

**The Importance of the African Immigrant Experience for Health Promotion:  
An Integrative Literature Review**

**by**

**Adeyoola O. Adeniji**

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## **Abstract**

As the minority population in the U.S. increases, the number of African immigrants also continues to rise (McCabe, 2011). A single race category fails to capture distinct experiences across the black population. With such a growing population, the African immigrant population continues to be understudied ((Reed et al., 2012). A literature review including studies of African immigrant populations in the U.S., Europe, and Australia was conducted. Findings indicate that dietary acculturation, language barriers, and several other factors warrant further consideration when serving the needs of African immigrants. Furthermore, there is a need to provide additional support services for recent immigrants, refugees, and undocumented immigrants of African origin. Cultural competence training must incorporate the African immigrant experience. The difficulty of acculturation must also be recognized and efforts to aid this process promotes positive health outcomes among this population. As we progress to engage African immigrants in research, there are obstacles and challenges to consider and strive to overcome.

## **Introduction**

### ***Rise of the African Immigrant Population***

According to the U.S. Census Bureau, the United States is projected to become more diverse, with minorities comprising 57% of the population by 2060 (Bernstein, 2013). As the United States continues to diversify, there is an increased need to assess and understand the health status of minority populations. There is also an increased need to examine the diversity within the minority experience. A significant population contributing to the growing diversity in the U.S. are African immigrants. The number of African-born immigrants living in the U.S. grew from about 200,000 in 1980 to nearly 1.5 million in 2009 (McCabe, 2011). In 2015, there were 2.1

million African immigrants living in the United States, with Nigeria, Ethiopia, and Egypt as the top birthplaces (Anderson, 2017). With African immigrants arriving to the U.S. from a unique continent, their experiences differ from the experiences of African-Americans. Rather than equating the black experience to a monolith, the African immigrant experience warrants further examination in the field of health promotion. Africans represent one of the fastest growing immigrant populations in the United States (Ilunga Tshiswaka & Ibe-Lamberts, 2014). Despite the rapidly growing population of African immigrants and their distinct experience from other black populations living in the U.S., the health status of African immigrants remains understudied (Reed et al., 2012). While general immigrant and refugee social indicators have been studied, African immigrant groups in the U.S. have been excluded (Kamya, 1997). Thus, there is a rising need to examine the African Immigrant Experience in promoting nutrition, physical activity, and health literacy. This paper will examine findings that demonstrate the unique experience of African immigrants as related to their health status. To note, the terms “African immigrants” and “African-born immigrants” may be used interchangeably. The term “host country” refers to the country being migrated to, whereas the term “homeland” refers to the country of origin. Although many studies distinguish North Africans from the remaining regions of the continent, this paper examines factors impacting Africans from various regions.

### ***Historical Divergence***

To understand the distinct experiences between African immigrants in the U.S. and African Americans, the divergent histories between the two groups must first be understood. While both groups share a common ancestral origin and past oppression from white Europeans, their historical upbringings vary. The business of slavery resulted in forcing millions of Africans to

the New World in the 1500s. Prior to the 1820s, it was estimated that 8.4 million people arrived from Africa whereas 2.4 million people arrived from Europe (Davis, 2014). As the slave trade increased, the population growth in Africa stagnated and eventually declined from 1750 to 1850 (Davis, 2014). Blacks living in America cultivated agriculture, raised livestock, and worked in an array of crafts, ranging from midwifery to carpentry (Davis, 2014). Although they came from various cultural heritages, African slaves shared underlying cultural understandings (Mintz & Price, 1976) According to Davis (2014), once the first set of Africans in America gave birth, their children were considered African *American*. African Americans made significant contributions ranging from introducing rice farming methods to pioneering the use of antiseptic techniques (Turner, 2008). Their contributions aided the development of the United States.

The transatlantic slave trade changed the lives of Africans forced to the Americas, as well Africans who were not taken (Davis, 2014). Those classified as African immigrants maintain a distinct history from the experiences of African-Americans. Following the transatlantic slave trade, Africans residing in the continent faced the devastating impacts associated with an absolute loss of a significant segment of their population (Lovejoy, 1989). The continent endured changes in settlement patterns and organization as well as novel mechanisms for defense. Thus, societies in Africa encountered significant changes in sociocultural and economic interactions (DeCorse, 2001). Colonization then began in African countries from 1871 to 1908. During this period, European powers signed unfair treaties with native chiefs in order to capitalize on land in Africa. Colonialism was motivated by various factors, including social Darwinism and radical nationalism among European nations. Social Darwinism claimed the superiority and inferiority of certain races, which portrayed colonialism as a method of civilizing “savage” societies. The

radical nationalism of European nations encouraged competitive claims in African countries as a means of proving the superiority and bolstering national pride. Furthermore, African countries contained valuable resources capable of boosting the economic prosperity of European nations (Pella, 2015). These and other motivating factors propelled European nations to occupy Africa, create arbitrary state boundaries, and exploit natural resources. Moreover, Europe imposed administrations that impact the culture, politics, and development of African countries to date (Pella, 2015).

