Health and Medicine among First-Generation African Immigrants in the United States

Anne Fuller

Follow this and additional works at: https://scholarworks.wm.edu/honorstheses

Part of the African Languages and Societies Commons, Alternative and Complementary Medicine Commons, Anthropology Commons, Community Health Commons, Community Health and Preventive Medicine Commons, and the Medical Humanities Commons

Recommended Citation
https://scholarworks.wm.edu/honorstheses/1204
HEALTH AND MEDICINE AMONG FIRST-GENERATION AFRICAN IMMIGRANTS IN THE UNITED STATES

By
Annie Fuller

A thesis submitted in partial fulfilment of the requirements for graduation with HONORS
From the interdisciplinary program of AFRICANA STUDIES WITH AFRICAN CONCENTRATION

Accepted for Highest Honors
(Honors, High Honors, Highest Honors)

Mei Mei Sanford, Thesis Advisor

Elyas Bakhtiari

Oludamini Ogunnaike

THE COLLEGE OF WILLIAM & MARY
April 25, 2018
HEALTH AND MEDICINE AMONG FIRST-GENERATION AFRICAN IMMIGRANTS IN THE UNITED STATES

By
Annie Fuller

A thesis submitted in partial fulfilment of the requirements for graduation with
HONORS
From the interdisciplinary program of
AFRICANA STUDIES WITH AFRICAN CONCENTRATION

Reviewing Committee
Mei Mei Sanford, Thesis Advisor
Africana Studies
Elyas Bakhtiari
Sociology
Oludamini Ogunnaike
Religious Studies

THE COLLEGE OF WILLIAM & MARY
May 2018
# TABLE OF CONTENTS

## CHAPTER 1

- Introduction .................................................................................................................. 1
- Research Methodology................................................................................................. 3
- Literature Review ......................................................................................................... 5

## CHAPTER 2

- The Voices ..................................................................................................................... 18
  - Motifs
    - Diet & Exercise ......................................................................................................... 24
    - Class ......................................................................................................................... 26
    - Race ......................................................................................................................... 27
    - Mental/Physical Dichotomy ...................................................................................... 28
    - Cultural Conflict ..................................................................................................... 30

## CHAPTER 3

- Confounding Variables ................................................................................................. 32
- Conclusions .................................................................................................................. 34
- Appendix A .................................................................................................................. 40
- Appendix B .................................................................................................................. 41
CHAPTER 1

Abstract

The focus of this research will be on the medicines and health practices of first-generation African immigrants in the U.S. and the role they play in an increasingly holistic formal American health field. For the Eurocentric American, traditional African practices are predominantly viewed as antithetical to modernity; for the Afrocentric American, White western medicine can represent a rejection of African culture and thus one’s complete identity. The dynamic of these two perspectives within African immigrants in the U.S. is proficient in both resolving health crises and creating cultural conflict. The rise of alternative medicine within the formal American health field may illuminate the benefits of a multifaceted approach to medicine in popular media and possibly ease the tensions for first-generation African immigrants and their descendants. This research aims to explore first-generation African immigrant attitudes towards health and medicine in the United States through ethnographic accounts and observe the extent to which the acceptance of alternative medicine applies to African-derived practices.

Introduction

The world of medicine in the United States, while reliant on a foundation of natural science, is inherently sociological. Health and medicine follow trends among various ethnic, religious, and racial subsects of Americans. Certain illnesses target and are addressed differentially along these lines and therefore must be explored through a lens of relativism. African immigrants are one of many groups of Americans marginalized by the medical community – their experiences with formal and informal healthcare are rarely included in mainstream conversations of American health perspectives. It is time for a shift in the way American health is defined, observed, and discussed.

Historically, healthcare in the United States has placed great emphasis on treating symptoms; the physical consequences of an illness have been addressed while upstream sociological factors have remained unaddressed by physicians. While mainstream medicine practices are increasingly accepting of holistic approaches, the idiosyncratic practices of many
communities have yet to be formally explored. Specifically, the health practices of first-generation African immigrants have been ignored by mainstream America but have much to offer to American health at large. The conflict between “traditional African” and “Americanized” behavior manifests differently for African immigrants than it does for the American mainstream public opinion; this project aims to explore this conflict through the eyes of those who experience it to better understand its effect on health.

As a White, U.S.-born American young woman, I rarely find that my approach to health is disregarded or considered abnormal. This brings inherent benefits to my wellness overall; evidently, those whose behaviors are better understood by physicians will receive more suitable care when issues arise. The overall population of Black Americans have significantly more health problems when compared to their White peers,¹ and many immigrants feel misunderstood by their acquaintances and physicians in the face of culture shock.² As a crossover between these two marginalized groups of people, first-generation African immigrants have a unique experience of health and medicine in the United States. Additionally, their entire home continent faces presuppositions of health problems and primitive medicine, adding another obstacle to the normalization of their health experiences. Both the benefits of their approaches to medicine and the distinct problems to their health and wellbeing are buried under the experiences of White America.

The goal of this thesis is to highlight the experiences of first-generation African immigrant health and medicine in the United States and to amplify their voices through a more direct methodology. Contemporary American culture venerates science and the scientific method

---

as objective truth. This perspective, henceforth referred to as scientism, tends to ostracize the experiences of those with different understandings of reality. In my search for the best form of exposing neglected perspectives, I have turned to ethnography. This subjective form of research emphasizes the thoughts and opinions of those who are being researched. I hope to support the legitimacy of this methodology in the United States medical field as I explore health within first-generation African immigrant communities.

This thesis is not a conclusive study. I am not answering a single question or confirming a cause-and-effect relationship. Rather, I am shining light on a historically underrepresented group of people, exposing the flaws in current research methodologies and illuminating the complexities of personal experience. This is an ongoing project – I intend for this thesis to represent a sparked piece of flint for my own understanding of health and medicine in America. It is an inspiration for the future direction of public health and biomedical research perspectives. My work aims to contribute to a foundation on which sincere, biased, and thoughtful voices of all Americans can be heard.

**Research Methodology**

The search for symptoms throughout public health studies focuses on the biological causes of health issues and tends to ignore the social factors that contribute to these issues. Sociological studies alleviate this shortcoming but are generally unsuccessful in overcoming the problem of reductionism. Much of the current scholarship on public health relies on large-scale surveys, establishing connections between social behavior and health but failing to explore the nuances of perspectives and consciousness. I chose to utilize ethnography, or the scientific study of peoples and cultures, to explore health.
Ethnography allows one to understand a topic of study from the viewpoint of the studied rather than through the eyes of the researcher. This methodology incorporates personal experience into science and encourages subjectivity. Research within the American health field generally condemns scholarship that leaves room for interpretation – studies on medicine and health that have no clear question and answer from the researcher are often written off as inconclusive. I hope to support the legitimacy of ethnography in academia as a form of scholarship that encompasses a broader understanding of health as a whole.

