio of 9.25. This indicated that those with insurance were 9 times more likely to report they had access to healthcare than those who did not have insurance (see Table 3).

Table 3

Logistic Regression Predicting Perceived Access to Healthcare

							95% C.I.for EXP(B)	
	B	*S.E.*	*W*	*df*	*p*	Exp(B)	Lower	Upper
College degree (1)	1.17	1.08	1.18	1	.278	3.22	.39	26.63
Citizen or green card (1)	.23	.53	.19	1	.662	1.26	.45	3.52
Health insurance (1)	2.22	.78	8.09	1	.004	9.25	2.00	42.83
Constant	.88	.42	4.44	1	.035	2.42		

To determine if education, immigration status, and health insurance status were a significant predictor of healthcare usage in the past 12 months, a logistic regression was performed. Healthcare usage is a proxy for access to healthcare. The dependent variable in this analysis was healthcare usage, where 0 was *have not used a healthcare provider or institution in the past 12 months*, and 1 was *have used a healthcare provider or institution in the past 12 months*.

The results indicated that the model as a whole was a significant predictor of healthcare usage, χ^2 (3, N = 153) = 7.68, p =.05, indicating that the model was able to distinguish between respondents who used healthcare in the past 12 months and those who did not. The total model explained 4.9% (Cox & Snell R Square) and 12.8% (Nagelkerke R Square) of the variability in healthcare usage status, correctly classifying 93.5% of the cases. As shown in table 4, health insurance status was the only independent variable that made a statistically significant contribution to the model, having an p value of .027 and odds ratio of 6.84. This indicated that those with health insurance were

almost 7 times more likely to report using healthcare services in the past 12 months.

Table 4

Logistic Regression Predicting Healthcare Usage

							95% C.I.for EXP(B)	
	B	*SE*	Wald	*df*	*p*	Exp(B)	Lower	Upper
College degree(1)	-1.15	.80	2.08	1	.150	.32	.07	1.51
Citizen or green card(1)	-1.39	1.10	1.60	1	.206	.25	.03	2.15
Health insurance(1)	1.92	.87	4.89	1	.027	6.84	1.24	37.59
Constant	3.45	1.03	11.22	1	.001	31.50		

Predictors of Willingness to Use Healthcare

Education level, immigration status, and health insurance status were examined to determine if they were predictors of respondents' willingness to use healthcare. The independent variables were education level, immigration status, and health insurance status. The dependent variable was willingness to use healthcare and was measured using three different variables. Each of the three variables evaluated willingness to use healthcare based on health problems of varying severity. The first question asked willingness to go the emergency room with a broken arm. The second question asked willingness to seek medical care for dizziness, and the third question asked about willingness to go to the emergency room with a severe fever. Each of these questions was scored on a 1 to 5 scale where 1 *was not at all willing* and 5 was *extremely willing*. As the dependent variable was continuous, a multiple linear regression was conducted.

Results of the multiple linear regression for the broken arm question indicated that the model was not a significant predictor of willingness to use healthcare for a broken arm and the *p* value was greater than .05, $F(3, 149) = 1.45$, $p = .23$. The results indicated

that the model was not a better predictor of willingness to use healthcare for a broken arm than the mean willingness score of 4.43 (*SD* = .89) (see Tables 5 and 6 for ANOVA and coefficients information). Despite this, however, having health insurance was related to willingness to use healthcare for a broken arm (*p*=.04), as indicated by the significant beta Table 6.

Table 5

Regression Model Summary – Willingness to Use Healthcare for a Broken Arm

Model	*SS*	*df*	*MS*	*F*	*p*
Regression	3.45	3	1.15	1.45	.23
Residual	117.94	149	.79		
Total	121.39	152			

Table 6

Regression Coefficients Table – Willingness to Use Healthcare for a Broken Arm

	Unstandardized coefficients		Standardized coefficients			95.0% Confidence interval for B	
Model	*B*	*SE*	Beta	*T*	*p*	Lower bound	Upper bound
(Constant)	4.50	.16		28.36	.00	4.19	4.81
College degree	.13	.19	.06	.69	.49	-.25	.51
Immigration status	.06	.19	.03	.34	.74	-.31	.44
Health insurance	-.32	.16	-.18	-2.04	.04	-.63	-.01

When immigration status, health insurance status, and education level were regressed on willingness to seek medical care for dizziness, the results indicated that the model was significant, $F(3, 149) = 2.63$, $p = .05$, where the model explained 5% of the variability in willingness to seek medical care. Only health insurance status made a statistically significant contribution to the model, beta = -.22, $p = .01$, indicating that

those without health insurance were more willing to seek medical care when experiencing dizziness than those with health insurance (see Tables 7 and 8 for ANOVA and coefficients information).

Table 7

Regression Model Summary – Willingness to Use Healthcare When Experiencing Dizziness

	SS	*df*	*MS*	*F*	*p*
Regression	10.29	3	3.43	2.63	.05
Residual	194.43	149	1.31		
Total	204.72	152			

Table 8

Regression Coefficients Table – Willingness to Use Healthcare When Experiencing Dizziness

	Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B	
	B	*SE*	Beta			Lower Bound	Upper Bound
Model	*B*	*SE*	Beta	*t*	*p*	Lower Bound	Upper Bound
(Constant)	4.32	.20		21.20	.00	3.917	4.722
College Degree	-.10	.25	-.03	-.40	.69	-.59	.39
Immigration status	.04	.24	.01	.15	.88	-.45	.52
Health insurance	-.51	.20	-.22	-2.51	.01	-.91	-.11

The third multiple linear regression was conducted to evaluate if education level, immigration status, and health insurance coverage were predictors of willingness to go to the emergency room when experiencing a severe fever. Results of the multiple regression indicated the model as a whole was not a significant predictor of willingness to use healthcare when experiencing a severe fever and the p value was greater than .05, $F(3, 148) = 2.53$, $p = .06$. The results indicated that the model was not a better predictor of

willingness to use healthcare when experiencing a severe fever than the mean willingness score of 4.14 (*SD* = 1.14; see Tables 9 and 10 for ANOVA and coefficients information). However, again, having health insurance was related to willingness to use healthcare when experiencing a severe fever (*p*=.02). See Table 10.

Table 9

Regression Model Summary – Willingness to Use Healthcare When Experiencing Severe Fever

	SS	*df*	*MS*	*F*	*p*
Regression	9.57	3	3.19	2.53	.06
Residual	186.53	148	1.26		
Total	196.10	151			

Table 10

Regression Coefficients Table – Willingness to Use Healthcare When Experiencing Severe Fever

	Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B	
	B	*SE*	Beta	*t*	*p*	Lower Bound	Upper Bound
(Constant)	4.42	.20		21.7	.00	4.02	4.82
College Degree	-.02	.24	-.01	-.07	.94	-.50	.46
Immigration status	-.06	.24	-.02	-.26	.80	-.54	.42
Health insurance	-.48	.20	-.21	-2.42	.02	-.87	-.09

Cultural Beliefs as Predictors of Willingness to Use Healthcare

Multiple regressions were conducted to evaluate if cultural beliefs are predictors of willingness to use healthcare. The dependent variables were willingness to use healthcare when experiencing a severe fever, dizziness, and when your arm is broken. The independent variables were cultural beliefs and were measured using three different questions.

The first question stated that "it is generally better to take care of your own health than to go to the doctor," where ratings ranged from 1 (*strongly disagree*) to 5 (*strongly agree*). The second question asked five *true* (1) or *false* (0) questions related to male healthcare providers touching/seeing private parts, female healthcare provider touching/seeing private parts, receiving healthcare services from providers not from my culture, receiving healthcare services from providers not from my religion, and the belief in traditional medicine only. Third, respondents were asked the following: "How often do you not follow a doctor's advice, or treatment plan because it went against your personal beliefs?" where ratings ranged from 1 (*never*) to 5 (*always*).

The results of the regression where willingness to use healthcare (broken arm) was regressed on the cultural belief take care of your own health, the results indicated that the model as a whole was not a significant predictor of willingness to use healthcare (broken arm), $F(1,154) = .785$, $p = .38$ (see Table 11 and 12). When willingness (dizziness) was regressed on the cultural belief, take care of your own health, the model as a whole again was not significant, $F(1, 154) = .211$, $p = .65$ (see Table 13 and 14). The regression results were also not significant willingness (severe fever) and the cultural belief, take care of your own health, $F(1, 153) = .004$, $p = .95$ (see Table 15 and 16).