### ***The African Immigrant Experience***

As mentioned before, the African Immigrant Experience is unique and distinct. African immigrants often migrate for economic, educational, or occupational opportunities. They typically maintain cultural ties to their country of origin and may even send financial contributions to family members residing in their country of origin. Along with other immigrant groups, African immigrants encounter cultural shifts, communication barriers, and adjustments to the healthcare and educational systems. The process of acculturation or adapting to a new cultural environment can be stressful and demanding (Kamya, 1997). Unlike most immigrant groups, African immigrants must also adjust to their new status as a racial minority (Sellers, Ward, & Pate, 2006). Thus, they may experience a form of discrimination and prejudice uncommon in their majority-black homelands. Moreover, dual racism emerging from being both black and an immigrant is another unique experience for African immigrants, and potentially Afro-Caribbean immigrants (Sellers et al., 2006). According to Francis, the needs of African immigrants is a conglomerate resulting from race dynamics in their host country and general social service needs that apply to immigrant groups (Francis, 2000).

### ***Healthy Immigrant Effect-Fact or Fiction***

The Healthy Immigrant Effect or Healthy Migrant Hypothesis was noted throughout the review. The Healthy Immigrant Effect posits that the health of immigrants shortly after migration is significantly better than native-born people (McDonald & Kennedy, 2014). However, the validity of the healthy immigrant effect was contested. O'Connor et al. (2014) argues for reexamination of the healthy immigrant effect after finding that African men had poorer cardiometabolic health outcomes than African American men. African immigrant participants were found less likely to engage in vigorous physical activity or have health insurance. Additionally, despite lower rates of obesity, African immigrant men had higher rates of diabetes and prediabetes (O'Connor et al., 2014).

The healthy immigrant effect may also fail to account for refugees or other involuntary migrants. These populations may face increased morbidity and lower life expectancy due to their circumstances (Ibe-Lamberts, Tshiswaka, Osideko, & Schwingel, 2017; Drummond, Mizan, Brocx, & Wright, B, 2011; Carolan, 2010). Thus, the healthy immigrant effect was contested and warrants further consideration.

### ***Ties between Race and Ethnicity and How It Relates to Health***

The experience of African immigrants demonstrates the overall importance of minority health. Minority groups should be able to access necessary services to achieve positive health outcomes. Research has indicated that racial and ethnic minorities tend to have poorer health outcomes and experience lower quality of care. Therefore, vulnerable populations are experiencing less access

to critical healthcare services. Although minority health research can produce highly relevant findings, the limitations due to ethnic differences must be addressed (Egede, 2006).

The study of racial variations among individuals is not always ideal, as race is limited in biological significance (Egede, 2006). Due to the heterogeneity of the black population, race classifications alone may not provide an accurate representation of health outcomes. There is great diversity in health outcomes among various African descent populations (Agyemang, Bhopal, & Bruijnzeels, 2005). However, research tends to group black immigrants with African-Americans. This can be problematic in garnering accurate data and conducting proper analyses (Wafula & Snipes, 2014).

In fact, the lack of data on African immigrants may be attributed to the single race category of Black/African Americans (Commodore-Mensah, Himmelfarb, Agyemang, & Sumner, 2015). Beyond African immigrants, the black population is comprised of Afro-Caribbeans and African Americans. Afro-Caribbeans are those of African descent residing in Caribbean islands, such as Haiti or Jamaica. African Americans are those of African descent with ancestors forced to come to U.S. from the 1600s to 1800s (Commodore-Mensah et al., 2015). A single race category cannot fully capture the vast cultures, beliefs, and histories encompassing the black population. Thus, the concept of ethnicity may be a more viable alternative to garner a more accurate description of health outcomes among the diverse populations of African descent (Agyemang et al., 2005).

## **Methodology**

As evidenced, the unique experience and history of African immigrants warrants separate consideration for health promotion research. This review entails an examination of existing literature on African immigrant health. The health indicators examined include nutrition, physical activity, and health literacy. The primary population studied were African immigrant adults, men and women aged 18 and older. However, a few studies examine the health outcomes of African immigrant children and adolescents. In order to garner extensive research, an integrative review was conducted to synthesize various findings of existing literature. Due to the dearth of literature, studies on African immigrant health indicators in Europe and Australia were also examined (n=11).