This thesis is an expression of voices. While my framework is that of conflict within the health and medicine practices of first-generation African immigrants, my product is the compilation of experiences in and around this conflict. I am not in search of a specific method of first-generation African immigrant healthcare; there are no statistical certainties that can encapsulate an entire group of people. By having conversations with people rather than asking a list of questions to be checked off, I aim to avoid conformational bias in my exploration of these experiences. I hope to emphasize the complexity of character within these voices as I analyze patterns of attitude and behavior. This project intends to display these patterns to indicate practical methods for improving the health of individual Americans.

A total of 5 interviews was conducted over a period of four months; 3 interviews were in-person, 1 interview was over the phone, and 1 interview was written. The duration of the interviews lasted between 30 and 60 minutes and were conducted in an informal setting – usually, the location was the home or office of the interviewee. The in-person and phone interviews were guided by a series of 15 questions but consisted mostly of free form

---

3 Appendix A
conversations. The written interview consisted of a written response to the 15 guide questions that were utilized in the oral interviews. The phone interview was recorded and stored via Google Voice.

My thesis utilizes ethnographic accounts to compare with the current literature on health experiences in the United States. Although the perspectives from the interviews are the predominant expression of experience, I have studied the literature to understand the patterns that they represent. Scholarship on scientism, complementary and alternative medicine, African American health, and African healing systems have been utilized to understand the patterns behind the gathered ethnographic accounts. By analyzing the existing literature, I facilitate the development of practical comprehensions of health experiences among first-generation African immigrants. By exploring first-hand accounts, I highlight the importance of nuanced experience in the understanding of American health.

**Literature review**

**SCIENTISM**

Mainstream American opinion, including that which is dominant in the field of medicine, relies on scientism. More than strict scientific thought, scientism is defined by philosopher Tom Sorell as “a matter of putting too high a value on natural science in comparison with other branches of learning or culture.” Practical American knowledge emphasizes scientifically-gathered information as objective truth. Many informal methods of healing in the United States (e.g. faith healing) are marginalized because they lack legitimization from professional scientific institutions, regardless of their community-based empirical support. Most forms of healing are

---

scientific, in that they have evidentiary support; the institution of scientism must be differentiated from science in order to understand the health and medicine practices among first-generation African immigrants.

Thomas Burnett elucidates the history of American scientism in his article, “What is Scientism?” for the American Association for the Advancement of Science. He identifies its birth at the Scientific Revolution in 17th century Europe, where the highest authority of scholarship shifted from religion to the study of natural science. Scientism was solidified in the Western world by the consequential development of positivism, or the claim that “the only valid data is acquired through the senses.” This perspective maintains that every occurrence, connection, and question in the universe can be ultimately explained through scientific observation and analysis. Burnett asserts that scientism “has served to alienate a large segment of American society.”

Health and medicine are intricately tied to science, but healing methods that are unsupported by scientistic institutions are unduly dismissed. A complete comprehension of healing among first-generation African immigrants relies on the identification and breakdown of scientism as it affects the American field of health.

COMPLEMENTARY AND ALTERNATIVE MEDICINE

Complementary and alternative medicine is generally considered to be any health treatment that is unorthodox in the medical profession. Acupuncture, non-pharmaceutical herbal medicine, and aromatherapy are a few common examples of this form of healing. In conventional American life, complementary and alternative medicine is becoming progressively

5 Thomas Burnett, "What Is Scientism?".
6 Ibid.
integrated into formal healthcare. While specific causes for this trend cannot be precisely pinpointed, an analysis of such practices provides a broader understanding of the state of American health in contemporary times.

In her book, *Marginal to Mainstream: Alternative Medicine in America*, Mary Ruggie argues for the integration of complementary and alternative medicine. She emphasizes the divide between formal knowledge, which is reliant on scientific information and is restricted to professionals, and informal knowledge, which is accessible to everyone and consists of common sense and intuition, in the field of health. She maintains that mainstream American medicine relies on formal knowledge while complementary and alternative medicine does not. Ruggie insists that the latter is better incorporated into contemporary life because its legitimacy is increasingly supported by scientific research, providing evidence from the increase of NIH and other respected scientific studies on the topic. There is an apparent contradiction between the public’s need for scientific support and its distrust of formal medicine and institutional health authority; however, Ruggie eases this conflict by implicitly clarifying the difference between the American public’s trust in science and the faltering of scientism’s influence. She also emphasizes a trend of disenchantment with medicine among physicians themselves. She states that physicians’ “acceptance of [complementary and alternative medicine] requires scientific proof of safety and efficacy, but their attraction to it is grounded in their embrace of the art of healing.” Ruggie’s work reveals a delicate and ambiguous relationship between health and medicine in the United States today.

---

8 Ibid., 4-6.
9 Ibid., 33.
10 Ibid., 15.
Though Ruggie mentions the use of complementary and alternative medicine among specific minority groups, she fails to highlight its complicated relationship with non-American practices. The most frequently studied medicines that have clear roots in other cultures (such as acupuncture and yoga) are derived from Eastern Asia. Her book does not detail African-derived practices, which are evidently underrepresented in literature on this topic. While she does mention that “it is unclear whether culture or personal finances or poor access to conventional health care”\textsuperscript{11} underlie the tendency for first-generation immigrants to practice complementary and alternative medicine, she implicitly reveals a gap in scholarship on African immigrant involvement with alternative health behaviors.

Eric J. Bailey investigates the role of complementary and alternative medicine among African American populations in his book, \textit{African American Alternative Medicine: Using Alternative Medicine to Prevent and Control Chronic Diseases}. His goal is to provide an overview of these practices through a review of case studies in scientific and anthropological research journals. Additionally, he utilizes medical anthropology via ethnographic accounts to bring life into these research studies. The book is structured as a “teaching text and resource for students, health care researchers, health care policy makers, and the general public,”\textsuperscript{12} illuminating the importance of complementary and alternative medicine among a specific minority group of Americans and arguing for a better understanding of this importance among health providers.

There is significant literature on the use of informal medicine among Black American populations, which may shed light on the use of African immigrant practices in the United

\textsuperscript{11} Ibid., 42.
\textsuperscript{12} Eric J. Bailey, \textit{African American Alternative Medicine: Using Alternative Medicine to Prevent and Control Chronic Diseases}, (Connecticut, Greenwood Publishing Group, 2002), VIII.
States. Bailey begins his text with an overview of alternative medicine. “During the past 10 years,” he notes, “the number of published research articles on alternative medicine in medical journals has increased ten-fold. In the same period, the number of trade books published on this topic has increased fifty-fold.” While alternative therapy increases in popularity for the general population, significant demographic divides reveal that these practices have taken roots much more slowly among minority groups than non-minority groups. Multiple surveys reveal that African Americans practice complementary and alternative medicine less frequently than most other racial groups in the United States, and that such practices are utilized predominately by women from lower socioeconomic backgrounds. Bailey admits that many of these results may have been skewed by the distrustful relationship between the U.S. government and African Americans. As discussed later, scholar David McBride explicates how the American government has used poorer African American communities for public health and medical experimentation; because studies on complementary and alternative medicine are usually funded by the government, Bailey implies that surveys may not be as representative of African Americans as they are with other racial groups. Bailey also acknowledges that these findings are dependent on the limited definition of alternative medicine. Although specific remedies are listed (i.e. “herbal medicine, massage, megavitamins, self-help groups, folk remedies, energy healing, and homeopathy”), many complementary and alternative medicines that are practiced by African Americans are not necessarily considered under these categories. Voodoo, for example, is

---

13 Ibid., 3.
14 Ibid., 5-9.
15 Ibid., 8.
16 Ibid., 4.
considered a religion but provides a source of healing that is unique to African Americans.