Table 11

Regression Model Summary – Willingness to Use Healthcare (Broken Arm) and Take Care of Your Own Health

	SS	*df*	*MS*	*F*	*p*
Regression	.65	1	.65	.79	.38
Residual	127.10	154	.83		
Total	127.74	155			

Table 12

Regression Coefficients Table – Willingness to Use Healthcare (Broken Arm) and Take Care of Your Own Health

	Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B	
	B	*SE*	Beta	*t*	*p*	Lower Bound	Upper Bound
(Constant)	4.29	.16		27.63	.00	3.98	4.60
It is generally better to take care of your own health than to go to a doctor"	.08	.09	.07	.89	.38	-.10	.25

Table 13

Regression Model Summary – Willingness to Use Healthcare (Dizziness) and Take Care of Your Own Health

	SS	*df*	*MS*	*F*	*p*
Regression	.29	1	.29	.21	.65
Residual	213.07	154	1.38		
Total	213.36	155			

Table 14

Regression Coefficients Table – Willingness to Use Healthcare (Dizziness) and Take Care of Your Own Health

	Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B	
	B	*SE*	Beta	*t*	*p*	Lower Bound	Upper Bound
(Constant)	4.15	.20		20.63	.00	3.75	4.54
q22 It is generally better to take care of your own health than to go to a doctor"	-.05	.11	-.04	-.46	.65	-.28	.17

Table 15

Regression Model Summary – Willingness to Use Healthcare (Severe Fever) and Take Care of Your Own Health

	SS	df	MS	F	p
Regression	.01	1	.01	.00	.95
Residual	201.41	153	1.32		
Total	201.42	154			

Table 16

Regression Coefficients Table – Willingness to Use Healthcare (Severe Fever) and Take Care of Your Own Health

	Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B	
	B	*SE*	Beta	*t*	*p*	Lower Bound	Upper Bound
(Constant)	4.12	.20		20.93	.00	3.73	4.51
It is generally better to take care of your own health than to go to a doctor"	.01	.11	.01	.07	.95	-.21	.23

Cultural Beliefs That May Prevent One From Using Healthcare as Predictors of Willingness to Use Healthcare

To analyze the true and false cultural belief questions associated with the second set of questions, a multiple regression was performed where the five true and false questions were included in the model as five separate independent variables. The results indicated that the model as a whole was not a significant predictor or willingness to use healthcare (broken arm), $F(5, 144) = .91$, $p = .48$ (see Tables 17 and 18). This indicated that the model containing the five independent variables is no better a predictor of willingness to use healthcare when someone has a broken arm than the mean willingness scores of 4.42 ($SD = .89$). The second multiple regression between cultural beliefs that may prevent someone from using healthcare and willingness to use healthcare (dizziness) indicated that the model as a whole was not a significant predictor of willingness to use healthcare (dizziness), $F(5, 144) = .62$, $p = .69$ (see Tables 19 and 20). This indicated that the model containing the five independent variables is no better a predictor of willingness to use healthcare when someone has a broken arm than the mean willingness scores of 4.06 ($SD = 1.17$). Finally, the model was not a significant predictor of willingness to use healthcare when someone has a severe fever, $F(5, 143) = 1.51$, $p = .19$(see Tables 21 and 22). This indicated that the model containing the five independent variables is no better a predictor of willingness to use healthcare when someone has a broken arm than the mean willingness scores of 4.13 ($SD = 1.14$).

Table 17

Regression Model Summary – Willingness to Use Healthcare (Broken Arm) and Cultural Beliefs That May Prevent Someone From Using Healthcare

	SS	*df*	*MS*	*F*	*p*
Regression	3.61	5	.72	.91	.48
Residual	114.93	144	.80		
Total	118.54	149			

Table 18

Regression Coefficients Table – Willingness to Use Healthcare (Broken Arm) and Cultural Beliefs That May Prevent Someone From Using Healthcare

	Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B	
	B	*SE*	*Beta*	*t*	*p*	Lower Bound	Upper Bound
(Constant)	4.35	.09		47.91	.00	4.17	4.53
Male healthcare provider	.23	.18	.11	1.25	.21	-.13	.59
Female healthcare provider	-.08	.24	-.03	-.33	.74	-.56	.40
Healthcare provider not from culture	-.03	.41	-.01	-.07	.94	-.84	.78
Healthcare provider not from religion	.35	.39	.09	.90	.37	-.42	1.13
Believe in traditional medicine only	.57	.69	.07	.82	.41	-.80	1.94

Table 19

Regression Model Summary – Willingness to Use Healthcare (Dizziness) and Cultural Beliefs That May Prevent Someone From Using Healthcare

	SS	*df*	*MS*	*F*	*p*
Regression	4.30	5	.86	.62	.69
Residual	200.16	144	1.39		
Total	204.46	149			

Table 20

Regression Coefficients Table – Willingness to Use Healthcare (Dizziness) and Cultural Beliefs That May Prevent Someone From Using Healthcare

	Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B	
	B	*SE*	Beta	*t*	*p*	Lower Bound	Upper Bound
(Constant)	4.08	.12		34.07	.00	3.85	4.32
Male healthcare provider	-.09	.24	-.03	-.37	.71	-.57	.39
Female healthcare provider	-.33	.32	-.09	-1.02	.31	-.97	.31
Healthcare provider not from my culture	-.09	.54	-.02	-.17	.86	-1.16	.97
Healthcare provider not from my religion	.51	.52	.10	.99	.32	-.51	1.53
Believe in traditional medicine only	1.04	.91	.10	1.13	.26	-.77	2.84

Table 21

Regression Model Summary – Willingness to Use Healthcare (Severe Fever) and Cultural Beliefs That May Prevent Someone From Using Healthcare

	SS	*df*	*MS*	*F*	*p*
Regression	9.64	5	1.93	1.51	.19
Residual	182.93	143	1.28		
Total	192.58	148			

Table 22

Regression Coefficients Table – Willingness to Use Healthcare (Severe Fever) and Cultural Beliefs That May Prevent Someone From Using Healthcare

	Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B	
	B	*SE*	*Beta*	*t*	*p*	Lower Bound	Upper Bound
(Constant)	4.17	.12		36.08	.00	3.94	4.40
Male healthcare provider	-.01	.23	.00	-.02	.98	-.47	.46
Female healthcare provider	-.61	.31	-.18	-1.97	.05	-1.22	.00
Healthcare provider not from my culture	.74	.52	.14	1.42	.16	-.29	1.76
Healthcare provider not from my religion	-.34	.50	-.07	-.68	.50	-1.31	.64
Believe in traditional medicine only	1.24	.88	.13	1.42	.16	-.49	2.97

Frequency of Not Following Doctor's Advice or Treatment as a Predictor of Willingness to Use Healthcare

The final multiple regression analysis examined if frequency of not following doctors' advice or treatment because of personal beliefs was a significant predictor of willingness to use healthcare. Frequency was rated on a 5 point scale where 1 was *never*, 2 was *rarely*, 3 was *sometimes*, 4 was *often*, and 5 was *always*. The dependent variables were willingness to use healthcare when experiencing a severe fever, dizziness, or a broken arm.

Results indicated that the frequency of not following doctors' advice was not a significant predictor of willingness to use healthcare (arm broken), $F(1, 155) = 1.58$, $p = .21$. This indicated that the model was no better a predictor of willingness to use healthcare when you have a broken arm than the mean willingness score of 4.41 ($SD = .91$). Results also indicated that the frequency of not following doctors' advice was not a significant predictor of willingness to use healthcare (dizziness), $F(1, 155) = 2.04$, $p = .16$. This indicated that the model was no better a predictor of willingness to use healthcare when experiencing dizziness than the mean willingness score of 4.07 ($SD = 1.17$). Finally, results indicated that the frequency of not following doctors' advice was not a significant predictor of willingness to use healthcare (severe fever), $F(1, 154) = .01$, $p = .99$. This indicated that the model was no better a predictor of willingness to use healthcare when experiencing a severe fever than the mean willingness scores of 4.13 ($SD = 1.14$).

Table 23

Regression Model Summary – Willingness to Use Healthcare (Broken Arm) and Frequency of Not Following Doctor's Advice or Treatment Due to Personal Beliefs

		SS	*df*	*MS*	*F*	*p*
1	Regression	1.29	1	1.29	1.58	.21
	Residual	126.80	155	.82		
	Total	128.09	156			

Table 24

Regression Coefficients Table – Willingness to Use Healthcare (Broken Arm) and Frequency of Not Following Doctor's Advice or Treatment Due to Personal Beliefs

	Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B	
	B	*SE*	*Beta*	*t*	*p*	Lower Bound	Upper Bound
(Constant)	4.21	.17		24.16	.00	3.87	4.56
How often do you not follow a doctor's advice or treatment plan because it went against your personal beliefs	.12	.09	.10	1.26	.21	-.07	.30

Table 25

Regression Model Summary – Willingness to Use Healthcare (Dizziness) and Frequency of Not Following Doctor's Advice or Treatment Due to Personal Beliefs

	SS	*df*	*MS*	*F*	*p*
Regression	2.78	1	2.78	2.04	.16
Residual	211.44	155	1.36		
Total	214.23	156			

Table 26

Regression Coefficients Table – Willingness to Use Healthcare (Dizziness) and Frequency of Not Following Doctor's Advice or Treatment Due to Personal Beliefs

	Unstandardized Coefficients		Standardized Coefficients	*t*	*p*	95.0% Confidence Interval for B	
Model	*B*	*SE*	*Beta*			Lower Bound	Upper Bound
(Constant)	3.78	.23		16.77	.00	3.33	4.22
q24 How often do you not follow a doctor's advice or treatment plan because it went against your personal beliefs	.17	.12	.11	1.43	.16	-.07	.41

Table 27

Regression Model Summary – Willingness to Use Healthcare (Severe Fever) and Frequency of Not Following Doctor's Advice or Treatment Due to Personal Beliefs

	SS	*df*	*MS*	*F*	*p*
Regression	.00	1	.00	.00	.99
Residual	202.17	154	1.31		
Total	202.17	155			

Table 28

Regression Coefficients Table – Willingness to Use Healthcare (Severe Fever) and Frequency of Not Following Doctor's Advice or Treatment due to Personal Beliefs

	Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B	
Model	*B*	*SE*	*Beta*	*t*	*p*	Lower Bound	Upper Bound
(Constant)	4.13	.22		18.69	.00	3.69	4.57
How often do you not follow a doctor's advice or treatment plan because it went against your personal beliefs	.00	.12	.00	.02	.99	-.23	.23

Answers to Research Questions

Results of the logistic regression indicated that those with insurance were nine times more likely to report that they had access to healthcare than those who did not have insurance (see Table 3). Additionally, those with health insurance were almost seven times more likely to report using healthcare services in the past 12 months.

Regarding Research Question 1, results of the multiple linear regressions indicated that immigration status, health insurance status, and education levels did not predict willingness to use healthcare for a broken arm, nor did they predict willingness to use healthcare for severe fever. However, immigration status, health insurance status, and education levels were able to predict willingness to use healthcare for dizziness.