## ***Search Methods***

Multiple methods were utilized to thoroughly search for literature. Searches were conducted using Google Scholar. The following search terms were used: *African Immigrant Health, Black Immigrant Health, African Immigrant Nutrition, African Immigrant Activity, African Immigrant Physical Activity, African Immigrant Exercise, African Immigrant Literacy, African Immigrant Health Literacy*. I also examined the references from published articles to garner additional literature for a comprehensive review. 63 papers were identified, and 46 papers are included in this review.

## **Review of the Literature and Findings**

### *Paucity of Literature*

One major finding is the paucity of literature on this subject area. While conducting the literature search, many articles recurred. Studies also acknowledged how the lack of distinction between African American and African populations can contribute to the paucity in research (Ting, 2010). Moreover, many health studies on African immigrants focus on infectious diseases, such as HIV and hepatitis B. Whereas, noncommunicable, chronic diseases are understudied. Studies have found African immigrants more likely to have hypertension, pre-diabetes, and diabetes than African-Americans. However, chronic, cardiometabolic health indicators are understudied among African immigrants. (Commodore-Mensah et al., 2015). Therefore, stereotypes regarding the infectious and viral diseases afflicting the entire continent may result in certain health concerns remaining unexplored.

Furthermore, many articles provided information on African immigrants residing in a specific state (Harcourt et al., 2014; Foley, 2005; Vaughn & Holloway, 2010; Reed et al., 2007; Simbiri, Hausman, Wadenya, & Lidicker, 2010; Jacobus & Jalali, 2011; Boise et al., 2013; Sewali et al., 2015). States, including Texas, Maryland, Virginia, and New York have experienced significant increases in African immigrant populations as compared to other states throughout the country (Commodore-Mensah et al., 2015). However, research studies are not being conducted in these high African immigrant population states. There is also a lack of research examining health indicators of African immigrants throughout the country, which reduces the generalizability of many studies. In addition, the use of the term “immigrant health” was readily associated with Latino and Hispanic populations. Narrow search terms were necessary to find information

related to African immigrants.

### *Language Gaps and Need for Interpreters*

The presence of language gaps continues to be a barrier to accessing health services for many African-born immigrants. Not only are African immigrants adjusting to a new environment, but the language of their host county may differ from the official language of their native country. Language acculturation and availability of interpreters can greatly impact the health outcomes of African immigrants. Interpreters may be needed to navigate the complex US health care system, obtain necessary health services, or participate in health research.

McGillivray et al. (2007) noted the need for additional linguistic support services for research subjects. His study provided interpreters trained in the languages of Eastern Africa to ensure proper, informed consent of participants. Harcourt (2014) provided research surveys in the preferred language of participants, ranging from Somali to Pidgin English. This contrasts from studies requiring participants to comprehend English (Ibe-Lamberts et al., 2017). Foley (2005) employed both anglophone and francophone focus groups to collect information from African immigrant women participants. Participants identified language gaps as barriers to accessing treatment. Furthermore, since participants were sharing perceptions regarding access to HIV testing and treatment, the need for interpreters trained in confidentiality was also expressed (Foley, 2005). Lack of confidentiality in accessing interpreter services was deemed a barrier to accessing healthcare (Boise et al., 2013).

African immigrants' perceptions of language barriers and the need for interpreters was highlighted in multiple studies (Wafula & Snipes, 2014; Adekeye, Kimbrough, Obafemi, & Strack, 2014; Reed et al., 2007; Gong et al., 2006; Gele & Mbalilaki, 2013). Language acculturation or adequate proficiency in the language of the host country was associated with better self-rated health (Okafor, Carter-Pokras, Picot, & Zhan, 2013). For example, an African immigrant coming to the U.S. from an English-speaking country may perceive greater ease in obtaining positive health outcomes. In contrast, African immigrants in the U.S., who speak French show less acculturation, greater difficulty obtaining insurance, and less utilization of health care services (Simbiri et al., 2010).

While interpreters can enhance the ability of African immigrants to comprehend and navigate the complicated health care system, they must not be forced onto patients (Pavlish, Noor, & Brandt, 2010). African immigrants may sense differential treatment or discrimination when health care staff detect an accent (Adekeye et al., 2014). Thus, African immigrants who are comfortable with the English language may experience discrimination due to their accent (Wafula & Snipes, 2014). It can be demeaning if the patient is proficient in English, yet a professional insists that an interpreter is provided (Pavlish et al., 2010). Thus, healthcare professionals must be respectful of a patient's request or refusal for an interpreter.

Unfortunately, linguistic imperialism stigmatized indigenous African languages, resulting in the influence of languages, such as French and English within African nations (Phillipson, 1996). However, the presence of these common or official languages among African immigrants provides an opportunity to address the language gap in accessing healthcare. Due to the great

diversity within the continent, most African countries are multilingual (Zsiga, Boyer, & Kramer, 2015). The feasibility of providing interpreters for each distinct language is highly limited. However, increasing the availability of interpreters for official languages, such as Arabic or French is valuable and achievable. As the population of African immigrants continues to increase, the provision of additional linguistic support services must be prioritized in order to promote positive health outcomes within this population.