Bailey clarifies this structure:

The African American form of voodoo medicine consists of three components. The first is the mystic component, which deals with the supernatural such as spells and spirits. The second component is that part of voodoo that deals with psychological support of the individual, and the third part is herbal and folk medicine. African American voodoo prospers particularly in the South, primarily because it fills a void left by inaccessibility and denial of medical care by formal American health practitioners.\(^\text{17}\)

Combined with the knowledge that Black Americans have less access to and less satisfaction with formal health care than their White counterparts,\(^\text{18}\) Bailey relies on his own ethnographic research to overcome these significant confounding variables and highlight the importance of alternative care among Black American communities.

Bailey focuses on four case studies out of 285 from independent ethnographic work in Detroit for their applicability to African American alternative medicine. The role of complementary and alternative medicine in the health and wellbeing of these case studies is best expressed through their own voices. Their perspectives are summarized by Bailey as follows:

Informant 54: A middle-aged African American man with a history of essential hypertension who uses sassafras and leaf teas in treating his slightly elevated blood pressure. Although under doctor’s care, he continues his folk treatment regimen in conjunction with his physician’s prescribed medication because, “If I tell him that I am using herbs, he would think that I was silly.” (Bailey 1988:1110)

Informant 4: A 59-year-old African American woman who practices a folk care regimen (vinegar and herbal teas) to treat her high blood pressure and believes that one’s health is the responsibility of the individual, not the physician. Moreover, her lack of information about the seriousness of high blood pressure and the hereditary component of hypertension had delayed her from seeking health care from medically trained professionals. (Bailey 1991:293)

Informant 31: A 44-year-old, middle-income African American health care professional, she adhered to a folk ethnomedical treatment pattern as well as the mainstream treatment pattern. A native Detroiter, this woman received her medical training from a local

\(^{17}\) Ibid., 43.
\(^{18}\) Ibid., 42.
university and thereafter served as a nurse clinician for 10 years at a major urban hospital. She eventually became disenchanted with the clinical aspect of the medical field and switched to the health insurance field because she felt that it would better serve the African American community. (Bailey 1991:29)\textsuperscript{19}

The motivations for African Americans to pursue various practices to promote their health are clearly diverse. One African American person may choose complementary and alternative health care because she trusts her own authority more than her physician’s (Informant 31), while another may choose a similar path regardless of his reliance on his physician’s authority (Informant 54). Experiences with the formal American health field and with complementary and alternative medicine are both vital to the health of African Americans. As Bailey makes clear, a proper understanding of health must take into consideration the social and personal factors that affect a person. While Bailey’s work cannot be generalized to first-generation African immigrants, a Pan-Africanist perspective reveals similarities in health among all Black Americans that are best understood through the most available scholarship: African American health.

AFRICAN AMERICAN HEALTH

By analyzing medicine practices in modern African American communities through a Pan-Africanist perspective, the foundational factors of first-generation African immigrant health in the United States are better understood. Health behaviors among African Americans illuminate the intricacies of the American health experience – evidently, health and wellbeing are supported through the amalgamation of formal and informal healing perspectives regardless of scientism’s role in the United States. Research on African American health also indicates the significant role that race plays in American health, identifying an obstacle for first-generation

\textsuperscript{19} Ibid., 10
African immigrants that is not inherently tied to their immigrant status. Additionally, African American medicine has undeniable roots in traditional African healing systems. These systems are therefore better able to be contextualized for first-generation African immigrants.

Loudell Snow approaches African American health from a holistic perspective in *Walkin’ Over Medicine*. Her book presents years of ethnographic research in small African American communities in Arizona and Michigan; she gathers the experiences of patients and healers, both traditional and formal, and expresses the entire range of experiences among primarily poor community members. Snow reviews a wide range of biomedical studies on African American health to compare to her own anthropology. Her work explicates forms of healing that are least understood by the majority of Americans, such as blood healing and witchcraft. The research is empathetic and provides a well-rounded view on healthcare from a personal perspective.

Snow’s work reveals that the tensions between healthcare techniques often manifest as a “private” life and a “public” life that are dependent on context. An African American may hide her/his physician interactions from family and hide her/his familial remedies from a physician. Another form of compartmentalization that can be observed from Snow’s text is the individual attitude and the group attitude – the individual controls the balance of the private/public dichotomy while the group controls the efficacy of the medicine in practice. The balance between what remains private and what is expressed publicly is mainly determined by how an individual feels that label will affect the potency of the health behavior. One of Snow’s participants expresses that, at the core of her own health consciousness,

She does not trust doctors and what they might do to you – and she does not trust the alternative practitioners utilized by some of her neighbors (and some of her own children) and what they might do to you. If physicians sometimes keep patients coming back just to
make money, well, so do some of the other sorts of healers. In fact they may make you sick to begin with so that they will have a ready-made clientele.\textsuperscript{20}

The groups of healers clearly have the power to heal or not to heal; a broken leg requires a surgical team to fix, and a blood illness requires support from family and traditional healers to overcome. While this participant certainly relies on these various sources of healing when she is ill, her decision to rely on a particular system ultimately relies on her own authority. The best navigator of public and private worlds is the person who lives in both.

Snow succeeds in providing context for the balance between formal and informal healthcare while emphasizing that they are not mutually exclusive. She emphasizes this balance as the quintessential manifestation of holistic medicine through the stories of her participants:

Thus it is that Marya can understand one headache to be the result of stress and another the result of an envious woman’s hex; thus it is that Janine believes that a prayer can be more efficacious than penicillin; thus it is that a woman long dead senses her daughter’s misery and hurries to her side. And thus it is that a traditional healer in Grand Rapids who never finished high school is able to relieve a problem when the physicians at a university medical center could not.\textsuperscript{21}

Her work establishes the depth of health behaviors among African American communities, focusing on giving voices to the underrepresented. However, Snow’s attempt to connect these case studies with a broader trend of Black experience is not well drawn out. Her research review explores the disparities of Black American health without invoking socioeconomic context. While her anthropological work is enlightening regarding Black American health experience, her historical evidence is lacking and does not allow for substantiated generalization for other populations such as first-generation African immigrants.

\textsuperscript{20} Snow, \textit{Walkin’ Over Medicine}, 272.
\textsuperscript{21} Ibid., 35.

