2016

An Analysis of Western Medicine Mistrust Among Selected African Immigrant Women in Minnesota

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By

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A Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of
Master of Science in Community Health Education
In
the Department of Health Science

May 2016

ENDORSEMENT

April 5, 2016

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ABSTRACT

Mistrust in Western medicine contributes to many individuals noncompliance, avoidance of treatment, or seeking other outlets or alternative treatments. As a result, health outcomes are poorer for those individuals who proactively avoid treatment from health care professionals. Factors that contribute to racial and ethnic health disparities have been accounted for in research and literature; however, immigrant health disparities have not been well studied. The primary purpose of this study was to analyze factors that contributed to Western medicine mistrust among selected African immigrant women in Minnesota. Participants were recruited from community centers, churches, and by snowball sampling within the Minneapolis-Saint Paul metropolitan area. Data was collected from twenty-one participants who completed the survey instrument. Qualitative and quantitative methods were used to collect data from African women who have immigrated to Minnesota and who have had at least one interaction with a health care provider who practices Western medicine. Findings indicated that the majority of the respondents were somewhat likely to trust Western medicine health care professionals and treatments. Many women also specified that they feared prescribed medications and

their effectiveness, being used as an experiment, and ill intentions of Western health care practitioners towards Africans.

AKNOWLEDGEMENTS

First, I would like to thank my advisor, Dr. Joseph Visker, for his guidance and insight throughout the entire graduate process. You were there to answer my questions and steer me in the right direction whenever I was lost.

I would also like to thank my committee members, Dr. Judith Luebke and Dr. Mark Windschitl for their helpful revisions, hard questions, and encouragement.

Most importantly, I must express my very profound gratitude to my mother who has pushed me to further my education and to be the best at all times. You are my rock.

And finally, I am so grateful to my husband for his unfailing support and continuous encouragement throughout my years of study.

This accomplishment would not have been possible without all of you.

Thank you.

Wanjiru

For Maitu

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CHAPTER 1

Statement of the Problem

Introduction

The United States is home to the world's best medical facilities, doctors, medications, and treatment options. Despite access to these premier healthcare services, many individuals avoid healthcare professionals who practice Western medicine. Health beliefs and behaviors are heavily influenced by culture (Betancourt, 2006). When a patient and a doctor meet, there are usually two cultures that are coming together in the same setting. This can present barriers such as miscommunication, misunderstanding, and mistrust of Western medicine. What often results, are physicians who do not understand their patients' perspectives and patients who are reluctant to adhere to their physicians' medical advice (Kleinsinger, 2010).

When treatment options are provided to patients, many do not follow through for a variety of reasons. Affordability, health literacy, beliefs, communication skills and mistrust affect the way we make decisions about our health. In a study that examined medical mistrust among black women who were at an increased risk for carrying breast cancer genes, known as, BRCA1/2 mutations, researchers found that the women with higher medical mistrust had lower genetic counseling and testing engagement (Sheppard, Mays, LaVeist, & Teryak, 2013). Conversely, the researchers found that women with lower medical mistrust had greater genetic counseling and testing engagement (Sheppard et al., 2013). In this study, the researchers utilized the Medical Mistrust Index and an overall score was created to assess a range of medical mistrust (Sheppard et al., 2013).

This points to the consequences of unmanaged health conditions that have the potential to develop into chronic diseases or early mortality. In a study that investigated noncompliant patients, trust between the patient and physician was an important factor that influenced patient compliance (Kleinsinger, 2010).

When the Affordable Care Act was signed into legislation in 2010, the number of insured Americans drastically increased. In the last five years, approximately 16.4 million uninsured individuals have gained access to health coverage (U.S. Department of Health and Human Services [DHHS], 2015). Millions of people who did not have health insurance, were given the opportunity to become insured. Even with increased access to healthcare services, gaps in care continue to exist in the United States. For instance, in 2013, nearly 32% of all immigrants in the United States remained uninsured (Migration Policy Institute, 2015).

Statement of the Problem

In 2013, roughly 41.3 million immigrants lived in the United States (Migration Policy Institute, 2015). When compared to the native-born population, immigrants were three times more likely to be uninsured (Migration Policy Institute, 2015). As a result, healthcare access among immigrants in the United States is poor when compared to native-born populations. Additionally, many immigrants believe that seeking medical treatment can lead to difficulties with immigrant officials (Migration Policy Institute, 2015). Mistrust in Western medicine may cause many individuals to be noncompliant, to avoid treatment, or to seek other outlets and alternative treatments such as traditional healing methods that are part of their cultural heritage (Carteret, 2013).

Significance of the Problem

Research has shown that health disparities contribute to immigrant populations to poor health status and outcomes. While factors that contribute to racial and ethnic health disparities have been accounted for in research and literature, immigrant health disparities have not been well studied (Edberg, Clearly, & Vyas, 2010). There are gaps in the health system that are overlooked and consequently, many lives are affected. I believe that the health education profession's "patient" is the community; therefore, every aspect of health and every person should be represented. Marginalized populations deserve to be studied so that they too, have an equal opportunity for living healthy lives.

Mistrust of Western medicine is an issue that cannot be ignored any longer. At this time, there is minimal research available on mistrust of Western medicine from African immigrants. By directing my focus specifically on African immigrant women in Minnesota, I can contribute to the health education discipline by providing insight as to why certain individuals or groups of people avoid and mistrust effective medical treatments.

As a health coach, I have the opportunity to provide health education to men and women from very diverse backgrounds. One recurring theme that I have noticed over the last seven years in my coaching practice is the lack of trust that many individuals have in Western medicine. This trend sparked my interest because I am passionate about guiding individuals to wellness through evidenced based medicine. So when there is a barrier, such as mistrust, I feel obligated to understand the issue.

By studying the attitudes, knowledge, and perceptions of Western medicine among African immigrant women in Minnesota, the community health education and

health sciences disciplines will gain insight into the factors that may prevent this sample from trusting Western medicine. Public health and medical professionals can then establish meaningful ways to actively engage African immigrant women so that their level of trust for Western medicine increases.