Regarding Research Question 2, multiple regressions were conducted to evaluate if cultural beliefs are predictors of willingness to use healthcare. The dependent variables

were willingness to use healthcare when experiencing a severe fever, dizziness, or a broken arm. The independent variables were cultural beliefs and were measured using three different questions.

The first question stated, “It is generally better to take care of your own health than to go to the doctor,” where ratings ranged from 1 (*strongly disagree*) to 5 (*strongly agree*). The second question asked five *true* (1) or *false* (0) questions related to male healthcare providers touching/seeing private parts, female healthcare provider touching/seeing private parts, receiving healthcare services from providers not from my culture, receiving healthcare services from providers not from my religion, and the belief in traditional medicine only. Third, respondents were asked, “how often do you not follow a doctor’s advice, or treatment plan because it went against your personal beliefs,” where ratings ranged from 1 (*never)* to 5 (*always*).

The results of the regression indicated that ratings on better to take care of your own health rather than go to the doctor did not predict willingness to use healthcare for any of the three health conditions (broken arm, dizziness, or severe fever).

Additionally, the results of the regression revealed that male healthcare providers touching/seeing private parts, female healthcare provider touching/seeing private parts, receiving healthcare services from providers not from my culture, receiving healthcare services from providers not from my religion, and the belief in traditional medicine only did not predict willingness to use healthcare services for any of the three health conditions (broken arm, dizziness, or severe fever).

Finally, results indicated that the frequency of not following doctors’ advice was

not a significant predictor of willingness to use healthcare for any of the three health conditions (broken arm, dizziness, or severe fever).

Summary

In Chapter 4, I presented the results of data analyses from the survey questionnaire that answered two major research questions and they were as follows:

1. To what extent do BGIMC members' education, immigration status, and health insurance status predict their perceived access to healthcare services and their willingness to use healthcare services? and
2. To what extent do cultural beliefs predict the willingness of BGIMC members to use healthcare after education, immigration status, and health insurance status variables are controlled?

I conducted several types of analyses such as frequencies of response, logistic regression for only two responses such as *Yes* (1) and *No* for (2), regular regression and multiple regression for the scale of 1 to 5 scores, and linear regression for ratio scale of five choices. Other components of the logistic regression used were the analysis of variance (ANOVA) and a regression coefficient to test for significant differences between means. The Microsoft Excel Spreadsheet, and Statistical Program for the Social Sciences (SPSS) were the tools used for data analysis. The analyses and interpretation of data showed that the most reliable predictor of health access and willingness to use healthcare services is health insurance.

A discussion of the results is presented in Chapter 5. In addition, the study limitations, interpretation of findings and implications for social change, conclusions

from the study, and recommendations for further study are also presented.

Chapter 5: Summary, Conclusions, and Recommendations

Introduction

This study investigated the influence of cultural beliefs on BGIMC members' perceived access and willingness to use healthcare services. It was designed to determine the extent to which the following factors influence the use of healthcare services: education, immigration status, cultural beliefs, and insurance coverage. I leveraged a focus group's results and developed a cultural survey instrument that assessed the willingness of BGIMC members to use healthcare services in the United States. The instrument measured the relationship among demographic variables, insurance status variable, variables related to cultural beliefs, perceived access to healthcare, and willingness to use healthcare. Systematic sampling was used to collect data that were analyzed for appropriate interventions. Logistic and linear multiple regressions were conducted. The results of the logistic regressions indicated that those with insurance were nine times more likely to report that they had access to healthcare than those who did not have insurance. Additionally, those with health insurance were almost seven times more likely to report using healthcare services in the past 12 months. Further, the results of the multiple linear regressions indicated that immigration status, health insurance status, and education levels did not predict willingness to use healthcare for a broken arm or severe fever. However, immigration status, health insurance status, and education levels were able to predict willingness to use healthcare for dizziness. Finally, results indicated that cultural beliefs were not a predictor of willingness to use healthcare.

In this chapter, I provide a summary, interpretation of the findings, the study limitations, implications for social change, a concluding statement, and recommendations for action and further study.

Nature of Study

The study focused on determining the GBIMC members' perceived access and willingness to use healthcare services. A quantitative method using a survey questionnaire was utilized. The number of questions on the survey instrument was 25, organized into three themes. The first theme introduced the questionnaire and concentrated on the demographic profile and the educational background of respondents. The second theme was related to the respondents' perceived access to healthcare services, and the last theme focused on the cultural influence on respondents' willingness to use healthcare services. This study was grounded in the conceptual frameworks of critical theory and complexity theory that proclaimed that the constant review of health policies for updates prevents many health issues in societies and promotes access to healthcare services (Anderson, 1998). This study provides new focus/guidelines for policy makers on immigrant healthcare access and utilization.

Interpretation of Findings for the Research Questions

I reached the following conclusions on data analysis pertaining to the BGIMC's perceived access and willingness to use healthcare services. These interpretations led to some needed recommendations on health issues facing the BGIMC members.

Research Question 1 asked, "To what extent do BGIMC members' education, immigration status, and health insurance status predict their perceived access and a

willingness to use healthcare services?" The findings revealed that only one of the variables, health insurance status, made a unique statistically significant contribution to the model, having a *p* value of .004 and recording an odds ratio of 9.25. This indicated that respondents with insurance were nine times more likely to report they had access to healthcare than those who did not have insurance (see Table 3), and willingness to use healthcare also indicated that only health insurance status made a statistically significant contribution to the model. This is consistent with the NAS (2009) conclusion that immigrants did not have access to healthcare due to lack of health insurance, as a result of working in industries such as agriculture, construction, and service that did not provide health insurance. Further, Siman (2009) offered a similar explanation that 55% of noncitizens are employed in firms with less than 100 employees. These firms have the flexibility of providing health insurance to employees, but many chose not to do so. Immigrants cannot afford to purchase private insurance because of cost, and that is hindering their use of healthcare services (Siman, 2009).

According to Shaw and Sahl (2011), critical and complexity theories advocate for the adequate provision of healthcare services to every patient regardless of affordability. These theories call for the availability of health insurance programs in the minority communities to enhance their healthcare access just as the outcome of this study indicated (Shaw & Sahl, 2011). Mennin (2013) asserted that the right educational programs are needed to foster understanding between healthcare providers and patients. This will improve healthcare access in minority communities because patients will become more familiar with the healthcare system. Mennin further indicated that

theoretical models and research methods are needed to understand healthcare organizations and effect change in the immigrant healthcare access. Doyal and Gough (1991) agreed with Mennin by stating that healthcare providers need to be clearly informed about the importance of addressing health insurance benefits with patients in order to utilize them effectively in accessing healthcare services. Doyal and Gough further stressed that documented and undocumented citizens should have equal access to healthcare services in the United States, and new policies on healthcare insurance coverage should be addressed. The findings of this study demonstrated the essence and the dire need of health insurance coverage for the members of the BGIMC.

Research Question 2 asked, "To what extent do cultural beliefs predict the willingness of BGIMC members to use healthcare services after education, immigration status, and health insurance status variables are controlled?" The dependent variables were willingness to use healthcare when experiencing a severe fever, dizziness, or a broken arm. The independent variables were cultural beliefs and were measured using three different questions. The findings indicated that cultural beliefs were not predictors of willingness to use healthcare. This means that cultural beliefs do not influence the BGIMC members' decision in healthcare services usage. This finding is not in line with what Bustamante Var & Van Wees (2012) found in their investigation. They indicated that culturally sensitive healthcare and the immigrant integration process are interlinked. Therefore, situations can easily arise in which immigrants' cultural belief and standard of care clash, and that some health related beliefs and practices could lead to unhealthy and fatal care. Further, Watson and Day (2008) indicated that stigma about mental health

keeps minority women from utilizing treatment at the initial stages of mental health disorders and that research has proven that cultural beliefs and stigmatization from illness affect immigrants' willingness to seek healthcare services. In addition, Watson and Day (2008) indicated that a lack of culturally competent healthcare providers who understand and address immigrant health issues effectively hinders their use of healthcare services. As mentioned earlier, my study findings also indicated that the cultural beliefs were not predictors of willingness to use healthcare. This result differs from what researchers have found in the literature on the cultural impact on healthcare access (Vaughn, Jacquez, & Baker, 2009). It might be because the scope of my research was not as large as the ones in those studies. Further, my study concentrated only on the Bronx Ghanaian immigrant Muslims who were affiliated with the community; therefore, other Ghanaian Muslims not affiliated with the BGIMC did not impact the result of this study. Hence, if a large number of the Ghanaian immigrant Muslims in the Bronx were located in the BGIMC vicinity, this study results would have been different and would probably conform with the study results in my literature review which indicated that cultural beliefs do influence immigrants' perceive access and a willingness to use healthcare services.

Limitations

This study was limited to members of the BGIMC who were 18 years or older and who have lived in the United States for more than a year. There were 160 participants selected using a systematic sampling only as the members left the BGIMC premises. However, only 156 participants completed the entire survey. The research data were collected, analyzed, and interpreted by me as proposed in Chapter 3. The Microsoft Excel

Spreadsheet, and Statistical Program for the Social Sciences (SPSS) were the tools used for data analysis, and logistic and multiple linear regressions were used to analyze the collected data.

These research findings may not be generalized due to their scope, meaning that data from the BGIMC only may lead to overrepresentation of other Ghanaian Muslim groups not affiliated with the community. Further, although I am confident that the sampling procedure allowed for a fairly representative sample and findings reflect the situation of the BGIMC members in New York, some of the BGIMC members could not wait to complete the study due to work and family demands; therefore they were excluded from the study. If those who could not wait were equally distributed across all groups, the bias to the study would have been limited. However, if this group was not equally distributed across the sample, then this is another issue that limits the projectability of the study. In addition, this study is not being applicable to the entire Ghanaian population because it concentrated on the Bronx Ghanaian Muslims Community only and not Ghanaians Muslims from other boroughs in New York and Ghanaians of other religious faith. Although the findings may not be applicable to other African immigrant populations, recommendations from this study could be adopted. For example, health education could improve members' familiarity with the healthcare system, and communication between communities and their healthcare providers can be improved; therefore, healthcare access and utilization issues can be addressed effectively. Further, a similar design could be replicated in other Ghanaian and African immigrant communities to help assess the similarity of results.