McBride highlights the difference between the claimed intentions of the United States and the government’s actual motivations. The consequences of the imperialistic drive of the U.S. are two-sided. The U.S. facilitated a racialized system of oppression via the Atlantic Slave Trade; this historical detriment to the quality of life of African-derived peoples in the Americas inspires health and technological intervention in contemporary times. However, the imperialism behind the Atlantic Slave Trade and the resulting racial prejudices are ingrained in the character of the United States. In the context of western scientism, this combination of perspectives has resulted in a system where Black Americans are used as medical testing subjects for the U.S. government. McBride analyzes the government’s response to a malaria outbreak in the U.S. south during the 1920s that effected predominately African Americans – rather than addressing the underlying issues of poverty and lack of access to consistent health care, the government turned to biomedical testing for the sake of scientific advancement. Assistant surgeon general of the U.S. Public Health Service Kenneth Maxcy “urged that epidemiological elements or

---

‘principles’ were behind the malaria crisis in the South, not concrete social and economic conditions, behaviors, and interest groups.”

McBride explicates the consequences:

Seeking more knowledge about malaria pathogens as well as prophylactic measures that used pharmaceuticals, the new public health leadership sought wider use of their laboratory-oriented specialties, especially parasitology, hematology, and, pharmacology. New drugs, someday they hoped, could eventually keep individuals bitten by malarious mosquitoes from contracting the disease and, someday, kill the parasites. To the new public health experts, the primary causes and solutions for communicable disease epidemics of malaria, tuberculosis, and syphilis lay in the microbiological world, not the socioeconomic one.

Rather than addressing the sanitary and other medical conditions of African Americans in the American South, the government focused on scientific experimentation under the veil of public health improvement. McBride references the Tuskegee study, in which the government purposefully exposed hundreds of African Americans to syphilis without informed consent in order to test the efficacy of preliminary biomedical treatments, as yet another reason for distrust between Black populations and the American government.

While McBride’s work reveals the roots of distrust and health disparities between Black American populations and the U.S. government, he fails to suggest a solution to these issues. My thesis attempts to address this distrust through more empathetic and responsible research on health among a specific Black population, allowing the voices to become the authority of the experience and encouraging a different direction of health scholarship. Ethnography facilitates empathy as well as a fuller comprehension of contributing factors that create health disparities. The links between social and economic motifs and health disparities must be understood before

---

23 Ibid., 151.
24 Ibid., 153.
25 Ibid., 131.
the disparities can be practically addresses – through empathetic research, these links can be more clearly established.

AFRICAN HEALING SYSTEMS

In the age of scientism, scholarship on religion is overwhelmingly made distinct from that of health. Healing, however, is evidently unrestrained by the dichotomy of the secular and the religious. Jacob K. Olupona and Regina Gemignani explore religion among African immigrants in the United States in their volume, *African Immigrant Religions in America*. Their work provides insight into unique and alternative forms of healthcare when compared to the formal American field of medicine. The editors argue that religion is a vital angle from which to study the sociological implications of African immigration – these religions both color the experience of African immigrant communities and shape historically American religions by way of cultural interactions.

Olupona and Gemignani review a number of authors who cover the healing systems in a few religious African immigrant communities. West-African-derived Aladura churches, for example, view the world holistically and consequentially practice faith healing. Muslim African immigrant communities navigate the complex world of Islam in the United States, as race generally divides Middle Eastern Muslims from African American members of the Nation of Islam. Most of these communities also integrate indigenous beliefs and practices that are not common in mainstream American Christianity or Islam. Ghanaian deliverance, for example,

---

utilizes a spiritual healing via exorcism that protects against life-hindering forces. The editors reveal the interdependence of religion, health, and race with these elaborations.

While each religious sect provides a unique source of healing for African immigrants, all have similar motivations to alleviate the effects of racism and culture clash in the United States. Olupona and Gemignani highlight religion as a weapon against the ostracizing effects of immigration – most African immigrant religions in the U.S. emphasize a bridging spirituality that allows African immigrants to alleviate the conflict of living within two separate cultures. Physical health is also facilitated through these religious communities. “Addressing the needs of recent African immigrants,” Olupona notes, “many mosques and churches have developed institutionalized structures to provide secular support with legal assistance, housing, and employment.” Religion as a healing system attends to the upstream sociological factors that affect health among many African immigrants.

Although Olupona and Gemignani emphasize religion as an important aspect in African immigrant health, they fail to observe holistic health from a secular standpoint. Their book deviates from Suzanne Terrell’s The Other Kind of Doctors: Traditional Medical Systems in Black Neighborhoods in Austin, Texas (Immigrant Communities and Ethnic Minorities in the United States and Canada), which analyzes religion in health among African immigrants through her own perspective with very little incorporation of the voices of the people she interviews. However, immigrant health is not solely tied to religion; my research aims to incorporate both religious and secular sources when studying informal healing.

---

27 Ibid., 268.
28 Ibid., 43.
CHAPTER 2

The Voices

I had the pleasure of talking to five people who were interested in the academic investigation of health and medicine among first-generation African immigrants. Two participants are female, three are male, and all are between early and late adulthood. Catherine T. is a Senegalese immigrant who grew up in the city and moved to the United States over 20 years ago. Wassila T., Catherine T.’s husband, was born and raised in a rural area outside of Dakar and came to the U.S. with Catherine T. Sosthenes K. is originally from a small town in Ghana and now resides in Northern Virginia. Wanda H. 29 immigrated from Senegal and now works in budgeting for an American institution. Endalkachew B. has lived in the United States for 9 years and spent most of his life in his country of birth, Ethiopia. While all participants have commonalities in their experiences as first-generation African immigrants, each has a unique perspective on health and medicine.

CATHERINE T.

Catherine T. is a city woman – raised in Dakar, Senegal, she moved to an area just outside Washington, D.C. when she immigrated to the United States. This upbringing clearly comes through in the directness of her actions and her words. However, her urban-bred efficiency does not overshadow her kindness. She is a listener; caring and gracious, Catherine T. makes sure her chatting partners know they are heard. She is a gregarious conversationalist and a sincere sharer who is very open in her opinions. Freely discussing her own health successes and

29 Name has been changed.
strife, Catherine T. emits a deep passion for health analysis and its possible benefits to herself and her peers.

The power of the mind is evidently key to Catherine T.‘s definition of health. Proper diet, exercise, and regular visits to the physician contribute to physical health, but none can be achieved without the awareness and the drive required to support one’s own wellbeing. A person who is well must be conscious of how to maintain this wellness and act accordingly, while a person who is ill must be able to isolate the causes of this illness. Catherine T. emphasizes this ideology through a discussion on stress: avoiding stress both facilitates health and combats illness. Reading, for example, allows her to both escape social stressors through a redirection of focus and sharpen her self-awareness through an analysis of characters’ actions. For Catherine T., health consciousness is the foundation of health itself.

Consequently, holistic medicine is vital for the maintenance of Catherine T.‘s health. She relates a comprehensive support of wellbeing to a chronic health issue of hers that keeps her dependent on a physician. It is not sufficient to merely focus on physical symptoms; specialists as well as family practitioners must understand the broader social factors that contribute to her health and illness. Just as physical ailments affect her mental strength, situations with work and family contribute to aches and pains. The more time Catherine T. has spent in the United States, the better her relationships with her physicians become and the more she feels in control of her health and wellness.