Research Questions to be Answered

- For sampled African immigrant women, what factors contributed to trusting medical advice from physicians who practice Western medicine?
- For sampled African immigrant women, what factors detracted from trusting medical advice from physicians who practice Western medicine?
- What were sampled African immigrant women's attitudes or perceptions towards Western medicine?

Limitations

1) Due to finite resources, the study sample was limited to 21 participants.
2) Participants may have been reluctant to participate for the fear of being judged or chastised for being non-compliant with medical treatments.
3) Language barriers may have interfered with assessing an individual's level of mistrust in Western medicine.
4) The requirement for the participant to be proficient in English may have decreased access to a more representative study sample.
5) The researcher developed the survey instrument and validity of the survey instrument and validity was not confirmed from pilot testing.

Delimitations

1) The study sample was recruited through community settings such as church organizations, community centers, and snowball sampling. I recruited participants using non-probability sampling methodology in order to collect qualitative and quantitative data that were representative of the study sample.
2) The participants were adult women, aged 18 or older, of African decent, proficient in English, and who had immigrated to Minnesota and had spent one year in the United States. The study sample consisted of 21 participants who resided in Minnesota.

Assumptions

1) Identifying, studying, and analyzing gaps in care were worthwhile endeavors that may have yielded meaningful outcomes.
2) Western medicine mistrust among African immigrant women in Minnesota may be significant; yet there is minimal literature available.
3) Recruited participants understood the Likert scaling questions.

Definition of Terms

Health disparity: Inequalities in health status between more and less advantaged groups (National Cancer Institute, 2015).

Immigrant or Permanent resident alien: An individual who legally moves to a foreign country as a permanent resident (U.S. Department of Homeland Security, 2015).

Medical distrust/mistrust: A wariness or pessimistic outlook of a vulnerable situation in which a patient receiving care believes that the health care

professional has negative intentions or motivations for their (the patient's) health (Hall, Dugan, Zheng, & Mishra, 2001).

Medically uninsured: A person who does not have any private health insurance, Medicare, Medicaid, CHIP, state-sponsored or other government sponsored health plan (Centers for Disease Control and Prevention [CDC], 2013).

Mistrust: To have doubts or lack confidence in another person's intentions (Merriam-Webster, 2015).

Noncompliant patient: A patient who does not adhere to taking their medications, following medical treatment plans prescribed by their doctors, and/or avoids healthy behaviors (Kleinsinger, 2010).

Western medicine: A system that is utilized by healthcare professionals that treats symptoms and diseases with drugs, radiation, or surgery (National Cancer Institute, 2015).

CHAPTER 2

Review of Literature

Introduction

Many individuals immigrate to the United States to pursue freedom, opportunity, safety, access to health care services, and new beginnings. Since the early 1800s, the United States has been popularly known "as the land of the free, home of the brave". For many, this is the land where people are given the chance to improve their lives. In 2013, the United States was home to approximately 41.3 million immigrants (Zong & Batalova, 2015). In this context, an immigrant is defined as an individual who resides in the United States and who does not have U.S. citizenship at birth (DHHS, 2015). Immigration is at an all time high and many economists predict that it will continue to grow (Zong & Batalova, 2015).

Twenty percent of international migrants have moved to the United States (Zong & Batalova, 2015). As a result of this dynamic shift, life in the United States is impacted by immigration at varying levels and capacities. Communities, workforces, classrooms, policies, and culture are all influenced by the evolving demographics of the United States.

An area notably impacted by immigration is the United States health care system. Research has shown that racial and ethnic disparities in health exist among immigrants (Betancourt, 2006). These health disparities contributed to poorer health outcomes when compared to native-born individuals (Betancourt, 2006). Furthermore, nearly thirty two percent of immigrants do not have health insurance (Zong & Batalova, 2015).

Preventable and treatable diseases such as HIV/AIDS, heart and blood vessel diseases, diabetes, cancer, and asthma are largely unmanaged and exacerbated among immigrants in the United States (Betancourt, 2006).

Immigrant health matters because every individual in the United States deserves the opportunity to have freedom, opportunity, safety, access to health care services, and new beginnings. This chapter will review the current state of immigrant health research, the scope of the issue, the health status of today's U. S. immigrants, and the challenges that immigrants face with Western health care services.

Current State of Immigrant Health Research

Despite the growing trend of immigrants relocating to the United States, there is insufficient research that focuses on immigrant health and well-being (Edberg, Clearly, & Vyas, 2010). As a result, immigrant health is severely understudied and practically invisible in the United States. This public health dilemma of immigrant health is contributing to a large gap in care for immigrants. Many researchers argue that comprehensive research is needed in order to create an effective framework that will guide the planning, implementation, and evaluation of interventions for immigrant health (Edberg, Clearly, & Vyas, 2010). This information would add to the current understanding of health and immigration status.

The Minnesota Immigrant Task Force (2005) recommends that all health care providers collect information on language preference, ethnicity and race of all patients, to demonstrate of the provider's ability to support the patient. The Task Force believes that this pertinent information will contribute to improvements in care for immigrants because the information provided by the patient would reveal a health care facility's ability to

serve their patients needs (Minnesota Immigrant Task Force, 2005). The current state of immigrant health research is sparse and not comprehensive. Therefore, little is known about immigrant health in general.

Scope of the Issue

Available evidence suggests that medical and public health communities recognize that there are significant opportunities for engaging ethnic and minority individuals in health care services in the United States (Betancourt, 2006). Specifically, social determinants such as low levels of education, low socioeconomic status, inadequate housing, and living near hazardous industrial material, affect the overall health of minority and ethnic populations (Betancourt, 2006). Additionally, lack of access to care contributes to minority populations' poor health outcomes (Betancourt, 2006). Also, due to the costs associated with being treated by health care providers, many immigrants are less likely to adhere to treatment by providers (Betancourt, 2006).

Furthermore, studies have shown that disparities exist with physician referrals to specialty care, general services covered by Medicare, and diagnostic and therapeutic procedures for ethnic and minority groups (Betancourt, 2006). Consequently, ethnic and minority individuals who do seek health care services may not be treated the same as native born, white Americans. For example, in a cross-sectional study conducted from 1994 to 2002, observed sex and racial differences were noted in acute myocardial infarction treatments of 598,911 patients (Vaccarino et al., 2005).