Recommendations for Action

The increased interest in health insurance reform across the country presents a timely opportunity to address health problems experienced by many immigrants (NAS, 2009). These reforms, however, will help the African population only if their health needs and other related community issues are taken into account (NAS, 2009). This study recommends that the healthcare reform legislation should address health disparities at the national level to help every community. The following proposals serve as a core set of recommendations for action and further research.

Immigrant communities are affected by a lack of health insurance coverage, and that triggers high healthcare costs and poor quality treatments (NAS, 2009). Although healthcare reform aims at improving the healthcare system by providing equal access to affordable health coverage, the result of this research suggests that the necessary actions required to address the health related issues of the BGIMC members are needed for immediate effect and should focus on programs for increasing health insurance coverage.

According to Siman (2009), because immigrants are more likely to live below the poverty line, healthcare affordability is a serious concern. Policy makers should make improving access to healthcare a priority by coming up with income-based standards for all health related costs in addition to subsidies for people with low incomes. The results of this research suggest that the BGIMC should establish a fruitful relationship with the community's healthcare providers in order to take advantage of the affordable health insurance and other government subsidies and health programs for immigrants.

Many documented and undocumented immigrants work in industries that are less likely to provide employer-coverage health insurance, and most of them do not qualify for public insurance programs (Bustamante et al., 2012). To ease the healthcare services use for these people, the healthcare reform policies proposed for 2014 and beyond should increase the amount of subsidies already in place for immigrant communities, and that will increase the insurance rate (Bustamante et al., 2012). In addition, minority and immigrant communities require a community-based outreach health promotion and prevention programs to address their healthcare issues (NAS, 2009). This program will assist individuals who are medically underserved to utilize subsidized preventive and primary care services. It will help the newly insured immigrant patients with understanding and accessing healthcare services available to them and foster cultural education relative to healthcare use between communities and healthcare providers. Further, the national healthcare reform proposals in 2009 recommend hospitals investigate and address the health issues of the communities they serve by coming up with new criteria for Disproportionate Share Hospital payments (DSH) and to maintain the tax-exempt status to benefit the community (Rittenhouse, Shortell, & Fisher, 2009). These community-based programs should be evaluated periodically to ensure they address the health needs of immigrant communities and to include health insurance coverage to everyone.

A community health education promotion kit should be developed by the Ghanaian community leaders to assist in health education and health promotion strategies within the community. This will educate members on the process of attaining legal

residence status to assist them in finding employments that provide health insurance benefits in order to have adequate access to healthcare. A community radio should be utilized effectively to reach out to all community members to disseminate community health enrichment information in order to take advantage of these programs to improve their lives.

Recommendations for Further Study

A number of recommendations for further study are presented based on the findings of this research as well as the literature review in Chapter 2. The recommendations suggest further areas of research to help understand and alleviate health disparities among immigrants in the United States. Vaughn et al. (2009) indicated that immigrant families might encounter problems using healthcare services for many reasons. Among them are a lack of culturally competent healthcare providers who understand and address their healthcare issues effectively, affordability of treatment costs, perceptions of lack of respect by healthcare providers, the complexity of our healthcare system and a lack of health insurance which can contribute to reduced access and willingness to use healthcare services (Vaughn et al., 2009).

There is a need for further research on the effect of immigrant culture beliefs and a willingness to use healthcare services. As indicated earlier, Flores (2010) asserted that appropriate research methodology is required in order to effectively document and analyze health disparity issues among immigrants. Lack of familiarity of immigrants' culture by healthcare providers, and patients' lack of familiarity with the skills involved in negotiating the U.S. healthcare system were believed to have caused communication

difficulties and effective healthcare delivery (Braveman & Woolf, 2011). As I indicated above, the scope of this research was not as large as similar studies reviewed in the literature, and it concentrated only on Ghanaian Muslims that were affiliated with the BGIMC. Therefore, the Ghanaian Muslims whose places of worship were different from the BGIMC members did not impact this study's results. Further, there were other non-Muslim Ghanaian immigrants in the Bronx whose healthcare access may be influenced by health insurance and cultural belief. In addition, the inclusion of Ghanaian immigrant Muslims from other communities of the Bronx might have changed the outcome of this study's results. As a result, further study that involves a large scope of Ghanaian Muslims and Ghanaians from another religious faith from the Bronx is recommended.

As indicated in the literature review for this study, Footracer (2009) argued that the significant limitations of current and past research were the failure to examine medical care differences beyond comparing African-American and European-American patients. A few major studies were conducted in ethnically diverse locations of the United States, but only a few studies have assessed whether disparities in care existed for African immigrants, and only a few researchers have examined differences in subgroups within these populations (Footracer, 2009). These concerns were particularly significant for African immigrant subgroups whose healthcare have been affected by lack of health insurance programs and other issues affecting healthcare access and utilization; the reasons for not studying these subgroups were unknown (Footracer, 2009). No comprehensive health study had been conducted with members of the BGIMC or other African ethnic groups. Therefore, a comprehensive study on African immigrants

subgroups is also required

According to Bustamante et al. (2012), the Patient Protection and Affordable Care Act (ACA) will provide additional funding for community health centers in the country. These centers are supposed to increase the integration of all immigrants into primary care, and this could partially ameliorate healthcare disparities between documented and undocumented immigrants. However, it will be as effective as health insurance coverage for positive impact on healthcare access and utilization (Bustamante et al., 2012). Bustamante et al. further indicated that the Patient Protection and Affordable Care Act (ACA) will provide both the U.S.-born and documented immigrants similar opportunities, but these policies will help immigrants who have lived in the United States longer. The waiting period to receive some benefits will be 5 years or longer (Bustamante et al., 2012). Moreover, documented immigrants who have lived in the United States for less than 5 years will be subject to the health insurance mandate but will not qualify for Medicaid. Undocumented immigrants, on the other hand, are excluded from all ACA provisions. The overall effect of ACA on new documented and undocumented immigrants in the United States is yet to be determined (Bustamante et al., 2012). In light of this information, future research is required to compare the effect of excluding undocumented immigrants from the Patient Protection and Affordable Care Act on the cost incurred from undocumented immigrants emergency room usage. The outcome may facilitate effective decision in immigrants' healthcare coverage.

Implications for Positive Social Change

According to Cruz (2009), to address immigrant healthcare issues efficiently, both

moral and economic reasoning should be taken into consideration. Proponents of immigrant healthcare reform contend that immigrants are like native-born in their need for security in health and nutrition and that resources should be equally distributed to improve healthcare access (NAS, 2009).

A fact-finding report published by the Immigration Policy Center in 2009 indicated that because of the increase in immigrants and the nation's baby boom phenomena, participation in the U.S. healthcare system will increase and monetary benefit will be realized (Cruz, 2009). Therefore, a change in eligibility requirements to include immigrants and noncitizens in the healthcare system would spread the costs of sustaining public benefits, and more tax dollars would be available to relieve the financial strain of Social Security and Medicare (Cruz, 2009). Healthcare coverage is just another step toward recognizing that undocumented immigrants play a vital role in our economy, whether they have legal status or not.

According to Rosenbaun (2011), the ACA has established the basic legal protections for patients that until now have been absent, and that is a near-universal guarantee of access to affordable health insurance coverage from birth through retirement. When fully implemented, the Act will cut the number of uninsured Americans by more than half (Rosenbaun, 2011). It will result in health insurance coverage for about 94% of the American population, reducing the uninsured by 31 million people, and increasing Medicaid enrollment by 15 million beneficiaries. The immigrant communities will benefit from this program by having more access to healthcare services. The ACA will increase the fairness, quality, and affordability of health insurance coverage to all

patients. The BGIMC will benefit from the ACA-implemented programs on healthcare insurance coverage as the results of this study indicated.

Rosenbaun (2011) further emphasized that the ACA will continue to establish new rules for the health insurance industry and create a new market for health insurance purchasing in order to overcome some of the health disparities in the healthcare industry. This approach will also strengthen the existing forms of health insurance coverage while building a new and affordable health insurance market for individuals and families who do not have affordable employer coverage or another form of essential health coverage such as Medicare or Medicaid. This health coverage is in dire need at the BGIMC according to this research results.

Healthcare programs or forums to understand the perception of Ghanaian immigrants on healthcare are especially needed (Musah, 2009). According to Ryan (2009), conceptual frameworks of critical and complexity theories address communities' social issues and societal norms, indicating that accommodating new challenges in healthcare industry is very crucial. Some of these challenges are America's adjustment to, and addressing the healthcare needs of, minority populations, and that includes African immigrants (Ryan, 2009).

The healthcare industry should adopt a better approach of educating the public with the healthcare research findings, one that can increase the understanding of everyone instead of a portion of the society (Egede & Brosworth, 2008). This will bring changes and new ways of organizational management toward effective use of healthcare services, which will increase understanding of our healthcare system among African immigrants,

and specifically, among the BGIMC membership.

Concluding Statement

This study found that respondents with insurance were nine times more likely to report that they had access to healthcare than those who did not have insurance. Further, those with health insurance were almost seven times more likely to report using healthcare services in the past 12 months.

The results of the multiple linear regressions indicated that immigration status, health insurance status, and education levels did not predict willingness to use healthcare when someone's arm was broken, nor did they predict willingness to use healthcare when someone has a severe fever. However, immigration status, health insurance status, and education levels were able to predict willingness to use healthcare when someone experiences dizziness. Finally, results indicated that cultural beliefs were not a predictor of willingness to use healthcare.