WASSILA T.

Wassila T. was raised in a small town outside of Dakar, Senegal. Although his voice is quiet, his presence is powerful. His personality fills a room instantaneously, energizing everyone
who shares the space. He is friendly, considerate, and very talkative – his thoughts and opinions are endless, and he loves to share as many as he can. This is not to say he is a shallow or materialistic man. Wassila T. makes strong connections in his conversations and speaks with a clarity that reveals equal parts introspection and passion.

Health, both formal and informal, are at the forefront of Wassila T.’s mind. His definition of health is reliant on balance – a balanced meal, a balanced level of physical activity, and a balance between work life and family life are all vital for good health. While he states that his social balance is necessary to his wellbeing, he is adamant that he alone is responsible for his health. It is his decision to spend more time with those who support his emotional wellness or less time with those who harm it. His health is dependent on a combination of a variety of external factors, but the balance of these factors is entirely dependent on his own choices.

Wassila T. emphasizes the importance of positive thinking when using various medicines. However, he does not believe positive thinking has intrinsic value if it is unsupported by biological evidence. As a scientist, he relies on research to support the efficacy of any medicine – from staying hydrated to ingesting Vitamin C tablets, Wassila T. requires empirical data for his medicines. Importantly, he maintains that this empirical data is not as effective without confidence. Positive thought enhances the holistic effects of medicines; pragmatically, confidence in a medicine facilitates consistent use of the medicine. Wassila T. impresses the importance of balance between the physical and mental realms of being for a complete support of health.
SOSTHENES K.

Sosthenes K. was born and raised in Tsito, a town in the Volta Region of Ghana near the Togo border, and moved to an area in the Eastern Region at the end of his childhood and the beginning of young adulthood. Sosthenes K. is a man with soft power – he is humble and shy yet transparently firm in his convictions. His quiet demeanor subsequently favored a written interview over an oral discussion. Evidently, he is succinct in both thought and communication. Sosthenes K. is not a man who likes to waste his time or energy, and his perspectives on health and medicine are reflective of his direct character.

Sosthenes K. is a respectful man, a product of both compassionate discipline and intrinsic esteem. He described his childhood as very normal. He spent his days actively, playing soccer in place of watching a TV he did not have at home. He went to church frequently and connected this behavior to his peaceful and cooperative young experiences. Christianity is the foundation of his childhood, the thought process behind his opinions, and the development of his personality. Like the physical and mental realms of human existence, the spiritual realm is a vital domain that regulates Sosthenes K.’s health.

Lifestyle is very important to the wellbeing of Sosthenes K. He separates physical, mental, spiritual, and physical health fields; consequently, exercise is a proactive medicine that is just as important as a medical check-up. Self-awareness is also critical to Sosthenes K. for maintaining good health. This is not limited to recognizing the symptoms of disease in oneself. Preventative knowledge is key for his definition of a healthy person. This includes an identification of compatible traits between oneself and others to maintain healthy relationships, as well as an education of one’s genetic makeup to develop cautious habits for probable disease
vulnerabilities. Sosthenes K. approaches a holistic wellbeing through very scientific and pragmatic methods.

WANDA H.

Wanda H. grew up in Dakar, Senegal and travelled to France to complete her higher education. She moved to the United States with her husband and found a culture shock that was much more significant than she found in France – the way of speaking and behaving between colleagues contributed to a quieter manner after her immigration. Though soft-spoken, Wanda H. does not come across as withdrawn. She speaks very decisively and sincerely, and her thoughts teem with empathy. Her thoughtful self-reflection on health and medicine was marked by a constant consideration of others’ viewpoints, likely facilitated by diverse education and a compassionate character.

Wanda H. describes health as a daily behavior rather than a state of mind. Avoiding processed foods, exercising regularly, and attending regular check-ups define health as much as the lack of a common cold or other ailment. As a Muslim, Wanda H. sustains a unifying perspective on all forms of experience. One behavior can help or harm multiple dimensions of existence. Fasting, for example, satisfies her spiritual mindset, sharpens her mental focus, and increases her physical energy. For Wanda H., the line between formal and informal medicine is much more porous than many of her peers.

Additionally, she maintains that health is relative. Wanda H.’s definition of a healthy body is underweight when compared to a healthy body as defined by her family in Senegal. People require different amounts of exercise, food, medication, and physician visits; both opinions and physical bodies are differentially influential on health and health behaviors. The
core of Wanda H.’s perspectives on health have not been significantly altered since her arrival to the United States because she has always viewed wellbeing as flexible.

ENDALKACHEW B.

Endalkachew B. is a product of many different perspectives. He was born in a small town outside the capital of Ethiopia and did not move until he attended university in Accra. His passion for physics and math led him to follow his education around the world – he studied for a few more years in India and moved to the United States approximately 9 years ago. His words reflect his eclectic mind, conveying a sense of scientific pragmatism throughout a variety of cultural exposures. As he grew, he collected knowledge from these different viewpoints that subsequently strengthened his own perspectives on life and health.

The definition of health has changed over time for Endalkachew B. Preventative medicine was almost entirely lacking from his childhood. Most of his understanding of health was centered around illness; his wellbeing was derived from curing colds and fixing scrapes, not from changing his diet or increasing his amount of exercise. Endalkachew B. noted that this understanding was influenced by both culture and by physical environment. Growing up, recreation was more active and his family had easier access to good food. Because his lifestyle inherently benefited his health, he never considered it a form of medicine. However, his health consciousness raised significantly upon his arrival in the United States. His awareness of his own health, including use of preventative medicine and an increase in general check-ups by a physician, became much more important to him as he integrated with American culture.

A background of scientific studies and disease-centered healthcare has contributed to Endalkachew B.’s reluctant attitude toward complementary and alternative healthcare. His
medicinal practices are almost entirely within the formal field of healthcare. Although he has had friends throughout his life who have visited traditional healers, he has never been interested in visiting that realm of health. His father worked in the field of health and his education has been focused on the physical; he feels that medicine without formal scientific support is not true medicine at all. Endalkachew B. maintains that such practices may benefit mental health, which is a vital component of wellbeing, but strictly as a result of the placebo effect. For Endalkachew B., health is supported only through formal pathways.

Motifs

My conversations were unsurprisingly diverse. Every experience has unique roots and are lived in very distinctive ways. However, there were clear underlying motifs that marked each discussion, either in materialistic similarities or shared motivations. Identifying these motifs allows for a deeper understanding of first-generation African immigrant experience with health; additionally, this analysis can result in better supported implications when compared to the literature. The following motifs will be observed across the ethnographic accounts gathered by this project, contributing to practical conclusions concerning the improvement of health and medicine among first-generation African immigrants.