### *African Immigrants and Dietary Patterns*

#### *i. Dietary Acculturation*

When exploring needs for nutrition education and promotion among African immigrants, the concept of dietary acculturation was continually highlighted. Dietary acculturation involves following the dietary consumption patterns of the host country (Okafor et al., 2014). However, the measurement of dietary acculturation varied across studies. Okafor et al. (2014) asked participants to rate their level of changes in diet post migration. Quantitative and qualitative survey items were posed to understand the extent of dietary change (Okafor et al., 2014). Meanwhile Adekeye et al. (2014) evaluated dietary acculturation based on the availability of the healthy foods more readily accessible in native homelands. Dietary acculturation has also been assessed through use of a food-frequency questionnaire. Participants were asked to appraise their intake of foods and nutrients from the previous year to determine dietary patterns (Delisle et al., 2009).

Additional indicators, such as shopping patterns and food environments have been analyzed to determine dietary acculturation among African immigrants (Patil, Hadley, & Nahayo, 2009).

Even, the draw and tell method has been utilized to measure dietary acculturation among children. Children were asked to create two drawings about food and explain the significance of these food items (Blanchet, Sanou, Batal, Nana, & Giroux, 2017). This method may be effective in allowing children to use a medium more appropriate for their age group. However, the lack of consistency in definitions of dietary acculturation may be problematic in carrying out future research on African immigrants. A clearer definition or set of indicators must be delineated to obtain a thorough measure for dietary acculturation.

Despite the inconsistencies in definition, most studies agreed that greater levels of dietary acculturation led to adverse health outcomes. Moderate dietary acculturation was associated with a higher likelihood of poorer self-rated health. Thus, African immigrants who adapt dietary patterns to the host culture may be making unhealthy changes to their diet (Okafor et al., 2014). Immigrants indicated multiple barriers to the availability and affordability of healthy foods (Adekeye et al., 2014). The drastic change in availability of fruits and vegetables can lead to dietary acculturation (Patil et al., 2009). The lack of time to prepare traditional meals, fatigue of parents, and the school environment may increase the likelihood of acculturation among children of immigrants (Blanchet et al., 2017). While some immigrants maintain certain elements of their traditional diet, acculturation to the host diet may still occur. However, this finding was among immigrants from sub Saharan African descent, not necessarily only African immigrants (Agyemang, Addo, Bhopal, de Graft Aikins, & Stronks, 2009). Overall, globalization appears to have a negative impact on dietary habits (Delisle et al., 2009).

A study by Delisle et al. (2009) found that younger African immigrants and those who migrated recently were more likely to exhibit dietary acculturation. Dietary acculturation can have significant implications on both maternal and child health outcomes (Lindsay, Gibney, & McAuliffe, 2012; Renzaho, Swinburn, & Burns, 2008). A study by Blanchet et al. (2017) found that several black immigrant children reported lower consumption of healthy, native foods. Some children reported replacing these foods with unhealthy foods. Again, these findings apply to black immigrant children, including those with both African and Caribbean parents. However, it remains evident that traditional or native diets are often healthier than Western diets.

*ii. Traditional Diets*

It appears that traditional diets have protective factors for African immigrants. A Western diet refers to a pattern characterized by energy-dense, fatty foods. In contrast, the traditional diet of the Bubi people of Equatorial Guinea is characterized by roots and tubers, with little consumption of animal protein and fat (Delisle et al., 2009). The high intake of fruits and vegetables found in the traditional Bubi diet was classified as “somewhat protective” (Delisle et al., 2009). The high intake of protective food groups may attribute to the healthy impacts of traditional African diets. Food groups, such as legumes, fruits, vegetables, and whole grains are common in the traditional diets of African immigrants (Lindsay et al., 2012). In fact, up to 92% of calories in Liberian and Somalian diets are comprised of vegetables. Data indicates that Liberian refugees can more readily access fruits and vegetables in their native country (Patil et al., 2009). Furthermore, Congolese participants noted specific, traditional vegetables known to be protective for health, specifically to lower blood sugar. Traditional Congolese diets were perceived as being comprised of organic and natural products (Ilunga Tshiswaka et al., 2017).

Finally, Ibe-Lamberts et al. (2017) found two major themes from African immigrant participant discussions. African dishes are perceived as being comprised of fresh, natural ingredients. This mirrors the expressions from Congolese immigrants in Ilunga Tshiswaka's study (Ilunga Tshiswaka et al., 2017). Additionally, the self-preparation of African dishes is viewed as a means of controlling dietary intake (Ibe-Lamberts et al., 2017). Interestingly, participants expressed knowledge of high sodium levels of certain traditional dishes. However, the ability to prepare these meals functions as a method to control their intake of sodium (Ibe-Lamberts et al., 2017).