There is a clear need to understand better how to ensure access to healthcare services and to deliver appropriate care to immigrants. To increase health services use, immigrant communities and their stakeholders must develop coherent and comprehensive strategies to eliminate healthcare disparities. The BGIMC is advised to implement some of the recommendations derived from the outcome of this study, which should have immediate effect. As previously advised, health and general education will play a great part in educating the community to be familiar with the healthcare system, and that will further increase understanding between them and their healthcare providers.

According to Collins, Kaplan, and Marks (2009), health disparities affect minority

groups mostly due to cultural background and socioeconomic status, although other factors also play a role. They further stated that the United States needs to establish an effective system for the assessment of preventive services and support for interventions to improve health at reasonable cost. Such a system will not only benefit the American citizens but will have a positive impact on immigrant healthcare access due its cost-effective focus.

A collective effort will be required to address the healthcare needs of both documented and undocumented immigrants in the United States. In addition to communities' role and health providers' role within the communities, the government must effect change by enacting policies to address health concerns of everyone that reside in this country. Undocumented immigrants living in this country should not be blamed for doing so, but the laws governing immigrants should rather be revised and be enforced. Until that is accomplished, documented and undocumented immigrants who contribute daily to the wealth of the United States should have access to healthcare services.

The healthcare reform should extend healthcare coverage to everyone in the United States including documented and undocumented immigrants. Addressing that concern will alleviate the health issues of many immigrant communities in the United States and that includes the BGIMC. Its members will be familiar with the healthcare system, healthcare cost will not be an issue due to Medicaid availability, and a healthy work force will be evident and that is to the nation's advantage.

References

Adler, N., Bush, N., & Pantell. M. (2012). Rigor, vigor, and study of health disparities. *Proceedings of the National Academy of Sciences, 109*(S2), 154-159.

Agency for Healthcare Research and Quality (AHRQ). (2010). *National healthcare quality report* (AHRQ Publication No. 11-0004). Washington, DC: U.S. Department of Health and Human Services. Retrieved from http://www.ahrq.gov/research/findings/nhqrdr/nhqr10/nhqr10.pdf

Anderson D., Sweeney D., & Williams T. (2009). *Quantitative methods for business*. Mason, OH: Cengage.

Anderson, P. (1998). The importance of theories in healthcare. *British Medical Journal Publishing Group, 37*(5), 1221-1242.

Bibbs, S. (2012). *Perceived access to breast healthcare may lend insights into breast cancer risks in African-American women.* Retrieved from http://www.blackwomenshealth.org/news/2012/05/08/breast-cancer/perceived-access-to-breast-health-care-may-lend-insights-into-breast-cancer-risks-in-african-american-women/

Bleich, S., Jarlenski M., Bell, C. & Laveist, T. (2012). Health inequalities: Trends, progress, and policy. *Annual Review of Public Health 33*, 7-40. doi:10.1146/annurev-publhealth-031811-124658

Braveman, P., & Woolf, S. (2011). Where health disparities begin. The role of social and economic determinants: Why policies may make matters worse. *Health Affairs, 30*(10) 1852-1859.

Brody, H. (2010). Medicines ethical responsibility for healthcare reform: The top five list. *New England Journal of Medicine, 362*, 283-285.

Bustamante, V., & Van dee Wees, P. (2012). Integrating immigrants into the US health system. *Virtual Mentor, 14*(4), 318-323. Retrieved from http://virtualmentor.ama-assn.org/2012/04/stas1-1204.html

Capps, R., & Karina, F. (2006). *Immigration and child and family policy*. Washington DC: The Urban Institute.

Centers for Disease Control Fact Sheet. (2010). *HIV and AIDS among African Americans*: *Centers for Disease Control and Prevention*. Retrieved from www.cdc.gov

Churchill, J., Ruppe, R., & Merne Smaldone, A. (2009). Use of continuous insulin pumps in young children with type 1 diabetes: A systematic review. *Journal of Pediatric Healthcare, 23*(3), 173-179.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences (2nd ed.).* Hillsdale, NJ: Lawrence Erlbaum.

Cohen, J., & Cohen, P. (1975). *Applied multiple regression/correlation analysis for behavioral sciences.* Hillsdale, NJ: Lawrence Earlbaum.

Cohen, R., & Swerdlik, J. (2010). *Psychological testing and assessment*. Boston, MA: McGraw-Hill.

Collins, J., Kaplan, J., & Marks, J. (2009). Chronic disease prevention and control: Coming of age at the Centers for Disease Control and Prevention. *Preventing Chronic Disease, 6*(3), A81. Retrieved from http://www.cdc.gov/pcd/issues/2009/jul/08_0171.htm

Creswell, W. (2008). *Research design: Qualitative, quantitative and mixed methods approaches.* Thousand Oaks, CA: Sage.

Cruz, L. (2010). Determinants of oral healthcare utilization among diverse groups of immigrants in New York City. *American Dental Association, 141*(7), 87- 98.

Crzywacz, J., & Donadio, K. (2012). Occupational injury and work organization among immigrants Latino residential construction workers. American Journal of Industrial Medicine, 55(8), 698–706.

Cunningham, P., & Felland, L. (2008). Falling behind: American access to medical care deteriorates. *Center for Studying Healh System Change*. Retrieved from http://www.hschange.org/CONTENT/993/

Derose, K., Gresenz, C., & Ringel, J. (2011). Understanding disparities in healthcare access and reducing them through a focus of public health. *Health Affairs, 30*(10),1844-1851.

Devellis, R. (2003). *Scale development: Theory and application*. Thousand Oaks, CA: Sage.

Dogra, N., Bentacourt, J., Park, E., & Sprague, M. (2009). The relationship between drivers and policy in the implementation of cultural competence training in healthcare. *Journal of the National Medical Association, 101*(2), 127-133.

Doyal, L., & Gough, I. (1991). *A theory of human need*. New York, NY: Palgrave Macmillan.

Egede, L., & Bosworth, H. (2008). The future of health disparities research 2008 and beyond. *Journal of General Internal Medicine, 23*(5), 706-708.

Eppel, E. (2009). *The contribution of complexity theory to understanding and explaining policy process: A study of tertiary education policy and process* (Unpublished doctoral dissertation). Victoria University of Wellington, Wellington, New Zealand.

Erdfelder, E., Faul, F., & Buchner, A. (1996). GPOWER: A general power analysis program. *Behavior Research Methods, Instruments, & Computers, 28*(1), 1–11.

Field, A. (2010). *Discovering statistics using SPSS.* London, England: Sage.

Flores, G., & The Committee on Pediatric Research. (2010). Racial and ethnic disparities in the health and healthcare of children. *Pediatrics, 125*(4), e979 -e1020. Retrieved from http://pediatrics.aappublications.org/content/125/4/e979.full

Footracer, K. (2009). Immigrant healthcare in the United States: What ails our system? *Official Journal of American Academy of Sciences, 22*(4), 33-37.

Fortheringham, S., & Carlton, M. (2009). *Multiple dependent hypothesis tests in geographical weighted regression geocomputation.* Sydney, Australia: University of New South Wales.

Freeman, D. (2005). *Statistical models: Theory and practice*. New York, NY: Cambridge University Press.

Galimi, J. (2008). *Fallon community health plan capitalizes on integrated care*

management. Retrieved from http://mediaproducts.gartner.com/reprints /casenet/157466.html

Gelfand, D., & Hartmann, D. (1975). *Child behavior analysis and therapy*. New York, NY: Pergamon Press.

Geyen, D. (2012). Behavioral changes for African Americans to improve health, embrace culture, and minimize disparities. *ECI Interdisciplinary Journal for Legal and social Policy, 2*(1), 2.

Giljie, A., & Maltred, K. (2008). Obstruction for quality care experience by patients with chronic fatigue syndrome. *Patient Education Counseling, 73*, 36-41.

Goulding, C. (2002). *Grounded theory: A practical guide for management, business and market researchers.* Thousand Oaks, CA: Sage.

Greenhalgh, T., Plsek, P., Wilson, T., Fraser, S., & Holt, T. (2010). Response to the appropriation of complexity theory in healthcare. *Journal of Health Services Research, 15,* 115-117.

Gusmano, M. (2012). *Undocumented patients access to healthcare for undocumented: Immigrant as a family health issue*. Retrieved from www.undocumented patients.org/issue brief/healthcare use

Herbert, P., & Sisk, J., & Howell, E. (2008). When does a difference become a disparity? Conceptualizing racial and ethnic disparities in health. *Health Affairs, 27*(2), 374-382.

Houston, R., & Venkatesh, A. (1996). The healthcare consumption patterns of Asian immigrants: Ground theory implications for consumer acculturation theory.

Advances in Consumer Research, 23, 418-429.

Howie, J. (2009). Diagnosis in general practice and its implications for quality of care. *Journal of Health Services Research and Policy, 15*(20), 120-122.

Jones, C. (2010). The moral problem of health disparities. *American Health Journal of Public Health, 100*(S1), S47-*51.*

Kaiser Family Foundation. (2011). *Summary of new health reform law*. Retrieved from www.kff.org/healthreform

Kao, D. (2009). Generational cohorts. Age at arrival and access to health services among Asian and Latino immigrant adults. *Journal of Healthcare for the Poor and Underserved, 20*(2), 395-414.

Kaplan, S. (2011). Perception of Ghanaian immigrants on healthcare in NYC, unpublished raw data.

Karakowsky, L. (2001). Do we see eye-to-eye? Implications of cultural differences for cross-cultural management and practice. *The Journal of Psychology Research, 135*(5), 501-517,

Keller, S., Silberberg, M., Hartmann, K., & Micherne, J. (2010). Perceived discrimination and use of healthcare services in a North Carolina population of Latino immigrants. *Hispanic Healthcare International, 8*(1), 4-13.