Health Status of Today's U. S. Immigrants

The evidence shows that racial and ethnic health disparities exist in the United States. Due to the poor health outcomes that result, immigrant health must be researched in order to combat a preventable health endemic. Although there is variation among different ethnic groups and within groups, the common health issues for immigrants in the United States include poor mental health (including depression), obesity, diabetes, tuberculosis, nutritional deficiencies, intestinal parasites, chronic hepatitis B infection, and lack of immunization (Edberg, Clearly & Vyas, 2010).

Research has shown that at the time of arrival, immigrants who come to the United States on work visas or as a spouse of a U. S. citizen are more likely to have better health than the average native-born Americans (Edberg, Clearly & Vyas, 2010). However, longitudinal study of children of immigrants revealed that immigrants who reported to have good health at the time of their arrival eventually saw a decline in their health status (Hernandez & Charney, 1998). Moreover, immigrants who come to the United States as spouses of permanent resident aliens typically had poorer health than the immigrants who were married to U. S. citizens (Edberg, Clearly & Vyas, 2010). This research was supported by a large longitudinal study, the Children of Immigrants Longitudinal Study, which followed a sample of 5,200 children of immigrants from 1991 - 2006(Edberg, Clearly & Vyas, 2010).

Challenges Immigrants Face with Western Health Care Services

As the United States becomes increasingly diverse, it is imperative for researchers to add to the existing dearth of immigrant health literature. In order to develop a

framework and best practices for improving the health status of immigrants, current challenges faced in Western healthcare systems must be identified and standardized (Edberg, Clearly, & Vyas, 2010). Medical mistrust can stem from a number of factors including reluctance to trust government agencies and institutions, negative experiences, and exclusion (Edberg, Clearly, & Vyas, 2010). Lack of knowledge of healthcare services, attitudes towards accepting public assistance, and language and cultural differences are also barriers that keep many immigrants and their families from accessing and trusting Western medical health services (Hernandez & Charney, 1998). Researchers who surveyed nearly 7,000 culturally diverse adults in the U. S., found that 65% of African Americans and 58% of Hispanics, compared to 22% of whites, were fearful of being treated unfairly because of their race and ethnicity (Betancourt, 2006). Additional studies have shown that there is a negative association between perceived discrimination and health, indicating that as perceived discrimination increases, overall health decreases (Edberg, Clearly, & Vyas, 2010). Betancourt also found that individuals had trouble understanding their medical doctor, felt that their medical doctor did not listen, and were afraid to ask medical questions (2006).

From a healthcare provider's perspective, lack of cultural competence, language barriers, and cultural insensitivity detract from their ability to provide quality healthcare services to immigrants (Hernandez & Charney, 1998). Due to the diversity within one's own culture, it is nearly impossible for healthcare providers to have great understanding of an immigrant individual's culture (Betancourt, 2006). Rather, medical schools in the United States are providing students with tools to bridge "cultural distancing" (Betancourt, 2006).

Summary

In summary, there are many factors that contribute to poor immigrant health outcomes in the United States. Despite the health resources that are available, a lack of trust in Western medicine precludes optimal health and well-being within this community. As the United States diversifies, so will the need for representative research, new data, a meaningful variation in health care delivery, improved communication skills, and more trusting relationships between immigrant patients and their health care providers.

CHAPTER 3

Methodology

Research Procedures

Published research on Western medicine mistrust among African immigrant women is limited. In an effort to contribute to the health science literature, specific information from this study sample was collected. I observed, measured, and analyzed the attitudes, knowledge, perceptions, and level of mistrust of Western medicine among sampled African immigrant women in Minnesota. My goal was to study the degree to which these women mistrust Western medicine and to identify the factors that influence their trust in Western medicine. In an effort to capture an accurate snapshot of the study sample, I collected data from African immigrant women who frequent cultural centers and churches in the Minneapolis-Saint Paul metropolitan area. These research settings allowed me to gain access to a representative sample. This chapter will review the research design, rationale for design, subject selection, instrumentation, data collection procedures, data processing and analysis, and study replication.

Description of Research Design and Rationale for Choice

A qualitative and quantitative research design was used to examine Western medicine mistrust among selected African immigrant women in Minnesota. This type of data collection and analysis provided a broader understanding of the issue. Survey research provided insight into the participants' attitudes, beliefs, and understanding of Western medicine treatments and health care providers.

Subject Selection

The subjects for this study were recruited at community centers, churches, and by snowball sampling within the Minneapolis-Saint Paul metropolitan area. Snowball sampling, a non-probability sampling technique, was used to recruit additional participants for the study. Subject selection criteria included: 1) female gender; 2) aged 18 to 79 years; 3) immigrated from Africa; and 4) have lived in the United States for at least one year. Additionally, sampled subjects were required to have had at least one interaction with a physician who practices Western medicine in the United States. Furthermore, subjects must have been able to independently make their own medical decisions, without a personal representative. These qualifications best reflected the purpose of this research.

Instrumentation

A survey instrument was used to assess mistrust of Western medicine among selected African immigrants in Minnesota. The purpose of the survey instrument was to acquire data on the study sample's experience with physicians, who practice Western medicine; to identify factors that contribute to trust and mistrust of Western medicine physicians and treatments; and to assess attitudes towards Western medicine.

The survey consisted of twenty questions that were designed to answer the three research questions of this study. Research question one and two were each comprised of two quantitative survey questions and one qualitative survey question. Research question three was comprised of seven quantitative survey questions. There were two qualitative survey questions that were open-ended questions, eleven quantitative questions that were

Likert-scale questions, and there were seven demographic questions. All answers were kept confidential. See Appendix A for the survey instrument.