### *iii. Food Insecurity*

The last finding related to dietary and nutrition patterns of African immigrants is food insecurity. The concept of food insecurity among African immigrants must include religious and cultural considerations. Hadley et al. (2007) defines food insecurity as lacking access to safe, nutritious, and culturally appropriate foods. African immigrants, specifically refugees are at increased risk of food insecurity resulting from insufficient income. Less adaptation to Western dietary patterns and less accessibility to culturally appropriate foods may be associated with food insecurity.

Food insecurity was also related to length of stay in the United States. Refugees who resided in the United States for longer periods of time were less likely to be enrolled in the Food Stamp Program (Hadley et al., 2007). Jacobus & Jalali (2011) also noted the pertinence of cultural and religious considerations in regard to food insecurity. Factors, including affordability, proximity, as well as cultural and religious guidelines were incorporated in their explanation of food access

(Jacobus & Jalali, 2011). Some African immigrants are Muslim, which requires both cultural and religious considerations for dietary intake. Traditional Islamic law prohibits consumption of haram food but permits Muslims to consume halal food. Such foods may be expensive to import or may require distant travel to a specialty store (Jacobus & Jalali, 2011). Therefore, lack of access to culturally appropriate and religiously permitted food items constitutes food insecurity for many members of the African immigrant population.

### ***African Immigrants and Physical Activity***

Similarly to dietary patterns, many cultural factors also impact the ability and willingness of African immigrants to engage in physical activity. Adekeye et al. (2014) found physical activity to be a concern for African immigrant participants, with many expressing knowledge about the importance of an active lifestyle. However, participants reported time and safety as barriers to engaging in activity, due to working multiple jobs or living in risky and unsafe communities (Adekeye et al., 2014). In fact, time and safety were cited as concerns by participants in a number of studies (Ibe-Lamberts, 2016; Murray et al., 2013; Ibe-Lamberts et al., 2017) These repeated barriers must be evaluated when addressing physical activity concerns among African immigrants.

While African immigrants maintain a solid knowledge regarding overall benefits of physical activity, they strongly value the benefits related to weight loss and maintaining body image. Thus, physical activity may be prioritized as a means of altering or managing personal body image, rather than for overall health (Ibe-Lamberts, 2016). The emphasis on migrating to a new country to obtain an education, care for family, and seek better opportunities also influences the

priority level of physical activity for African immigrants. The promotion of physical activity trails behind other goals that accompany migrating to a new country (Ibe-Lamberts et al., 2017).

Ibe-Lamberts (2016) also highlights the use of cultural practices as a way for African immigrants to engage in physical activity. Dancing is often performed by African immigrants at cultural or church events. For example, Nigerians maintain the practice of hosting parties even while living in the United States. These parties consist of traditional food, fashion, dance, and music. Dancing allows African immigrants to maintain traditions and native ties (Ibe-Lamberts, 2016). On the other hand, activities like yoga were not perceived as “culturally relevant” practices for African immigrant participants. Thus, dancing can be promoted as a form of culturally appropriate physical activity (Ibe-Lamberts, 2016; Ibe-Lamberts et al., 2017). The value of culturally sensitive recommendations can be applied to the area of physical activity (Wieland et al., 2012).

### ***African Immigrants and Health Literacy***

Health literacy is comprised of low understanding of signs and symptoms, but also difficulty in understanding the health care system (Murray et al., 2013). Low health literacy is a stronger contributing factor to health outcomes than age, ethnicity, and socioeconomic status (Adekeye et al., 2014). Low health literacy is also associated with poor management of chronic diseases, such as diabetes (Wieland et al., 2012). Many African immigrant participants perceive the U.S. healthcare system as complex. With providers lacking cultural competency, rushed appointments, and excessive information provided at every visit, African immigrants found great difficulty in navigating the system. Therefore, low health literacy poses a barrier to African immigrants seeking necessary care (Adekeye et al., 2014).

Challenges with cross-cultural interactions often result in avoiding or delaying care. Upon recognition of an accent or cultural dress, many African immigrant participants perceived a change in treatment from healthcare professionals (Adekeye et al., 2014). Visible frustration resulting from communication barriers can be discouraging to African immigrants (Carroll et al., 2007). On the other hand, positive nonverbal communication by clinicians can enable patients to speak comfortably and raise questions or concerns. This can provide great benefit to African immigrants with low health literacy. Regardless of competency in the English language, the medical language, or “medicalese” used by doctors is difficult to interpret and poses great concern for cross-cultural interactions (Murray et al., 2013).