DIET & EXERCISE

Diet was heavily mentioned by every participant, implying a critical role in both health and health consciousness. All participants either implied or directly stated a significant difference in food access between their home country in Africa and the United States. Even for those who were raised in the city, organic food was much more readily available in their home country than in America. Processed food is undeniably detrimental to health and serves as a
significant obstacle for first-generation African immigrant health. Importantly, diet also affects health in indirect ways – my discussions have revealed a correlation between diet and health awareness. Both Wassila T. and Endalkachew B. noted that their definitions of health did not necessarily incorporate a good diet until a good diet was no longer a guaranteed part of life. Dietary awareness is one of many factors contributing to the notion of health as a process rather than a lack of illness.

Diet is not limited to the type of food consumed. Catherine T. believes that big meals directly lead to unhealthy existence. She learned from her mother that large meals weigh people down, leading to both physical and mental sluggishness. This is particularly true at night, where large amounts of food cannot be worked off. Smaller meals earlier in the day help Catherine T. feel much healthier. She has noted this in disappointment after her move to the United States. In Senegal, bigger meals could be consumed in the middle of the day. The fast pace of American life keeps her very busy for the majority of her day, frequently limiting her to eat larger meals later at night. Her children, too, are limited to the same schedule. Catherine T. is restricted to behavior that is detrimental to her and her children’s health as a result of American culture and not solely sociopolitical structure.

Her story is mirrored in the stories of the other participants, all of whom discuss the negative effects of American culture on their dietary habits. Both Wassila T. and Wanda H. identify their tea consumption as a stress reliever, notably caused by heightened stress at work. In addition, the decreased access to healthy food in America serves as its own stressor. Wanda H., a proponent of decreased meat consumption, notes that fresh produce is much harder to attain in the United States than in Senegal. Her physical health and mental acuity are accordingly inhibited. African-derived foods, then, provide stress relief and boost physical health. Sosthenes
K. religiously follows his grandmother’s soup recipe of okra, ginger, and other African herbs as a medicine to maintain health. Diet evidently serves to divide trust in health practices between American and African roots.

Along with diet, physical activity is consistently acknowledged as a key aspect of a healthy person throughout this study. The benefits to health are evident – exercise improves muscular and cardiovascular health, as well as mental sharpness and stress reduction. Every participant mentioned that regular exercise is vital to personal health. As with diet, they all noted the detriments of American culture on the consistence of their exercise. Long work hours restrict the hours that can be used recreationally, and access to low-cost exercise instruments is constrained. While many factors that limit exercise are not unique to American culture, such as computer-based jobs and recreation, the time constraint was a notable boundary for the participants.

CLASS

Socioeconomic class is a part of everyone’s identity – it defines the boundaries of consumer access for all citizens. For immigrants, class usually undergoes a large shift between countries of residence. A transition from a wealthy, socially-esteemed lifestyle to a poor and marginalized one (or vice versa) can have profound effects on the ways people view their health.

All my participants had middle-class childhoods and are currently middle-class Americans. Their socioeconomic statuses correlate strongly with their levels of education; most were able to secure comfortable financial situations through occupations that required extensive schooling. While Wassila T., Sosthenes K., and Endalkachew B. are from rural areas and Catherine T. and Wanda H. are from urban environments, all had financial access to similar
education foundations. Although they were not upper-class, they were all able to visit physicians when necessary either through personal funding or government subsidization.

Even as middle-class Americans, all participants are in strong agreement – healthcare in the United States is far too expensive. Most Americans believe that the cost of healthcare is too high, and immigrants are no exception to the rule. While the participants generally agree that they are able to see physicians more frequently in the United States than in their home countries, they do not believe this inherently correlates to better access. Access to healthcare is increasingly limited as costs rise. Wassila T. is the only participant to have discussed a positive side of American healthcare in detail – although other participants agree that healthcare is generally of higher quality in the United States than in their home countries, they all focused their conversations on its ineffectiveness as a result of high cost. Wassila T. compared the systems in America and in France, praising the United States for the immediacy of doctor availability. Urgent care centers and primary physicians allow any person who is sick to receive treatment very quickly. However, he implied that this availability is merely a façade of access. The costs of treatment and of insurance prevent lower-class citizens from receiving formal care; while anyone can see a physician at any time, they may not be able to afford the consequences.

RACE

The United States is built on a foundation of racism. Blackness in America has its roots in the Atlantic Slave Trade and developed through Jim Crow laws – anyone with an African ancestor is considered Black. While the differences between African Americans and African

---

immigrants are numerous and substantial, the challenges they face as Black Americans have significant overlap.

When compared to the literature, I have found in my own ethnographic data that participating first-generation African immigrants have much more trust in the professional health field than their African American peers. None of the participants mentioned or implied a hesitation about visiting a physician for an undiagnosed illness. While Sosthenes K. feels that many Americans visit physicians when a home remedy would suffice, he never expressed any fears of repercussions or insufficient care resulting from professional care. Catherine T., like all my participants, discussed the importance of building a relationship with a physician for long-term healthcare. When her physician of 15 years retired, she felt very comfortable initiating a new relationship with the replacement. The American government’s historical mistreatment of Black Americans appears to have a diminished effect on recent Black Americans, though a larger focus on race in this study would be required to confirm this trend.

Although my research has indicated a lower rate of race consciousness among my participants than among African Americans as it relates to health, no conclusions about first-generation African immigrants at large can be made. The parameters and repercussions of race and racism are different between slavery-shaped America and colonialism-shaped Africa. While physician trust seems higher among the participants, the grander effects of African race dynamics cannot be well understood solely in the context of American race.

MENTAL/PHYSICAL DICHOTOMY

When exploring the dichotomy between the mental and physical realms of being, all participants agreed that good health is reliant on their interdependence. Each said that mental
illness affects physical health and physical illness affects mental health. They also agreed that mental health is more ambiguous and harder to analyze. These concepts of health are clearly shared by other Americans.

The divide between formal and informal healthcare seems to parallel the physical/mental dichotomy. The participants of my research turn to complementary and alternative medicine for a more holistic form of healing than can be achieved through a doctor’s office, indicating that informal medicine is more adept at treating their mental health. Catherine T. explained mental illness as a source of suffering that cannot be detected at a medical check-up. Sosthenes K. described personal behaviors, such as the avoidance of stress, as a primary method for maintaining mental. These perspectives reveal a reliance on non-professional medicine and healthcare for the mental realm of health.

However, this divide is quite flexible. The ethnographies indicate that informal care is not restricted to mental health. Catherine T. described her home remedy ointment as a pain reliever specific to physical ailments, Wanda H. attributes her physical endurance to her periods of fasting, and Wassila T. mentioned his siblings’ healing of Hepatitis A through natural plant remedies. Each of these treatments are informal and are used to address physical ailments, which consequently improve mental health as well.