Data Collection Procedures

Data collection began shortly after the IRB Approval Letter was generated. See Appendix E for the IRB Approval Letter. On February 20, 2016, an Organization Email Template was sent to community centers and churches in the Minneapolis-Saint Paul metropolitan area. See Appendix D for the Organization Email Template. Meeting times were set up with organizations that replied and agreed to participate in the study. Prior to my arrival to the organization, the study was explained to potential subjects. I met those subjects in a separate room, screened them according to the subject selection criteria, and explained the scope of the study to those who were eligible to participate. Those who did not meet the selection criteria were thanked for their time and asked to exit the room. The remaining recruited subjects were asked to read and verbally agree to the Informed Consent Form. See Appendix B for Informed Consent Form. Next, the survey instrument was administered in English to all subjects that verbally agreed to the Informed Consent Form. Once subjects completed the survey, they were provided with a Participant Recruitment Handout to give to other individuals whom they thought would be eligible and interested in participating in the study (snowball sampling). See Appendix C for the Participant Recruitment Handout. Subjects that were recruited via snowball sampling, contacted me, were screened according to the subject selection criteria, and a time to meet was set up with those who were eligible to participate in the study. Those who did not meet the study criteria were thanked for their time. I met the potential subjects in local areas, explained the scope of the study, provided the subjects with the Informed

Consent Form, and upon verbal agreement to participation, administered the survey instrument. When the recruited subject completed the survey, they were provided with a Participant Recruitment Handout. All subjects had as much time as they needed to take the survey, ask any questions that they may have had about the study during the survey, and after the survey had been completed. Twenty-one surveys were administered from February 20, 2016 to March 20, 2016.

Data Processing and Analysis

Data was summarized and organized in a table format. The data were categorized by research question and all answers were analyzed. Descriptive statistics such as frequencies and percentages as well as measures of central tendency were used to summarize the data. Responses to open-ended questions were summarized by recurring themes. One goal of data processing and analysis was to determine if there were any patterns or similarities among the responses. Another goal of the data processing and analysis was to learn about mistrust of Western medicine among African immigrant women.

CHAPTER 4

Findings

Data Analysis

The study sample consisted of 21 African immigrant women who lived in the Minneapolis-Saint Paul metropolitan area for a minimum of one year. The average number of years of residency in the United States was 11.5 years. The majority of the women or 47.60% (n=10), were from Kenya, 33.30% (n=7) of the women were from Liberia, and 19.00% (n=4) of the women were from Somalia. Fifteen respondents reported visiting a Western health care practitioner 1 to 3 times in the last twelve months (71.40%), while 14.3% (n=3) visited 4 to 6 times, and 9.5% (n=2) visited 7 or more times in the last 12 months. The payment method used by fifteen respondents was health insurance (71.40%), such as private insurance or employer sponsored health insurance. The age distribution of the study sample ranged from 19 to 63 years. See demographic Table 4.1 Age Distribution. Other frequent characteristics of the study sample included thirteen respondents having a college degree or higher (61.90%), and thirteen respondents being married (61.90%). Table 4.2 provides the frequency and percentage for the respondents' education level.

Table 4.1

Age Distribution

Age Range	Frequency	Percent
18 - 29	8	38.1
30 - 39	5	23.8
40 - 49	1	4.8
50 - 59	5	23.8
60 - 69	1	4.8
Missing Data	1	4.8
Total	21	100.0

Table 4.2

Education

Level	Frequency	Percent
High School diploma or GED	6	28.6
College degree or higher	13	61.9
Missing Data	2	9.5
Total	21	100.0

Research Question 1

Research question 1 asked, "*For sampled African immigrant women, what factors contributed to trusting medical advice from physicians who practice Western medicine?"* Quantitative and qualitative data were collected to address the first research question. Table 4.3 reports findings from two quantitative survey questions that were used to analyze research question one. Findings showed that five respondents somewhat believed (23.80%) and five respondents mostly believed (23.80%) that access to physicians who practice Western medicine improved their quality of life, while 14.3% (n=3) of the study sample never believed. Nine respondents (42.90%) reported that their health improved when they followed Western medicine treatment plans from their health care provider. The third question, which was qualitative in nature, addressed factors that contributed to

trusting medical advice from physicians who practice Western medicine. Table 4.4 highlights the themes of the responses that were given most often by participants.

Table 4.3

Research Question 1: For sampled African immigrant women, what factors contributed to trusting medical advice from physicians who practice Western medicine?

Survey Question 10	Strongly believe *n (%)*	Mostly believe *n (%)*	Somewhat believe *n (%)*	Rarely believe *n (%)*	Never believe *n (%)*
I believe that access to physicians who practice Western medicine has improved my quality of life.	4 (19.0)	5 (23.8)	5 (23.8)	4 (19.0)	3 (14.3)
Total 21					

Survey Question 5	All of the time *n (%)*	Most of the time *n (%)*	Some of the time *n (%)*	Rarely *n (%)*	Never *n (%)*
My health improves when I follow Western medicine treatment plans from my health care provider.	3 (14.3)	6 (28.6)	9 (42.9)	1 (4.8)	2 (9.5)
Total 21					

Table 4.4

Survey Question 12: What are the most important factors that contribute to trusting medical advice from physicians who practice Western medicine?

Survey Question 12 Themes	Open-Ended Responses	
	Physicians have a lot of knowledge and are well educated	Lab tests, diagnostic tests are mostly accurate
	There are many medical specializations in Western medicine	Physicians use research and medical studies patient treatment decisions

Research Question 2

Research question 2 asked, "*For sampled African immigrant women, what factors detracted from trusting medical advice from physicians who practice Western medicine?"* Table 4.5 shows the quantitative findings that pertained to research question two. When asked about relying upon traditional healing methods, five respondents (23.80%) selected most of the time, five respondents (23.80%) selected some of the time, and five respondents (23.80%) selected never (23.80%). Furthermore, six respondents (28.60%) selected that they sought medical advice from traditional healers when they got sick, while 9.50% (n=2) of the study sample never sought medical advice from traditional healers when they got sick. Table 4.6 identifies the trends that contributed to the study sample's mistrust of medical advice from physicians who practiced Western medicine. The most common themes were 1) pharmaceutical drug effectiveness and chemical drug properties, 2) fear of wrongful experimentation on Africans, and 3) ill intentions from

health care professionals. Respondents reported that they did not trust pharmaceutical drug effectiveness, they believed that there were too many "poisonous" chemicals in drugs, they feared being treated as an experiment with treatment plans that they received from health care professionals, and the respondents noted that they did not trust that their health care providers had the best intentions for their health.

Table 4.5

Research Question 2: For sampled African immigrant women, what factors detracted from trusting medical advice from physicians who practice Western medicine?