Low health literacy has been continually cited as a structural barrier for African immigrants to understand the US healthcare system and access services (Wafula & Snipes, 2014; Zanchetta & Poureslami, 2006; Murray et al., 2013). The services provided by healthcare organizations fail to consider cultural differences among populations being served (Wafula & Snipes, 2014).

Additionally, health communication materials must cater appropriately to diverse populations, including African immigrants. Health education messages require thoughtful planning before dissemination. These messages must also be pre-screened to ensure cultural sensitivity and receptivity by the intended audience. The channels utilized to reach immigrant populations must be evaluated, as well as the health literacy needs of these populations (Kreps & Sparks, 2008).

Carroll et al. (2007) employed a word recognition method to evaluate knowledge of certain health services. Participants were tested for recognition of terms, such as “pap test” and

“mammography.” Some did not recognize the terms, and few understood the meaning of the procedures. Low health literacy and difficulty translating the terms to the native language of participants contributed to poor word recognition (Carroll et al., 2007). However, higher word recognition is associated with utilization of services. For example, African immigrants with higher dental word recognition were more likely to have attended a preventative dental care appointment. Health literacy was noted as a contributing factor to the acculturation impacting utilization of services (Geltman et al., 2014).

African immigrants proposed the use of community structures to improve their health literacy. Those with poor health literacy may have great healthcare needs but the least ability to navigate the complex healthcare system (Murray et al., 2013). A health education program led by a same-ethnicity facilitator would enhance health literacy, strengthen community ties, and improve access to health services (Carroll et al., 2007). The need for health education programming is evident and can make positive contributions to health literacy levels while addressing chronic disease concerns among this population (Murray et al., 2013).

### ***The Impact of Religion on Health Outcomes***

The reference to the diversity among African immigrants warrants a discussion on the diversity in religious beliefs. African immigrants may practice Christianity, Islam, or indigenous religions. Results from a study by Vaughn & Holloway (2010) indicate that Muslim participants regard their religion as fundamental to their values and ethnic identity. Moreover, their religious beliefs greatly influenced their decisions related to accessing care (Vaughn & Holloway, 2010). Pavlish

et al. (2010) noted similar findings among Muslim participants; Islamic faith contributed to decisions regarding health care.

Muslim, African immigrants have expressed less access to religious structures. Due to distrust, some African immigrants may be hesitant to access typical medical and social services and may seek religious structures for additional support. Religious communities may provide guidance in accessing necessary services and navigating the complex health system. (Simbiri et al., 2010).

Muslim African immigrants also report greater difficulty in accessing religiously acceptable food. Halal products may not be readily available, which can pose greater obstacles to obtaining acceptable food items (Jacobus & Jalali, 2011).

Physical activity participation is another consideration for Muslim African immigrants, specifically women. Female Somali participants reported that being Muslim did not pose a barrier to attending physical activity events. However, the lack of appropriate facilities may present an obstacle to participation (Gele & Mbalilaki, 2013). Thul & LaVoi (2011) report similar findings among East African immigrant adolescent females, whom are also Muslim. The need to maintain privacy and modesty were noted as perceived barriers to participating in certain forms of physical activity, such as swimming. The need for female-only physical activity programs was a potential alternative to consider. Female-only spaces would also allow the participants to maintain necessary privacy. Many participants expressed willingness to engage in activities, like swimming, if such spaces are provided (Thul & LaVoi, 2011).

In addition to social support, dietary habits, and physical activity-religion influences health behaviors, such as alcohol consumption among African immigrants. Tshiswaka et al. (2017) noted the impact of religion on the decision for African immigrants to consume alcohol. In fact, religion was found to have the strongest influence on the health behavior decisions of participants (Tshiswaka et al., 2017). The influence of religion is echoed in several studies and with various forms of health behavior, such as avoiding tobacco or using traditional health remedies (Carroll et al., 2007). Thus, religious influence functions as another consideration for African immigrant health promotion, due to the diversity among their religious beliefs.

## **Limitations**

### ***Overreliance on Self-Reports***

One major limitation of most published findings was the overreliance on self-reports. The use of self-report techniques was abundant throughout articles (Okafor, Carter-Pokras, & Zhan, 2014). Self-reports are highly utilized in the fields of psychology and social science. However, self-reports can be highly swayed by the wording, format, or context of the question (Schwarz, 1999). Okafor et al. (2013) relied primarily on self-rated health of participants. Self-rated health was measured through use of one Likert scale question. Options ranged from “excellent” to “poor.” The use of self-report rating scales requires the respondent to determine the researchers’ definition of the rating (Schwarz, 1999). The format of the question may result in distinct interpretations, impacting results of the study (Schwarz, 1999).