My participants also discussed the power of formal healthcare to indirectly treat mental health. Sosthenes K. emphasized the importance of his physician as his first resource when feeling physically ill from depressed emotions. Endalkachew B. detailed his opinion that mental health issues create more challenges than physical health issues; minor mental illness, he maintained, is more damaging to day-to-day activities than minor physical illness. Overall, the participants indicated that mental health ultimately controls both the mind and the body.
CULTURAL CONFLICT

I expected to find significant conflict between African-derived and American-derived behaviors among first-generation African immigrants. Cultural collision often creates discomfort that is difficult to express – many immigrants undergo higher rates of anxiety and depression that correlate to this conflict. However, conflict has not been a predominant theme in my discussions. These women and men expertly navigate a single world that appears to be divided into two perspectives. While it is certainly true that friction exists between health behaviors among first-generation African immigrants, I have found that it does not cause nearly as much tension as I initially expected. The participants express a very clear awareness of the differences in behaviors and expectations between their converging worlds.

These different worlds create multiple realities within first-generation African immigrants; the participants of this thesis have demonstrated expert navigation between these realities. Wassila T. provides a clear example of this navigation. To a non-immigrant American, lack of professional dental care indicates poor dental hygiene. To Wassila T., it is simply a matter of describing the difference in technique between himself, who visits the dentist regularly, and his father, who never went to the dentist through his entire life. Instead, he used a type of twig generally referred to in Senegal as sothiou to clean his teeth. Both have maintained excellent dental hygiene, but under two different understandings of reality.

Other participants have demonstrated similar ease of translation. Endalkachew B.’s concern for preventative health care has significantly increased since his arrival to the United States, and he has adjusted his health behaviors accordingly. Though Wanda H. does not visit

32 North, “The Immigrant Paradox.”
traditional healers herself, she discussed a friend who visited such a healer for blurry vision. The healer placed a clear bowl of water in front of the patient and initiated an eye massage; after the process was complete, Wanda H.’s friend had clear vision and the water had become murky. She found equal validity in her friend’s story and in her own experiences with formal eye physicians. While the understandings of reality between two countries may seem to conflict, these first-generation African immigrants display an ability to accept both in a single pattern of thought.
CHAPTER 3

Confounding Variables

HOME COUNTRY

The category of first-generation African immigrant encompasses an enormous group of people. The culture of people in Cairo is very different from that of people in Cape Town, but both could be incorporated into the parameters of this study. All but one of my participants are from West Africa, and all are from the northern hemisphere. Although there are significant cultural differences between Senegal, Ghana, and Ethiopia, they cannot be generalized to the entire continent.

Each individual voice is expected to be different. Catherine T. and Wassila T. are both from Senegal and married to one another, yet both have distinctive perspectives on health and medicine. Small variances in the choice on how to handle stress can contribute to larger differences in conclusions. For example, Catherine T.’s decision to read a book when she is under stress reveals a strategy of critical thought, while Wassila T.’s decision to drink tea when he is under stress reveals a strategy of clearing the mind. Clearly, no single voice will be representative of an entire region of Africa. However, the historical development of cultural practices that affect health behaviors are diverse across Africa. Future studies would benefit from a wider range of home countries to determine similarities that develop among Africans in America. Another method for clarifying this variable would be to conduct a series of regional studies. Other location-based differences, such as the variance between urban and rural areas, should also be explored.
EDUCATION

African immigrants are, as a group, the most comprehensively educated group of immigrants in the United States. Most have graduated high school (90%) and the majority have attended some college (75%). My sample of case studies reflects this characteristic; all my participants have attended a university.

Level of education has a significant impact on health behaviors. In many ways, health consciousness is heightened with increasing education. While discussing the many variables analyzed by my thesis, Wassila T. noted that higher-educated people tend to be more prone to proactive healthcare. Higher-educated people are also more likely to participate in complementary and alternative medicine, regardless of socioeconomic status. Broadening the range of education levels among participants would help elucidate the effects of education on health and health consciousness.

AGE

Health is strongly dependent on age, and the majority of my participants are middle-aged. Health perspectives and choices of medicine are likely influenced by age and may have skewed the effects of first-generation immigration in my study. Endalkachew B. specifically stated that his increased physician visits correlate to his aging. Consequently, the higher levels of trust my participants have in institutionalized health care when compared to the literature on African American health may be due to the American trend towards conservatism with age rather than

historical racism alone. Future studies would benefit from a wider range of age groups to overcome this variable.

**DURATION OF RESIDENCE**

The length of time an immigrant has resided in the United States affects the influence of American culture on the immigrant’s thoughts and behaviors. An African immigrant who has lived in U.S. for under five years will have a much different experience than one who has lived in the U.S. for over thirty; American social influences like racism and classism have less of an effect on health for the former. The durations of residence among my participants range from nine years to over twenty. The large variety may have skewed the conclusions I have drawn regarding behavior. To correct for this variable, I recommend either gathering a larger pool of participants or limiting the duration of residence for participants.

**Conclusions**

When discussing foreign traditional medicine, many native-born (and, specifically, White) Americans wonder how anyone can believe in healing that is unsupported by the natural sciences. How can a woman believe that palm oil will cure her infertility if there is no chemical connection between the two? The question of belief is not a common concern for first-generation African immigrants. Instead, they focus on action. A woman will take palm oil as a fertility treatment if it has worked for her family or friends; if it does not work for her, she will not continue the treatment. Belief is the key difference between the realities derived from these immigrants’ home countries in Africa and the western mindset. Catherine T. detailed the use of a Senegalese tree oil to heal joint aches, noting that it may seem strange to Americans who medicate themselves strictly via pharmaceutical drugs; she specifically stated that she uses it
because it works, not because its validity is confirmed by an external source of authority. She also mentioned a friend who visited a traditional healer to cure his back pain – while she has never visited a traditional healer herself, she plans to contact this healer if she ever experiences back pain on the basis of her friend’s testimony. As the participants of this research demonstrate, the efficacy of medicine is not intrinsically derived from the belief that it will work – instead, empirical data resulting from action is at the core of first-generation African immigrant medicine. Unlike health, the efficacy of medicine cannot be improved by a good mindset alone. If a medicine is effective, there is no reason to ever question whether one should believe in its potency.

Evidently, both health and medicine are not restricted to action alone in the United States. My ethnographic research has unveiled a significant increase in health consciousness among first-generation African immigrants after moving to America. Preventative care was not a focus among my participants in their home countries in Africa – doctors were for people who were ill, and medicine did not incorporate the upkeep of good health. The transition in ways of life upon arrival to the U.S., as well as American culture itself, may have made my participants much more aware of their health in everyday life. Diet and exercise evolved from general aspects of existence to factors for actively maintaining wellbeing; class and race transformed from social issues to key obstacles to being healthy. While health used to be shaped in the context of disease, it is now something to care for even when problems are not present. In Africa, my participants mostly framed health as an absence of illness. In America, they consider health as a constant quality of life.

Although American advertisements and social trends emphasize health as a lifestyle, they do not intrinsically improve health. News reports telling us that coffee either causes or prevents
cancer have little effect on the actual rates of cancer\textsuperscript{36} – they do, however, affect our anxieties over our health. While none of the participants explicitly stated that they feel their health has declined since they moved to America, they have all expressed stress over maintaining it. The increase of health consciousness may therefore provide some detriment to first-generation African immigrant health. Broadly, immigrant health tends to decline through progressive generations of residence – although many immigrants move to America for better access to healthcare for themselves and their children, the health of their family decreases with each new generation born.\textsuperscript{37} This Immigrant Paradox is attributed to increased exposure to socioeconomic obstacles like race and class. My study implies that an increase in health consciousness may also contribute to this decline in health by serving as an anxiogenic.