Survey Question 4	All of the time *n (%)*	Most of the time *n (%)*	Some of the time *n (%)*	Rarely *n (%)*	Never *n (%)*
I rely upon traditional healing methods from my country of birth.	3 (14.3)	5 (23.8)	5 (23.8)	3 (14.3)	5 (23.8)
Total 21					
Survey Question 3					
When I get sick, I seek medical advice from traditional healers.	2 (9.5)	6 (28.6)	5 (23.8)	3 (14.3)	5 (23.8)
Total 21					

Table 4.6

Survey Question 13: What are the most important factors that contribute to mistrusting medical advice from physicians who practice Western medicine?

Survey Question 13 Themes	Open-Ended Response		
	Mistrust of white/Western health care workers	Less experienced physicians/health care workers	Unfair treatment due to race/culture/religion
	Medications have side effects and do not work well	Lack of patient education	Physician/insurance monetary profit from patients
	Physicians may have bad intentions for people color	Fear of being used as an experiment for treatments	Too many chemicals in drugs
	Physicians may prescribe the wrong medications or treatments	Health care workers do not listen to me/understand my culture	Racial history, colonialism, wrongful experimentation on Africans/Blacks

Research Question 3

Research question 3 asked, "*What were sampled immigrant women's attitudes or perceptions towards Western medicine?"* Seven quantitative questions were used to analyze research question three. Table 4.7 shows the findings of these survey questions. The findings indicate that the study sample was very comfortable with going to and talking about their medical concerns to a physician who practiced Western medicine. The respondents were more likely to believe in Western treatments than traditional healers and their treatments. When asked about trusting medical advice from Western health care professionals, six respondents reported that they somewhat trusted (28.60%) Western

health care professionals. Seven respondents selected never (33.30%) when asked if they trusted traditional healers and their treatments.

Table 4.7

Research Question 3: What were sampled immigrant women's attitudes or perceptions towards Western medicine?

Survey Question 1	Very comfortable *n (%)*	Mostly comfortable *n (%)*	Somewhat comfortable *n (%)*	Rarely comfortable *n (%)*	Never comfortable *n (%)*
How comfortable are you with going to a physician who practices Western medicine?	7 (33.3)	4 (19.0)	6 (28.6)	3 (14.3)	1 (4.8)
Total 21					

Survey Question 2	Very comfortable *n (%)*	Mostly comfortable *n (%)*	Somewhat comfortable *n (%)*	Rarely comfortable *n (%)*	Never comfortable *n (%)*
I feel comfortable talking about my medical concerns with physicians who practice Western medicine.	7 (33.3)	5 (23.8)	5 (23.8)	2 (9.5)	2 (9.5)
Total 21					

Survey Question 11	Strongly believe *n (%)*	Mostly believe *n (%)*	Somewhat believe *n (%)*	Rarely believe *n (%)*	Never believe *n (%)*
I believe that physicians who practice Western medicine have the ability to help me manage my health.	6 (28.6)	6 (28.6)	4 (19.0)	3 (14.3)	2 (9.5)
Total 21					

Survey Question 8	Strongly trust *n (%)*	Mostly trust *n (%)*	Somewhat trust *n (%)*	Rarely trust *n (%)*	Never trust *n (%)*
I trust in Western medicine treatments.	6 (28.6)	3 (14.3)	7 (33.3)	3 (14.3)	2 (9.5)
Total 21					

Survey Question 7	All of the time *n (%)*	Most of the time *n (%)*	Some of the time *n (%)*	Rarely *n (%)*	Never *n (%)*
I trust traditional healers and their treatments.	3 (14.3)	2 (9.5)	4 (19.0)	5 (23.8)	7 (33.3)
Total 21					

Survey Question 9	Strongly trust *n (%)*	Mostly trust *n (%)*	Somewhat trust *n (%)*	Rarely trust *n (%)*	Strongly distrust *n (%)*
I trust the medical advice I receive from my health care provider.	4 (19.0)	6 (28.6)	6 (28.6)	3 (14.3)	2 (9.5)
Total 21					

Survey Question 6	All of the time *n (%)*	Most of the time *n (%)*	Some of the time *n (%)*	Rarely *n (%)*	Never *n (%)*
I trust physicians who practice Western medicine.	4 (19.0)	5 (23.8)	6 (28.6)	4 (19.0)	2 (9.5)
Total 21					

Summary

The findings from this study show that the study sample was more likely to trust Western medicine than traditional medicine from their country of birth. The respondents selected somewhat trust and some of the time for survey questions that were related to Western medicine treatments or health care professionals. The study sample valued Western health care professionals years of education in the medical field, access to labs and diagnostic testing, and relatively accurate results. Alternatively, respondents had concerns with Western pharmaceutical drugs, fear of being used as an experiment, and respondents did not trust that their health care provider had the best intentions for their health.

CHAPTER 5

Summary, Conclusions and Recommendations

Summary

In summary, this research study was unique because it focused on a topic and study sample that has been minimally researched. The data that were collected shows that while the studied sample somewhat trusted Western medicine; there were still opportunities for medical and public health professionals to develop more meaningful relationships with African immigrant women. The themes from the qualitative data highlighted specific factors that contributed to and detracted from trusting medical advice from physicians who practiced Western medicine among the study sample.

Interpretation of Findings

The demographic data indicates that the majority of the studied sample was highly educated and relatively young in age. Many of the participants that were studied, lived in the United States an average of 11.5 years and may have been highly exposed to Western medicine at the time of the study. The findings show that the studied sample was more trusting of Western medicine treatments and health care professionals than they were of traditional healers and treatments from their country of birth. However, while the findings were more favorable for Western medicine, they also show that the respondents selected somewhat trust and some of the time for survey questions that were related to Western treatments or health care professionals. This indicates that the study sample was not fully trusting of Western medicine. As a result, this is an opportunity for medical and public health communities to better engage and serve African immigrant women.