Kenney, G., & Huntress, M. (2012). *The Affordable Care Act: Coverage implications and issues for immigrant families*. ASPE Issue Brief-342. Retrieved from http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Coverage/ib.shtml

Kirmayer, J. L. (2012). Rethinking cultural competence. *Transcultural Psychiatric, 49*, 149-164. doi: 10.1177/1363461512444673

Larson, K., & Halfon, N. (2010). Family income gradients in the healthcare access of children. *Maternal and Child Health Journal, 14*(3), 332-342.

Leighton, K., & Broaddus, M. (2008). Public and private health insurance: Stacking up the costs. *Health Affairs, 27*(4).

Marielle, O., & Hulscher, M. (2009). Implementation of integrated care for patients with cancer: A systematic review of interventions and effects**.** *International Journal for Quality in Healthcare, 21*(2), 137-144.

Mennin, S. (2013). *Health professional education: Complexity, teaching, and learning*. Handbook of systems and complexity in health. New York, NY: Springer.

Merriam, S. (2009). *Qualitative research: A guide to design and implementation*. San Francisco, CA: Jossey-Bass.

Moir, M. (2009). Contextual leadership: *The social construction of leadership in a comprehensive healthcare system* (Unpublished doctoral dissertation). Antioch University, Yellow Springs, Ohio.

Morgan, G. (1989). *Images of organization*. New York, NY: Sage.

Musah, A. (2009). Health update. The Bronx Ghanaian immigrant Muslim community (BGIMC). Unpublished community data.

Nadeem, E., Lang, J., Edge, D., Fongwa, M., Belin, T., & Miranda, J. (2007). Does stigma keep poor young immigrants and U.S.-born black and Latina women from seeking mental healthcare? *Psychiatric Services, 58*(12), 1547-1554.

Nam, Y., (2008). Welfare reform and older immigrants' health insurance coverage. *American Journal of Public Health. 98*(11), 2029-2034.

Nandi, A., Galea, S., Lopez, G., Nandi, V., Strongarone, & Ompad, D. (2008). Access to and use of health services among undocumented Mexican immigrants in a US urban area. *American Journal of Public Health, 98*(11), 2011-2020.

National Academy of Sciences (NAS). (2009). *Race ethnicity and language data: Standardization for healthcare quality improvement.* Washington, DC: The National Academies Press.

Office of Minority Health (OMH). (2007). *African immigration project. National African HIV/AIDS initiative (NAHI).* Retrieved from http://minorityhealth.hhs.gov/Assets/pdf/checked/1/NAHI_Summit_Reports.pdfSummit Reports.

Omoniyi, T. (2003). Local policies and global forces: Multi-literacy and Africa's indigenous languages. *Language Policy, 2*, 133-152.

Ormond, B., Palmer A., & Phaedra L. (2009). A profile of the uninsured. Health insurance survey. Urban Institute report

Racher, F., & Annis, R. (2008). Community health action model: Health promotion by community. *Research and Theory for Nursing Practice, 22*(3), 182-191.

Rittenhouse, D., Shortell, S., & Fisher E. (2009). Primary care and accountable care. *Two* essential elements of delivery-system reform. *New England Journal of Medicine. 361*, 2301-2303. DOI: 10.1056/NEJMp0909327

Robert Wood Johnson Foundation. (2011). *Lessons learned: Closing the gap* (Research Report). Retrieved from Robert Wood Johnson Foundation website: http://www.rwjf.org/content/dam/web-assets/2011/11/closing-the-gap

Rodriguez, M., Bustamante, A., & Ang, A. (2009). Perceived quality of care, and usual source of healthcare among undocumented and other Latinos. *Journal of General Internal Medicine, 24*(S3), 508–513.

Rosenbaun S. (2011). The Patient Protection and Affordable Care Act: Implications for public health policy and practice. *Public Health Reports, 126*(1), 130-135.

Ryan, P. (2009). Integrated theory of behavior change: Background and intervention development. *Clinical Nurse Specialist, 23*(3), 161-172.

Ryee, Y., Belmonte, F., & Weiner, S. (2009). An urban school based comparative study of experiences and perceptions differentiating public health insurance. Eligible immigrant families with and without coverage for children. *Journal of Immigrant Minority Health, 11*, 22-228.

Scambler, G. (2001). *Habermas critical theory and health.* New York, NY: Routledge.

Scherzer, M., Rejeske, J., & Gurvitch, A. (2010). Health insurance and immigrants: *Obstacles to enrollment and recommendations (Research Report).* Retrieved from New Yorkers For Accessible Health Coverage website: http://www.thenyic.org /sites/default/files/Health_Insurance_and_Immigrants_Report.pdf

Selden, M., & Sing, M. (2008). The distribution of public spending for healthcare in the United States. *Health Affairs*, 27, w349-w359.

Siman, F. (2009). Cross-cultural issues and healthcare: Advocacy for immigrants in North Carolina. *North Carolina Medical Journal, 70*(2), 149-152.

Shanafelt, C. (2013). *Treating uninsured immigrants after healthcare reform*. Retrieved from http://www.healthycal.org/archives/9983

Shaw, M., & Stahl, B. (2011). Quality and communication. The relevance of critical theory to health informatics. *Journal of the Association for Information Systems, 12*(3), 255-273.

Small, L. (2011). Determinants of physician utilization. Emergency room use and hospitalizations among populations with multiple health vulnerabilities. *Health 15*(5), 491-516.

Song, H., Han, H., Lee, J., Kim, J., Kim, K., Ryu, J., & Kim, M. (2010). Does access to care still affect healthcare utilization by immigrants? Testing of an empirical explanatory model of healthcare utilization by Korean American immigrants with high blood pressure. *Journal of Immigrant Minority Health, 12*, 513-519.

Snowden, L., & Fawley, K. (2008). Racial/ethnic minority children's use of psychiatric emergency care in California's public mental health system. *American Public Health Association, 98*(1), 118-124.

Sreenivasan, G. (2007). Health and equality of opportunity. *The Hastings Center Report, 37*(2), 21-31.

Stratton, A., Hynes, M., & Nepaul, A. (2007). *Defining health disparities* (Issue Brief). Hartford, CT: Connecticut Department of Public Health.

Suen, H., & Ary, D. (1989). *Analyzing qualitative behavioral observation data.* Hillsdale, NJ: Erlbaum.

Tabachnick, B. G., & Fidell, L. S. (2012). *Using multivariate statistics* (6th ed.). Boston. MA: Pearson.

The Bronx Ghanaian Immigrant Muslim Community Constitution. (1990). *Article 3-1*. Unpublished document.

The Henry J. Kaiser Family Foundation. (2008). *Summary: Five basic facts on immigrants and their healthcare: Medicaid and uninsured* (Issue Brief No. 7761). Menlo Park, CA: Author.

Thompson, Z. (2009). Voices that must be heard: Bronx Community College hosts African women's empowerment day. *New York Community Media Alliance: 36*(9), 15-36.

Thorpe, J., Thorpe, C., Kennelty, K., & Pandhi, N. (2011). Patterns of perceived barriers to medical care in older adults: A latent class analysis. *BMC Health Services Research, 11*, 181.

U.S. Department of Health and Human Services. (2010). *Healthy people: National health promotion and disease prevention objectives*. Washington, DC: Author.

U.S. Department of Health and Human Services. (2011). *Action plan to reduce racial and ethnic disparities: A Nation free of disparities in health and healthcare.* Washington, DC: Author. Retrieved from http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

Vaughn L., Jacquez, F., & Baker, R. (2009). Cultural health attributions, beliefs, and practices: Effects on healthcare and medical education. *The Open Medical Education Journal, 2*, 64-74.

Waitzkin, H. (1989). A critical theory of medical discourse: Ideology, social control, and the processing of social context in medical encounters. *Journal of Health and Social Behavior, 30*, 220-239.

Weinstein, M., & Skinner, J. (2010). Comparative effectiveness and healthcare spending implications for reform. *The New England Journal of Medicine, 132*(4), 460-465.

Wilde, B., Larssen, G., Larsson, M., & Starrin, B. (1994). Development of a patient-centered questionnaire based on a grounded theory model. *Scandinavia Journal of Caring Sciences, 8*(1), 39-48.

Wynd, C., Schmidt, B., & Schaefer, M. (2003). Two quantitative approaches for estimating content validity. *Western Journal of Nursing Research, 2*(5), 508-518.

Yu, S., Huang, Z., & Kogan, M. (2008). State-level healthcare access and use among children in US immigrant families. *American Journal of Public Health, 98*(11), 1996-2003.

Appendix A: Consent Form

CONSENT FORM TO PARTICIPATE IN A RESEARCH STUDY

You are invited to take part in a research study regarding Barriers to Healthcare Access at the Bronx Ghanaian Immigrant Muslim Community (BGIMC). You were chosen for the study because you are a member of BGIMC and you are 18 years of age or older. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

Adam A. Musah, who is a doctoral student at Walden University, is conducting this study.

Background Information:

The purpose of this study is to investigate issues on healthcare access among the BGIMC members and recommend steps to alleviate any barriers found. The result of this study will be used to provide health and general education initiatives at the Bronx Ghanaian Immigrant Muslim community.

Procedures:

If you agree to be in this study, you will be asked to: Complete a 10-30 minute paper and pencil survey

Voluntary Nature of the Study:

Your participation in this study is voluntary. This means that your decision to participate or not is up to you. No one at the BGIMC will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind during the study. If you feel stressed during the study you may stop at any time. You may skip any questions that you feel are too personal.

Compensation:

There are no compensations for participating in this study

Risks and Benefits of Being in the Study:

Some participants may feel uncomfortable addressing some of the questions asked. If you decide not to continue or refuse to answer any questions you consider invasive or stressful, this will not be held against you.