The results of the study by O’Connor et al. (2014) demonstrate that the exclusive use of self-reported health may not produce an accurate representation of true health status. In addition to

the self-reporting employed in their study, biometric indicators, such as body mass index, waist circumference, and glucose concentrations were also collected (O' Connor et al., 2014). African immigrants may have more positive perceptions of their health, but additional indicators may be necessary to provide comprehensive insight. Self-reported health can be influenced by cultural beliefs. It functions as a measure of an individual's perception about their health, not an actual indicator of health status (O' Connor et al., 2014). Self-reports on weight and height often lead to an underestimation of weight and an overestimation of height (Gele & Mbalilaki, 2013). As a result, Gele and Mbalilaki (2013) collected measurements from participants during the screening process in order to garner accurate measurements for body mass index and waist circumference.

Furthermore, researchers posit that many studies on African immigrants determine health status through self-report (O' Connor et al., 2014). Another study by Read, Emerson, and Tarlov (2005) employed self-rating to assess health, with the use of a similar Likert scale to Okafor et al. Although Read et al. (2005) use a self-report format to measure overall health status, they also collect objective measures of health, including activity limitations. The researchers acknowledge the limitations of relying on self-rated health, which can be sensitive to cultural variation (Read et al., 2005).

A study on Vitamin D insufficiency among East African women asked respondents to provide subjective reports of joint pain, muscle weakness, and other symptoms of Vitamin D deficiency. However, objective indicators typically produce accurate results. In addition to these indicators, specimens were collected from participants to measure deficits in vitamin D (Reed et al., 2007). The combination of self-reported symptoms and biometric indicators of vitamin D levels enabled

researchers to gain a comprehensive understanding of participants' health status.

A potential solution to the overreliance on self-reports is the use of interviews. Foley (2005), as well as Ndirangu & Evans (2009) conducted interviews to collect perceptions among African immigrant women living with HIV. Interviews were also utilized to understand African immigrant women experiences with interpersonal violence (Ogunsiji et al., 2012; Ting, 2010). The sensitivity of such topics may favor the use of one-on-one interviews rather than group interviews or focus groups. Interviews also enable African immigrant participants to provide vivid narratives of their experiences (Vaughn & Holloway, 2010).

Studies have demonstrated that a difference in ethnicity between the interviewer and respondent can impact the responses provided (Weeks & Moore, 1981). Thus, an interview conducted with a white researcher from the US may not produce effective and authentic interactions. One study allowed a white female researcher from the US to facilitate interviews. Although the researcher had traveled, lived, and worked extensively throughout Africa, the lack of similar ethnicity may have influenced responses (Shandy & Power, 2008). Ilunga Tshiswaka et al. (2017) facilitated interviews with Congolese immigrants conducted by Congolese researchers. Interviews with researchers of the same ethnicity can provide benefit and can potentially resolve the challenges associated with self-reports.

### *Consideration for the Diversity of Africa*

Another limitation is the lack of diversification among African immigrants included in research. When studying African immigrant experiences, there may be concern regarding the

representation of the diversity within Africa. Africa is a continent comprised of 54 distinct countries with thousands of ethnicities and languages. It is nearly impossible to produce a generalizable study for all African immigrants. However, studies should strive to diversify their participation to ensure as many regions of Africa are represented.

Some studies focus on the experiences of immigrants from a specific country (Vaughn & Holloway, 2010; Pavlish et al., 2010; Wieland, Morrison, Cha, Rahman, & Chaudhry, 2012; Ilunga Tshiswaka, Ibe-Lamberts, Mulunda, & Iwelunmor, 2017; Ibe-Lamberts, Tshiswaka, Onyenekwu, Schwingel, & Iwelunmor, 2017). Moreover, many studies chose to focus on one region, such as East Africans or West Africans (McGillivray et al., 2007; Reed et al., 2007; Thul & LaVoi, 2011; Ogunsiji, Wilkes, Jackson, & Peters, 2012; Delisle, Vioque, & Gil, 2009; Hadley, Zodiates, & Sellen, 2007; Tshiswaka, D. I., Ibe-Lamberts, K., & Osideko,). Despite the effort to specify a particular region, diversity can still be neglected. For example, studies that indicate West African immigrants as the population of interest may collect data solely from Nigerian or Ghanaian immigrants. Furthermore, studies focusing on East Africans may garner information primarily from Somalis or Ethiopians. As the diversity of the black population in the United States is gradually being recognized, the diversity of the African immigrant population must also be acknowledged.

Some studies strived to produce representative samples of African immigrants. Murray, Mohamed, & Ndunduyenge (2013) conducted a study focused on East Africans and represented a variety of countries comprising East Africa. O'Connor et al. (2014) details a well-rounded approach to participation through study methods. According to demographics listed, 49% of

participants represented the Western region of Africa, 30% Central Africa, and 21% Eastern Africa. Although, specific countries of origin are not indicated, the study still demonstrates an effort to evaluate the health indicators from differing regions of the continent (O'Connor et al., 2014).