The qualitative findings provide insight to factors that contribute to and detract from participants trusting Western medicine. Many of the participants valued the education levels of Western health care professionals, access to lab and diagnostic testing, and mostly accurate test findings. Furthermore, the factors that detracted from the respondents trust in Western medicine revealed that many of the participants had concerns with Western pharmaceutical drugs, specifically how and when physicians prescribed them, and whether their health care provider had bad intentions for their health. Fear of being used as an experiment was another common theme among the study sample and may stem from historical events whereby researchers and medical professionals treated Blacks and Africans unethically. These factors support the research findings that have shown differences in treatment based on a patient's race or gender and that the fear of being treated unfairly because of one's race and ethnicity is common among ethnic minorities, specifically Blacks and Africans.

Conclusions

Age and the number of years an individual lived in the United States may have impacted the level of trust for respondents towards Western medicine. These findings indicate that while Western medicine is preferred among the study sample, the majority of the participants do not strongly trust Western medicine treatments or health care professionals. These findings support previous research studies that identified factors that impacted ethnic minorities experiences with health care professionals in the United States.

The lack of literature on immigrant health indicates that this population could benefit from comprehensive research. In effect, this research study allows public health

and medical communities to advance one step closer toward creating an effective framework that will guide the planning, implementation, and evaluation of interventions for immigrant health. What we do know is that common health issues for immigrants in the United States include poor mental health (including depression), obesity, diabetes, tuberculosis, nutritional deficiencies, intestinal parasites, chronic hepatitis B infection, and lack of immunization (Edberg, Clearly & Vyas, 2010). This research study has provided insight into some factors that may contribute to and detract from trusting physicians who practice Western medicine among African immigrant women. Thus, identification of these factors and the attitudes and perceptions of the study sample may help guide researchers to develop additional research.

In conclusion, the findings indicate that immigrant health and trust of Western medicine is multifactorial. Further research is needed to understand the barriers that African immigrants face with accessing and complying with Western medicine. As more research is conducted, interventions, which improve physician/patient relationships among African immigrants, may increase the level of trust that African immigrants have towards health care providers in the United States. In turn, this will help to minimize the gap of health disparities among immigrant populations.

Recommendations for Future Research

Future research on mistrust among immigrants is greatly needed to improve patient care and access to health care services. One suggestion for future researchers is to study a sample that has recently immigrated to the United States and who is less educated (less than a high school diploma). It would be interesting to compare the findings with

this study to see if there were any significant differences or similarities between the two study samples.

Moreover, I would suggest creating a survey instrument that has been translated into the study sample's native language. This may help to increase participation, improve comprehension of the survey questions, and yield more valid findings. I would also suggest that future studies consider exploring religious beliefs as another alternative for African immigrants. It would be interesting to see how much African immigrants rely upon their faith to improve or maintain their health when compared to Western medicine. Furthermore, studying immigrant men would provide a more complete picture of the attitudes and perspectives of Western medicine among African immigrants. Expanding the study nationally may indicate on how African immigrants in different regions of the United States view Western medicine. Finally, I would suggest that further research be done on treatment compliance among immigrants. A common theme among the study sample was that they felt that pharmaceutical drugs had a lot of chemicals, had many side effects, and were not very effective.

Recommendations for Health Education Practice

In health education practice, I would recommend that practicing medical and public health professionals offer natural remedies in addition to pharmaceutical drugs during treatment. This may increase trust and treatment compliance among African immigrant women and may quell negative beliefs of pharmaceutical drugs. I would also recommend that health care practitioners provide statistics on the effectiveness of the prescribed medication to African immigrant women. This may decrease feelings of being used as an experiment and may increase trust in the Western treatment plan. Lastly, I

would suggest increased cultural awareness for all practicing medical and public health professionals. Showing interest in African immigrant women's culture and background may increase their trust in Western health care practitioners.

REFERENCES

Betancourt, J. R. (2006a). Eliminating racial and ethnic disparities in health care: What is the role of academic medicine? *Journal of the Association of American Medical Colleges, 81*(9), 788-792. doi: 10.1097/00001888-200609000-00004

Betancourt, J. R. (2006b). Cultural competence and medical education: Many names, many perspectives, one goal. *Journal of the Association of American Medical Colleges, 81*(9), 499-501. doi: 10.1097/01.ACM.0000225211.77088.cb

Cateret, M. (2013). Cultural barriers to treatment and compliance. *Cultural Health Beliefs and Behaviors, Immigrant and Refugee Health, Patient Compliance.* Retrieved from http://www.dimensionsofculture.com/2011/03/cultural-barriers-to-treatment-and-compliance/

Centers for Disease Control and Prevention. (2013). *The medically uninsured*. Retrieved from http://www.cdc.gov/healthcommunication/toolstemplates/entertainmented/tips/medicallyuninsured.html

Edberg, M., Clearly, S., & Vyas, A. (2010). A trajectory model for understanding and assessing health disparities in immigrant/refugee communities. *Journal of Immigrant and Minority Health, 13*(3), 576-584. doi: 10.1007/s10903-010-9337-5

Hall, M. A, Dugan, E., Zheng, B., & Mishra, A. K. (2001). Trust in physicians and medical institutions: What is it, can it be measured, and does it matter? *The Milbank Quarterly, 79*(4), 613-639. doi:10.1111/1468-0009.00223

Hernandez D. J. & Charney E. (1998). *From generation to generation: The health and well-being of children in immigrant families.* Washington, DC: National Academy Press. Retrieved from http://www.nap.edu/read/6164/chapter/1

Kagawa-Singer, M., & Kassim-Lakha, S. (2003). A strategy to reduce cross-cultural miscommunication and increase the likelihood of improving health outcomes. *Journal of the Association of American Medical Colleges, 78*(6), 577-587. Retrieved from http://journals.lww.com/academicmedicine/Abstract/2003/06000/A_Strategy_to_Reduce_Cross_cultural.6.aspx

Kleinsinger, F. (2010). Working with the noncompliant patient. *The Permanente Journal. 14*(1), 54-60. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2912714

Merriam-Webster. (2015). *Dictionary: Mistrust*. Retrieved from http://www.merriam-webster.com/dictionary/mistrust

Minnesota Immigrant Health Task Force. (2005). *Immigrant health: A call to action. Minneapolis: Minnesota State Department of Health.* Retrieved from http://www.health.state.mn.us/divs/idepc/refugee/topics/immhealthrpt.pdf

National Cancer Institute. (2015). *Cancer health disparities definition*. Retrieved from http://www.cancer.gov/about-nci/organization/crchd/about-health-disparities/definitions