The result of this research will contribute to a positive social change in the Bronx Ghanaian Immigrant Muslim Community by providing data to base recommendations for appropriate intervention services.

Confidentiality:

Any information you provide will be kept confidential. The researcher will not use your information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in any reports of the study. Your signatures are not being collected in order to further protect your privacy, and your completion of the survey will indicate your consent, if you choose to participate.

Contacts and Questions:

You may ask any questions you have now. Or if you have questions later, you may contact the researcher. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Walden University's approval number for this study is IRB 11-15-0022887 and it expires on November 14, 2014.

You may keep the consent form.

Statement of Consent

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. In order to protect your privacy, your signature is not required. Completing the survey will indicate your consent to participate in the study.

Researcher's Signature _____

Appendix B: Survey Instrument

The Bronx Ghanaian Immigrant Muslim Community Healthcare Survey

This survey has been developed to gain more insight into the Bronx Ghanaian Immigrant Muslim Community members' healthcare access and use and other health related issues. Please be aware that there is no right or wrong answer, and that the outcome of the data gathered will be used to design health programs to benefit our community. You may decide not to complete the form or can withdraw at any time. Please do not write your name on the document.

YOU MUST BE 18 YEARS OR OLDER TO PARTICIPATE IN THIS STUDY

Location_____

Date_____

Demographic Questions

1. Are you a male (M) or a female (F)? (M)_____ (F)_____
2. In what year were you born? _____
3. What is highest level of education you have completed? (select only one)

o No schooling completed
o Nursery school to 8th grade
o 9th, 10th, or 11th grade
o 12th grade, no diploma
o High school graduate - high school diploma or the equivalent (for example: GED)
o Some college credit, but no degree
o Associate degree (for example: AA, AS)
o Bachelor's degree (for example: BA, AB, BS)
o Master's degree (for example: MA, MS, MEng, MEd, MSW, MBA)

o Professional degree (for example: MD, DDS, DVM, LLB, JD)

o Doctorate degree (for example: PhD, EdD)

4. What is your immigration status?

   (U.S. citizen or green card) _____ (neither) _____

5. How long have you lived in the Unites States?

   - o Less than 1 year
   - o 1 year
   - o 2 to 3 years
   - o 4 to 5 years
   - o 6 to 7 years
   - o 8 to 9 years
   - o 10 years or more

Health Related Questions

6A. If you are sick, do you know where to go look for help?

(Yes) _____ (No) _____

6B. If yes, where do you go?

- o Private Doctor
- o Herbalist or healer
- o Clinic
- o Emergency room
- o Other (specify)

7. During the last 12 months, was there any time when you had a medical problem but put it off, postponed, or did not seek medical care when you needed to?

(Yes) _____ (No) _____

8. Was there a time during the last 12 months when you needed to see a doctor, but could not because of the cost? (Yes) _____ (No) _____
9. In the past 12 months, which of the following healthcare providers or institutions, if any, have you used? (select all that apply)
    - Private doctor
    - Herbalist or healer
    - Clinic
    - Emergency room
    - Have not used a healthcare provider or institution in the past 12 months
10. **Answer if Private Doctor selected in #9 otherwise skip.** Overall, how satisfied or dissatisfied are you with the quality of healthcare you have received from your **Private Doctor**?
    - Very satisfied
    - Somewhat satisfied
    - Somewhat dissatisfied
    - Very dissatisfied
11. **Answer If Herbalist or Healer Selected in #9 otherwise skip.** Overall, how satisfied or dissatisfied are you with the quality of healthcare you have received from the **Herbalist or Healer**?
    - Very satisfied
    - Somewhat satisfied

- Somewhat dissatisfied
- Very dissatisfied

12. **Answer if Clinic selected in #9 otherwise skip.** Overall, how satisfied or dissatisfied are you with the quality of healthcare you have received from the **Clinic**?
    - Very satisfied
    - Somewhat satisfied
    - Somewhat dissatisfied
    - Very dissatisfied
13. **Answer if Emergency Room selected in #9 otherwise skip.** Overall, how satisfied or dissatisfied are you with the quality of healthcare you have received from the **Emergency Room**?
    - Very satisfied
    - Somewhat satisfied
    - Somewhat dissatisfied
    - Very dissatisfied
14. In the past 12 months, which of the following have you used <u>most frequently</u> for healthcare purposes? (Select only one)
    - Private doctor
    - Herbalist or healer
    - Clinic
    - Emergency room
    - Other (specify)
    - I have not used healthcare services

15. Do you have one person you think of as your personal doctor or healthcare provider?

    (Yes) _____ (No) _____

16. If yes to 15, which of the following do you consider your personal doctor or healthcare provider?

    - Private doctor
    - Herbalist or healer
    - Clinic
    - Emergency room
    - Other (specify)

17. How easy is it for you to obtain medical services when needed?
    - Not at all easy
    - Somewhat easy
    - Easy
    - Very easy
    - Extremely easy

18. About how long has it been since you last visited a medical doctor for a routine checkup?
    - Within the past year (1 to 12 months ago)
    - Within the past 2 years (1 to 2 years ago)
    - Within the past 5 years (2 to 5 years ago)
    - 5 or more years ago
    - Never

19. Has there been a time in the last two years when you did not do the following? Please indicate yes or no for each item below.

Did not follow the doctor's advice (Yes) _____ (No)_____

Did not follow the doctor's treatment plan (Yes) _____ (No)_____

Did not get a recommended test (Yes) _____ (No)_____

Did not see a referred doctor (Yes) _____ (No)_____

19A. If you break your arm, rate your willingness to go to the emergency room

- o Not at all willing
- o Somewhat willing
- o Willing
- o Very willing
- o Extremely willing

19B. If you experience dizziness, rate your willingness to seek medical care

- o Not at all willing
- o Somewhat willing
- o Willing
- o Very willing
- o Extremely willing

19C. If you have a severe fever, rate your willingness to go to the emergency room

- o Not at all willing
- o Somewhat willing
- o Willing
- o Very willing
- o Extremely willing

20. Do you have health insurance coverage?

    (Yes)_____ (No)_____

21. If Yes to Q20 otherwise SKIP: What type of health insurance coverage do you carry?

    - Employer provided_____
    - Self-purchased_____
    - Medicaid _____
    - Medicare_____
    - Other (specify) _____

Cultural Related Questions

22. What is your opinion about the following statement?

    "It is generally better to take care of your own health than to go to a doctor"

    - Strongly disagree
    - Somewhat disagree
    - Neither agree nor disagree
    - Somewhat agree
    - Strongly agree

23. Please answer true or false to the following questions:
    - Male healthcare provider seeing or touching my private parts prevents me from using healthcare services – (True)(False)
    - Female healthcare provider seeing or touching my private parts prevents me from using healthcare services – (True) (False)
    - Receiving healthcare services from providers not from my culture prevents me from using healthcare services – (True) (False)
    - Receiving healthcare services from a provider whose religion is different from mine prevents me from using healthcare services – (True) (False)

- I believe in traditional medicine only, so this prevents me from using healthcare services – (True) (false)

24. How often do you not follow a doctor's advice or treatment plan because it went against your personal beliefs?
    - Never
    - Rarely
    - Sometimes
    - Often
    - Always

25. If you could choose, would you prefer to be treated by a doctor who was male, a doctor who was female, or no preference?
    - Prefer male doctor _____
    - Prefer female doctor _____
    - No preference _____

This is the end of the survey. Thank you for finding time in your busy schedule to participate. The results of this survey will be used to provide health and general education initiatives at the BGIMC. Have a nice day/evening.

Appendix C: Research Documents Translation Letter

Ahamed Abubakar
[redacted]

November 03, 2013

Dear Sir/Madam,

Ref. Research Documents Translation

I have translated two research documents (a consent form and a survey instrument) for Mr. Adam Musah. The documents were translated from Hausa to English language.

I have many years of experience in English to Hausa translation and interpretation, and a native speaker of Hausa language as well. I work with several hospitals in the Bronx and the New York City public schools, interpreting for patients and students. I have a Master's degree in Computer Science and a Master of Science in Education. Further, I work as a mathematics teacher with the Kingsbridge International High School under the New York City Department of Education.

Please contact me at [redacted] if further information is required.

Sincerely,

[redacted]

Ahamed Abubakar

Appendix D: A Community Research Letter

AFRICAN PEOPLE ALLIANCE, INC.
Immigration • Health Care • Education
Cultural Exhibition • Housing • Legal Assistance

[redacted]

November 2, 2013

Adam A. Musah
[redacted]

Dear Mr. Musah,

ACCEPTANCE TO SERVE AS COMMUNITY RESEARCH PARTNERS

Based on my review of your research proposal, I give permission for you to conduct the study entitled Barriers to Health Care Access at the Bronx Ghanaian Immigrant Muslim Community at the African People Alliance facility. As part of this study, I authorize you to administer surveys to participants. Individuals participation will be voluntary and at their own discretion. We reserve the right to withdraw from the study at any time if our circumstances change.

We are with the understanding and agreement that the result of this study will be published by the institution involved. Further, data collected will remain entirely confidential and may not be provided to anyone outside of the research team without permission from the Walden University IRB.

I confirm that I am authorized to approve research in this setting.