### ***Additional Limitations***

Other limitations include the lack of thorough evaluation of study methodology within each paper. The methods utilized across papers varied significantly and may have impacted the quality of results garnered. Another potential drawback is the variety in study settings. Studies were conducted in various countries. Although this produces a diverse range of experiences from African immigrants, it may neglect the different social dynamics encompassing each host country. Finally, some studies considered the general black immigrant population, rather than specifically focusing on African immigrants. Conclusions based on the general black immigrant population fail to consider distinctions due to ethnicity. Thus, these study findings may not solely apply to African immigrants and not fully account for the African immigrant experience.

### **Discussion and Future Recommendations**

This review has detailed significant findings related to the importance of the African immigrant experience and its' impact on health outcomes. From the results, many recommendations can be implemented to improve the health outcomes for African immigrants. Several studies have cited the value of cultural competence training among health professionals. Cultural competence training should ensure the African immigrant experience is included. The diversity of the black population must be highlighted; thus, cultural competence efforts must be cognizant of the

intricacies and unique dynamics of the black population.

Furthermore, demographic variables must distinguish the black population when collecting health data and information. The category, “Black/African American,” groups African immigrants, Afro-Caribbeans, and African-Americans in a conglomerate. These subgroups have special health considerations and needs; their unique experiences must be acknowledged. Thus, in addition to collecting information about race, efforts should be made to collect information about ethnicity. The ethnicity of the patient or population being served will provide further information regarding dietary intake, potential barriers to physical activity, and health literacy needs. The intake of additional demographic information will aid in promoting positive health outcomes.

As we move forward, there must be additional efforts to engage African immigrants in research. Participation from this target population can result in data collection and further analysis to support African immigrants in achieving healthy behaviors and outcomes. However, there are obstacles to overcome when attempting to engage African immigrants. Reports indicate that African immigrants are more likely to engage in research involving partnerships with their community (Commodore-Mensah et al, 2015). The use of community partnerships will foster mutual goal setting and guide the development of appropriate clinical guidelines and protocols (Johnson, Ali, & Shipp, 2009). Another means of encouraging participation is for the research to benefit Africans in the U.S. and in Africa. The cultural ties maintained by several African immigrants may contribute to these efforts to share resources and facilitate improvements in their homelands. Lastly, confidentiality was reported as another benefit to encourage participation.

Researchers must ensure confidentiality to African immigrants, especially when conducting research regarding sensitive health information (Commodore-Mensah et al, 2015).

Studies being conducted by a same ethnicity researcher may also encourage participation among African immigrants (Pavlish et al., 2010; Ilunga Tshiswaka et al., 2017). Furthermore, engaging the target population in the creation of research tools and methods can provide great benefit (Delisle et al., 2009). Pilot studies that use methods, like interviews, focus groups, and workshops can engage the target population and allow researchers to make necessary adjustments before full-scale implementation (Renzaho, Halliday, Mellor, & Green, 2015). Several studies cited a need for additional research. Therefore, these considerations can guide future research and effectively address the pressing health needs of African immigrants.

Finally, undocumented African immigrants may be excluded from research studies due to participant eligibility. Some recruitment methods only target African immigrants with lawful permanent residency or citizenship. Thus, undocumented immigrants may be excluded from research (Okafor et al., 2013). While many studies do not directly exclude undocumented immigrants, the criteria for participation indicates this vulnerable population is being overlooked. Health providers have expressed difficulty in providing care for undocumented immigrants. Thus, an undocumented status can further complicate the ability to access necessary services (Foley et al, 2015). Furthermore, undocumented immigrants are typically not eligible for legislative assistance programs and may be more likely to be uninsured (Commodore-Mensah, 2015). As we move forward, it is vital to ensure that African immigrants, regardless of

residential status, are included in research studies and considered when aiming to improve access to care.

### **Conclusion**

The African Immigrant experience is complex. The process of acculturation requires great effort, time, and adjustment (Kamya, 1997). Unfortunately, health may not be the top priority of African immigrants who face significant adjustments to a new environment. Thus, several factors must be considered when striving to serve the health needs of African immigrants. Dietary patterns and the protective aspects of traditional diets present a new lens for the concept of dietary acculturation. The cultural relevance of physical activity is evaluated before African immigrants choose to engage in the activity. Finally, health literacy needs of African immigrants are multidimensional and require appropriate health communication and respect from providers. Additional cultural considerations, like language gaps and religious diversity must also be included while striving to improve the health outcomes of African immigrants. Furthermore, undocumented immigrants, refugees, and recent immigrants should receive additional support services (Harcourt et al., 2014; Hadley et al., 2007). The stressors associated with acculturation may be especially strained among these groups. We cannot neglect these experiences and we must ensure that health promotion is appropriately targeting all populations.

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