National Cancer Institute. (2015). *NCI dictionary of cancer terms*. Retrieved from http://www.cancer.gov/publications/dictionaries/cancer-terms?cdrid=454743

Sheppard, V. B., Mays, D., LaVeist, T., & Tercyak, K. P. (2013). Medical mistrust influences black women's level of engagement in BRCA1/2 genetic counseling and testing. *Journal of the National Medical Association. 105*(1). Retrieved from http://search.proquest.com.ezproxy.mnsu.edu/docview/1418299636?pq-origsite=summon&accountid=12259

U.S. Department of Health and Human Services. (2015). *The affordable care act is working*. Retrieved from http://www.hhs.gov/healthcare/facts/factsheets/2014/10/affordable-care-act-is-working.html

U.S. Department of Homeland Security. (2015). *Definition of terms*. Retrieved from http://www.dhs.gov/definition-terms#permanent_resident_alien

Vaccarino, V., Rathore, S. S., Wenger, N. K., Frederick, P. D., Abramson, J. L., Bramon, H. V., … Krumholz, H. M., (2005). Sex and racial differences in the management of acute myocardial infarction, 1994 through 2002. *The New England Journal of Medicine, 353*(7)*,* 671-82. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/16107620

Zong, J. and Batalova, J. (2015). *Frequently requested statistics on immigrants and immigration in the United States.* Retrieved from http://www.migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states

APPENDIX A

SURVEY INSTRUMENT

SURVEY INSTRUMENT

AN ANALYSIS OF WESTERN MEDICINE TRUST AND MISTRUST
SURVEY QUESTIONNAIRE

COMPOSED BY: WANJIRU JULIE GICHERU
MINNESOTA STATE UNIVERSITY, MANKATO
COMMUNITY HEALTH EDUCATION PROGRAM

THIS DOCUMENT WAS PROVIDED BY WANJIRU JULIE GICHERU

The purpose of this survey is to learn about your experience with physicians who practice Western medicine. I hope to identify factors that contribute to your trust and mistrust of Western medicine physicians and treatments, and to assess your attitudes and perceptions of Western medicine.

All answers are confidential and will remain anonymous. Please do not write your name anywhere on this document. If you come across any questions that you do not feel comfortable answering, please skip them.

Instructions:

There are three pages of questions in this survey. Please answer each question carefully and truthfully. Clearly mark your answer. Please mark or write the answer that applies the best to you.

AN ANALYSIS OF WESTERN MEDICINE TRUST AND MISTRUST SURVEY QUESTIONNAIRE

1. How comfortable are you with going to a physician who practices Western medicine?

   ___Very comfortable ___Mostly comfortable ___Somewhat comfortable ___Rarely comfortable ___Not comfortable

2. I feel comfortable talking about my medical concerns with physicians who practice Western medicine.

   ___Very comfortable ___Mostly comfortable ___Somewhat comfortable ___Rarely comfortable ___Not comfortable

3. When I get sick, I seek medical advice from traditional healers.

   ___All of the time ___Most of the time ___Some of the time ___Rarely ___Never

4. I rely upon traditional healing methods from my country of birth.

   ___All of the time ___Most of the time ___Some of the time ___Rarely ___Never

5. My health improves when I follow Western medicine treatment plans from my health care provider.

   ___All of the time ___Most of the time ___Some of the time ___Rarely ___Never

6. I trust physicians who practice Western medicine.

   ___All of the time ___Most of the time ___Some of the time ___Rarely ___Never

7. I trust traditional healers and their treatments.

   ___All of the time ___Most of the time ___Some of the time ___Rarely ___Never

8. I trust in Western medicine treatments.

   ___Strongly trust ___Mostly trust ___Somewhat trust ___Rarely trust ___Never trust

9. I trust the medical advice I receive from my health care provider.

   ___Strongly trust ___Mostly trust ___Somewhat trust ___Rarely trust ___Strongly distrust

10. I believe that access to physicians who practice Western medicine has improved my quality of life.

    ___Strongly believe ___Mostly believe ___Somewhat believe ___Rarely believe ___Never believe

11. I believe that physicians who practice Western medicine have the ability to help me manage my health.

    ___Strongly believe ___Mostly believe ___Somewhat believe ___Rarely believe ___Never believe

12. What are the three most important factors that contribute to trusting medical advice from physicians who practice Western medicine?

    Please list three factors:
    1. _____

    2. _____

    3. _____

13. What are the three most important factors that contribute to mistrusting advice from physicians who practice Western medicine?

    Please list three factors:
    1. _____

    2. _____

    3. _____

Please answer questions #14-20 so we can see how different types of people feel about Western medicine.

14. Zip code where you live: _____

15. Age: ___

16. Marital Status:
    ___ Married / Living with partner
    ___ Not married / Single

17. Education
    ___ Less than high school
    ___ High school diploma or GED
    ___ College degree or higher
    ___ Other_____

18. How many years have you lived in the United States? _____

19. In the last year, how many times have you seen a Western medicine health care practitioner?
    ____ 1-3 times
    ____ 4-6 times
    ____ 7 or more times

20. How do you pay for your healthcare? (check all that apply)
    ___ Pay cash (no insurance)
    ___ Health insurance (such as private insurance, Blue Shield, HMO)
    ___ Medicaid
    ___ Medicare
    ___ Veterans' Administration
    ___ Indian Health Services
    ___ Other_____

APPENDIX B

CONSENT FORM

CONSENT FORM

MSU IRBNet ID #868752

Title: An Analysis of Western Medicine Mistrust Among Selected African Immigrant Women in Minnesota
Faculty Advisor: Dr. Joseph D. Visker
Co-Investigators: Dr. Judith Luebke and Dr. Mark Windschitl
Student Investigator: Wanjiru Julie Gicheru
IRBNet#: 868752

What is the purpose of the study?
You are being invited to take part in a research study designed to assess the level of mistrust of Western medicine among selected African immigrant women in Minnesota.