Along with health consciousness, complementary and alternative medicine is clearly an active part of the lives of first-generation African immigrants. As with the rest of the American population, informal healthcare is practiced both consciously and unconsciously in the lives of my participants. However, behaviors that are notably “African” are either reframed or rejected entirely. This reframing comes in the form of a line drawn between culture and spirituality. For example, herbal remedies are passed down from family members and are therefore legitimized as cultural behaviors. Traditional healers, then, are explicitly derived from African spirituality and thus do not serve as effective medicine. It is unclear whether this line is drawn solely for the discussions between an African immigrant and a native-born white American or if the participants feel this difference themselves. Likely, it is both. Importantly, this line does not separate practices by actual effectiveness. Most participants noted that they have friends who

\textsuperscript{37} North, "The Immigrant Paradox: The Stalled Progress of Recent Immigrants' Children."
successfully visit traditional healers. Although they acknowledge that it is a valid source of healing for their acquaintances in Africa, they do not feel it is valid for themselves.

These findings indicate that African-derived practices are not as welcomed into the field of complementary and alternative health as other practices. The United States’ historical infantilization of Africa has undoubtedly created an environment that rejects the intrinsic validity of African behaviors and ideas in an American context. While this rejection is not all-inclusive, it has clear effects on the ways that first-generation African immigrants view their health practices and express them to others. An increased awareness about the stigma on African practices will enable the legitimization of practices like African traditional healers in the United States, facilitating its benefits for African immigrants and possibly other Americans as well.

As this project continues in my own life and in the scholarship of others, I recommend a reframing of methodology and subject focus. Future research would benefit from long-term studies; multiple interviews with participants would enable a deeper trust to be built, leading to more honest answers and a better understanding of cultural and behavioral nuances. I was expecting to find a larger amount of conflict in health perspectives among first-generation African immigrants. While I can conclude that these perspectives are expertly navigated, I cannot conclude that conflict was minimal. It is possible that my participants did not feel comfortable enough to fully share these anxieties with me. Additionally, people rewrite their personal narratives as their perspectives change; perhaps their senses of histories changed with their perspectives and they no longer see things from their former points of view. In either case, long-term studies would benefit these conversations through the establishment of stronger trust and the ability to elicit better-informed reflective thought.
This study was originally intended to incorporate the voices of both first-generation African immigrants and the American health professionals who work with them. This group of people proved more difficult to interview – the physicians I contacted were either unwilling or unable to share their personal experiences regarding a specific group of patients with me. They are also more difficult to contact as their network is much more loosely connected than that of first-generation African immigrants. Future studies would benefit from a more powerful persistence in contacting all types of participants and a more consistent follow-up procedure. Additionally, a heavier focus on social realms that differ between America and Africa (such as race, gender, sexual identity, and sexual orientation) would provide an even broader realm of voices to represent first-generation African immigrant health.

The ethnographic accounts presented in this research reveal just the surface of insightful understanding. Voices that have been historically ignored in academic literature are now being amplified and analyzed, paving the way for a more comprehensive perspective on American health in academic literature. This thesis serves as a methodological foundation for future scholarship on health and medicine among first-generation African immigrants in the United States. This study focused on a very small number of participants – as it develops into various manifestations throughout my personal and academic future, the research will gain infinitely more depth as more people become involved. By focusing on the details of underrepresented perspectives, American health is overall improved; by hearing these perspectives from the subjects themselves, American health becomes an experience to be shared.
QUESTIONS FOR FUTURE STUDIES

1) To what extent does the Immigrant Paradox apply to African immigrants?

2) What are the differences in experiences with health and medicine between first-generation African immigrants from northern Africa and from southern Africa? From eastern Africa and from western Africa? What are the similarities?

3) What are the differences in experience with health and medicine among first-generation African immigrants raised in urban homes and rural homes? What are the similarities?

4) How does education affect health and medicine among first-generation African immigrants? Do higher levels of education correlate with higher health consciousness?

5) Do first-generation African immigrants become more conservative with age? How would this increased conservatism affect experiences with health and medicine?

6) How does duration of residence affect health and medicine among first-generation African immigrants?

7) What specific medicines and healing strategies are used among first-generation African immigrants?

8) How is race consciousness different between African Americans and first-generation African immigrants? How do these differences affect attitudes toward health and medicine among first-generation African immigrants?

9) To what extent do first-generation African immigrants subscribe to Cartesian duality (mind/body separation)? How do their conceptualizations of physical personhood affect their views on health and medicine?

10) How does social identity (race, gender, sexual identity, sexual orientation, etc.) affect perspectives on health and medicine among first-generation African immigrants?
APPENDIX A – Questionnaire for First-Generation African Immigrants

The College of William & Mary
Africana Studies
Health and Medicine among First-Generation African Immigrants in the United States

1. Where were you born? Where did you grow up? Please briefly describe your childhood.

2. How would you define health?

3. What makes a person healthy?

4. Are there things you do for your health when you aren’t ill? If so, what are they?

5. Do you have any specific things that you do to stay healthy that you think other people don’t do? In other words, do you have any health practices you think are unique to you? If so, what are they?

6. Do you divide mental health from physical health? Please elaborate.

7. Do you have a regular doctor? If so, please describe the nature of your relationship. If not, please explain why.

8. Are there things you learned from your parents or your grandparents on how to support your health? If so, what are they?

9. If you have children, what do you teach them on how to support their health? Are there things your parents or grandparents taught you to do for your health that you teach to your children? Are there things your parents or grandparents taught you to do for your health that you purposefully withhold from your children? Please elaborate.

10. How do you know when you’re ill?

11. What do you do when you’re ill?

12. Are there different kinds of illnesses that send you to different specialists?

13. Do you have a specific community outside of the formal American healthcare system (outside physicians, specialists, etc.) that you rely on to support your health or for illness?

14. When other people are ill, do you suggest the same treatments for them as you would apply to yourself? Does it depend on the person?

15. What is your opinion on the current formal American healthcare system?
APPENDIX B – Questionnaire for Health Professionals

The College of William & Mary
Africana Studies
Health and Medicine among First-Generation African Immigrants in the United States

1. Please briefly describe your occupation. What led you to this field?

2. How would you define health?

3. What makes a person healthy? What makes a person ill?

4. Do you divide mental health from physical health? Please elaborate.

5. What is your experience with African-derived health and medicine?

6. Do you have regular interactions with African immigrants? Please describe the context.

7. Please describe any trends you have observed with regard to African-derived health behaviors.

8. How do you approach the topic of health when in contact with people from a different culture?

9. Have your interactions with African immigrant health practices affected the way you view health?

10. Is there anything else you would like to say concerning the current formal American healthcare institutions?
Bibliography