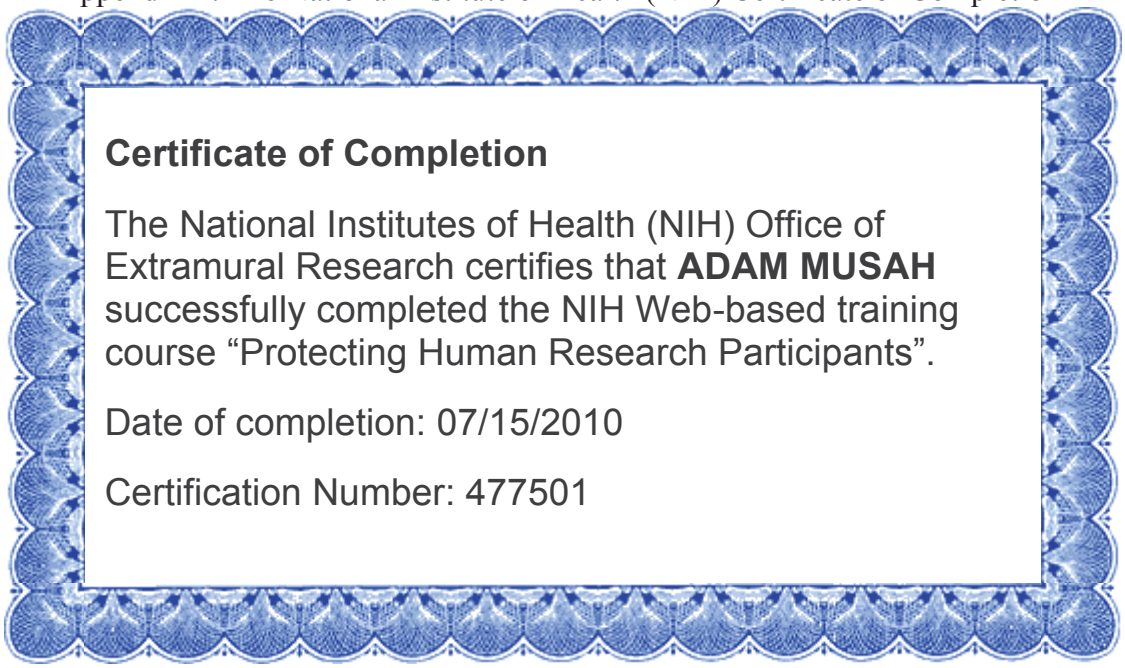
Thank you.

Sincerely,

[redacted]

Djouncdou Titikpina
President & CEO . African People Alliance, Inc.
[redacted]

Appendix E: The National Institute of Health (NIH) Certificate of Completion



Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **ADAM MUSAH** successfully completed the NIH Web-based training course “Protecting Human Research Participants”.

Date of completion: 07/15/2010

Certification Number: 477501

Appendix F: Permission to use Moderator Guide

From: Sue A Kaplan < >
To: Adam Musah < >
Date: Tue, Sep 6, 2011 9:40 am

Dear Mr. Musah:

Thank you for all of your expert advice and assistance with the focus groups I conducted with West African immigrants in New York. Please feel free to adapt and include the Focus Group Moderator Guide in your PhD dissertation, and to use any other materials resulting from our work together.

Best,
Sue A. Kaplan

Sue A. Kaplan, JD
Research Associate Professor
New York University School of Medicine
Division of General Internal Medicine

Appendix G: Copy Right Permission

RE: Copy Right Permission Request
From: Forrey, Scott <>
To: amusah
Date: Mon, Jun 2, 2014 6:19 am

Hi Adam,

Permission is granted. Please state "Used by permission of the Urban Institute" beneath the graph.
Good luck!

Scott Forrey Director,
Editorial Services and Publications
The Urban Institute
-----Original Message-----

From: amusah
Sent: Friday, May 30, 2014 5:05 PM
To: Forrey, Scott Cc:
Subject: Copy Right Permission Request

The Urban Institute
Hello Mr. Scott,
My name is Adam Musah and I am a graduate student at the Walden University. I would like to have a permission to use the Urban Institute analysis of 2009 American Community Survey graph that I found on the Google website. The graph is based on un insurance estimates for adults and children by citizenship status, and I would like to use that on my graduate research assignment. I will appreciate it if you grant me a permission to use it. I can also be reached at …….

Thank you Adam Musah

Curriculum Vitae

ADAM A. MUSAH

EDUCATION

Walden University – Minneapolis (MN)
PhD - Health Services Administration in progress as of Fall 2004
Specialization: Health Policy and Management
Expected date of graduation – May 2014
Dissertation topic – Barriers to Healthcare Access at the Bronx Ghanaian Immigrant Muslim Community.

City College of the City University of New York
Master of Science in Education, February 2004
Specialization: Elementary through High School Education
Relevant coursework: Teaching Strategies, Classroom Organization, Curriculum Development, and Individual Study in Educational Research

New York University, Robert F. Wagner Graduate School of Public Service
Master of Public Administration (MPA), May 2001
Specialization: Health Management and Finance
Relevant coursework: Advance Healthcare Payment Systems, Project Management, Financial Management, and Cost Accounting

Lehman College of the City University of New York

Bachelor of Science in Health Services Administration, 1998
Relevant coursework: Hospital Organization and Management, Finances in Healthcare Administration, Research and Program Evaluation in Health Services Administration, and Health Planning and Marketing

Bronx Community College of the City University of New York
Associate in Business Administration, June 1996
Relevant course work: Principles of Accounting I and II, Health Management and Business Law

TEACHING EXPERIENCE

University of Applied Management College in Ghana (UAM)
International Healthcare System, Healthcare Risk Management and Hospital

Management Instructor – from August 2013

Bronx Community College of the City University of New York
Healthcare Management Instructor – Adult Education Section - 3/2004 to present

Salome Urena Intermediate School (IS 218) – District 6, Manhattan, New York
Teacher – 7th and 8th grade mathematics 2001 – 2006

Globe School for Environmental Research – District 11, Bronx, New York
Teacher – 7th and 8th grade mathematics 09/2006 to 07/2013

Yankasa Adult Education Center Bronx, New York - Instructor
Taught adult basic education classes with strong emphasis on reading and writing from Jan. 2000 to Sept. 2003

Visiting Student/Instructor, Ghana Institute of Management and Public Administration (GIMPA) Accra, July 2000
Topic: Implications of healthcare delivery system of Ghana

ADMINISTRATIVE AND RELATED EXPERIENCE

Gouverneur Healthcare Center New York, NY 2000 - 2001
Consultant, NYU Advanced Project in Health Services Management and Finance

- Served on 5-person team consisting of NYU Wagner candidates to study the impact of Mandatory Managed Medicaid Enrollment on the health center
- Developed a set of objective indicators that the health center will use over time to monitor the rollout of Medicaid Managed Care
- Created a report describing the Medicaid Patient Base at the Health Center before and after Mandatory Managed Care implementation
- Produced a document projecting the fiscal and programmatic changes expected for the next five years based on one year's observation

Family Support Systems Unlimited, Inc. Bronx, NY 1998 – 2001
Accountant

- Worked closely with the Chief Accountant and the Director of Finance
- Managed accounts payable; Increased revenues by enforcing payment guidelines

- Responsible for Medicaid Remittance, analysis and reports
- Prepared monthly and quarterly program expense reports to NYC and NYS
  Department of Social Services and Administration for children services (ACS)
- Supervised college interns and trained special program candidates

RESEARCH EXPERIENCE

New York University, Robert F. Wagner graduate school of public service
Independent Research – Implications of healthcare delivery system of Ghana
Interviewed the following persons: The Deputy Director of GIMPA - Prof. S. A. Amoa, The Deputy Director of the Ministry of Health - Dr. John O. Gyapong, the Director of Orthopedics at the Korlebu Teaching Hospital - Dr. Segbenu, and about 200 inpatients and outpatients at the health center

Independent Study Directors: Prof. Dennis Smith, the Director of the Office of International Program, New York University and Dr. Stephen Adei Director of GIMPA, Ghana

City College of the City University of New York
The effect of manipulative on students' mathematics achievement in the New York public schools, May 2003. Research site, IS 218, a middle school in upper Manhattan Directors: Prof. J. Seltzer and Prof. Kopelman Max, Department of Education, City College

RESEARCH INTERESTS

- The most effective healthcare delivery system across the continent of Africa
- Comparative Analysis - The most effective healthcare delivery system among the following countries: The United States, Canada, Japan, China, Germany and France

- The most effective math teaching methodology world-wide from pre-k through 12 grades
- The effect of environment on students' behavior in the classroom

SCHORLARSHIPS, AWARDS AND HONORS

Upsilon Phi Delta Academic Honor Society – Walden University, Fall 2013 – PhD Program
Golden Key National Award - Walden University, Fall 2013 – PhD Program
Golden Key National Award, City College, Fall 2003
Public Service Scholarship, New York University, Fall 2001

Herbert Lehman College, BS Degree in Health Services Administration
Magma cum Laude June 1998, Dean's List 1997, Departmental Honors and the Golden Key National Award, fall 1997

Bronx Community College, Bronx, New York
AS Degree, June 1996 in Business Administration
Dean's List, 1995 and1996, Academic All Region Award, fall 1995
Phi Theta Kappa International Scholastic Honor Society and Alpha Beta Gamma International Business Honor Society

Outstanding Leadership Award in Ghanaian Community in the United States of America by Nima Association of New York, Incorporation, August 2000

CERTIFICATION

New York State and New York City Certified and Tenured Public School Teacher

PAPERS AND PRESENTATIONS

Presentation of research findings on the effect of math manipulative on students' test scores at the City College of the City University of New York, Fall 2003

Presentation of research findings on the implications of the healthcare delivery system of Ghana at the New York University on July 2000

Presentation of research findings on the Impact of managed care on the financial outcome of Gouverneur healthcare facility at the health facility in Manhattan on April 2001

Workshop presentation at Lehman College, July 2003 – Topic: Curriculum Development

directed by Dr. C. Folsom

PROFESSIONAL AFFILIATION

Member – Healthcare Financial Management Association (H.F.M.A.)

President – Yankasa Association of U.S.A. Incorporation (form 2005 to 2009). A Ghanaian non-profit and cultural organization located in the Bronx – New York.

COMMUNITY SERVICE/INVOLVEMENT

Events Director, Yankasa Association Annual fundraiser dinner dance
Educational consultant, Ghanaian community in the Bronx