What is the purpose of this form?
This consent form gives you the information you will need to help you decide whether to be in the study or not. Please read the form carefully. You may ask any questions about the research, the possible risks and benefits, your rights as a volunteer, and anything else that is not clear. When all of your questions have been answered, you can decide if you want to be in this study or not.
Why am I being invited to participate?
You are being invited to take part in this study because you have been identified as an African immigrant woman who has had at least one encounter with a Western medicine health care practitioner or treatment plan. If you choose not to participate or are not eligible, you do not need to proceed with the survey. Only African immigrant women, aged 18 – 79 years are permitted to take part in this study.

What will happen during this study and how long will it take?
If you agree to take part in this study, your involvement will last for approximately 5-10 minutes. You are being asked to take part in a survey, which is comprised of Likert scaling and open-ended questions. You will be asked about your level of trust and mistrust of Western medicine physicians and treatment plans. Your completion of the survey marks the end of participation in this study.

What are the risks of this study?
The risks encountered as a participant in this research are not more than experienced in everyday life. The survey is designed to assess perceptions of Western medicine and perceptions are not deemed to be sensitive in nature. Thus, the risk is minimal.
What are the benefits of this study?

There are no direct benefits to participants. However, the participants will be providing additional insight and understanding of the selected subjects, providing assistance to a graduate student interested in their culture, and a voice for those with similar

backgrounds. Future researchers and health care practitioners might use this research to improve relationships with African immigrant women by increasing trust during clinical visits. This in turn will improve patient compliance and therefore improve individual health status and quality of life.

Compensation
You will not receive any compensation for answering the questions.

Who will see the information?
The information you provide during this research study will be kept confidential. To help protect your confidentiality, we will ensure that only the principle researcher and co-researchers will have access to the data. Your name will NOT be attached to the study nor will any other information capable of personally identifying you. Electronic data, in the form of SPSS, will be stored on a password-protected computer. All forms will be destroyed no longer than 5 years after completion of this study. We will take all

reasonable steps to protect your identity. If the results of this project are published your identity will not be made public.

Do I have a choice to take part in this study?
Participation in this project is voluntary and participants have the right to stop at any time. Your decision whether to participate will not affect your relationship with Minnesota State University, Mankato. You will not be treated differently if you decide to stop taking part in the study. You may contact the Minnesota State University, Mankato Institutional Review Board Administrator, Dr. Barry Ries, at 507-389-1242 or barry.ries@mnsu.edu with questions about research with human participants at Minnesota State University, Mankato.

Thank you for your time. Please contact Dr. Joseph Visker if you have any questions or if you would like a copy of this informed consent document

Contact Information:
Joseph D. Visker, PhD, MCHES
Department of Health Science
Minnesota State University, Mankato
Email: joseph.visker@mnsu.edu
Phone: 507-389-2757

Wording adapted from: Truman Sate University. (2014). *Institutional Review Board Forms.* Retrieved from http://irb.truman.edu/forms.asp

APPENDIX C

PARTICIPANT RECRUITMENT HANDOUT

PARTICIPANT RECRUITMENT HANDOUT

Greetings,

My name is Wanjiru Julie Gicheru and I am graduate student of Health Science at Minnesota State University, Mankato. I am conducting a research study that assesses the level of trust of Western medicine among selected African immigrant women in Minnesota. Volunteers will be asked to participate in a survey. The survey will last 5-10 minutes. Participating in this study will allow us to better understand the needs of African immigrant women and will provide insight into the factors that will improve patient trust in clinical settings.

If you would like to participate please contact Wanjiru Julie Gicheru (information noted below). Thank you for your consideration!

In wellness,

Wanjiru Julie Gicheru
wanjiru.gicheru@mnsu.edu
Phone: 952-261-9484
Please note that this project has been reviewed and approved by the Minnesota State University Institutional Review Board (IRB); IRBNet #868752

APPENDIX D

ORGANIZATION EMAIL TEMPLATE

ORGANIZATION EMAIL TEMPLATE

Greetings,

My name is Wanjiru Julie Gicheru and I am graduate student of Health Science at Minnesota State University, Mankato. You are receiving this email because we would like to invite members of your organization to take part in a research study. The purpose of this study is to assess the level of trust of Western medicine among selected African immigrant women in Minnesota. Volunteers will be asked to participate in a survey. The survey will last 5-10 minutes. Participating in this study will allow us to better understand the needs of African immigrant women and will provide insight into the factors that will improve patient trust in clinical settings.

I would love the possibility of implementing this survey in your organization and would like to discuss the possibility of doing so. At your earliest convenience, please call or email me at 952-261-9484 or wanjiru.gicheru@mnsu.edu.

Thank you for your consideration and I look forward to hearing from you!

In wellness,

Wanjiru Julie Gicheru wanjiru.gicheru@mnsu.edu
Phone: 952-261-9484
Please note that this project has been reviewed and approved by the Minnesota State University Institutional Review Board (IRB); IRBNet #868752

APPENDIX E

IRB APPROVAL LETTER

IRB APPROVAL LETTER

MINNESOTA STATE UNIVERSITY MANKATO

February 19, 2016 Dear Joseph Visker, PhD:

Re: IRB Proposal entitled "[869059-3] An Analysis of Western Medicine Mistrust Among Selected African Immigrant" Review Level: Level [I]

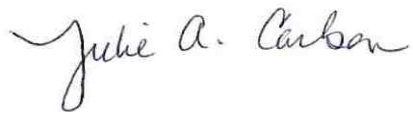
Your IRB Proposal has been approved as of February 19, 2016. On behalf of the Minnesota State University, Mankato IRB, we wish you success with your study. Remember that you must seek approval for any changes in your study, its design, funding source, consent process, or any part of the study that may affect participants in the study. Should any of the participants in your study suffer a research- related injury or other harmful outcome, you are required to report them to the Associate Vice-President of Research and Dean of Graduate Studies immediately.

When you complete your data collection or should you discontinue your study, you must submit a Closure request (see http://grad.mnsu.edu/irb/continuation.html). All documents related to this research must be stored for a minimum of three years following the date on your Closure request. Please include your IRBNet ID number with any correspondence with the IRB.

Sincerely,

Mary Hadley, Ph.D. IRB Coordinator

Sarah Sifers, Ph.D. LP IRB Co-Chair



Julie Carlson, Ed.D. IRB Co-Chair

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Minnesota State University, Mankato IRB's records.